STANDARD GRANT TERMS AND CONDITIONS FOR SERVICES

1. TERM OF GRANT

The term of the Grant shall commence on the Effective Date (as defined below) and shall end on the Expiration Date identified in the Grant, subject to the other provisions of the Grant. The Effective Date shall be fixed by the Granting Officer after the Grant has been fully executed by the Grantee and by the Commonwealth and all approvals required by Commonwealth Granting procedures have been obtained. The Grant shall not be a legally binding Grant until after the Effective Date is affixed and the fully-executed Grant has been sent to the Grantee. The Granting Officer shall issue a written Notice to Proceed to the Grantee directing the Grantee to start performance on a date which is on or after the Effective Date. The Grantee shall not start the performance of any work prior to the date set forth in the Notice to Proceed and the Commonwealth shall not be liable to pay the Grantee for any service or work performed or expenses incurred before the date set forth in the Notice to Proceed. No agency employee has the authority to verbally direct the commencement of any work under this Grant. The Commonwealth reserves the right, upon notice to the Grantee, to extend the term of the Grant for up to three (3) months upon the same terms and conditions. This will be utilized to prevent a lapse in Grant coverage and only for the time necessary, up to three (3) months, to enter into a new Grant.

2. INDEPENDENT GRANTEE

In performing the services required by the Grant, the Grantee will act as an independent Grantee ahd not as an employee or agent of the Commonwealth.

3. COMPLIANCE WITH LAW

The Grantee shall comply with all applicable federal and state laws and regulations and local ordinances in the performance of the Grant.

4. ENVIRONMENTAL PROVISIONS

In the performance of the Grant, the Grantee shall minimize pollution and shall strictly comply with all applicable environmental laws and regulations.

5. POST-CONSUMER RECYCLED CONTENT

Except as specifically waived by the Department of General Services in writing, any products which are provided to the Commonwealth as a part of the performance of the Grant must meet the minimum percentage levels for total recycled content as specified in Exhibits A-I through A-8 to these Standard Grant Terms and Conditions.

6. COMPENSATION/EXPENSES

The Grantee shall be required to perform the specified services at the price(s) quoted in the Grant. All services shall be performed within the time period(s) specified in the Grant. The Grantee shall be compensated only for work performed to the satisfaction of the Commonwealth. The Grantee shall not be allowed or paid travel or per diem expenses except as specifically set forth in the Grant.

7. INVOICES

Unless the Grantee has been authorized by the Commonwealth for Evaluated Receipt Settlement or Vendor Self-Invoicing, the Grantee shall send an *invoice itemized bv line item* to the address referenced on the grant promptly after services are satisfactorily completed. The invoice should include only amounts due under the Grant agreement. The grant number must be included on all invoices. In addition, the Commonwealth shall have the right to require the Grantee to prepare and submit a "Work In Progress" sheet that contains, at a minimum, the tasks performed, number of hours, hourly rate, and the Grant number or task order to which it refers.

B. PAYMENT

a. The Commonwealth shall put forth reasonable efforts to make payment by the required payment date. The required payment date is: (a) the date on which payment is due under the terms of the Grant; (b) thirty (30) days after a proper invoice actually is received at the "Provide Service and Bill To" address if a date on which payment is due is not specified in the Grant (a "proper" invoice is not received until the Commonwealth

accepts the service as satisfactorily performed); or (c) the payment date specified on the invoice if later than the dates established by (a) and (b) above. Payment may be delayed if the payment amount on an invoice is not based upon the price(s) as stated in the Grant. If any payment is not made within fifteen (15) days after the required payment date, the Commonwealth may pay interest as determined by the Secretary of Budget in accordance with Act No. 266 of 1982 and regulations promulgated pursuant thereto. Payment should not be construed by the Grantee as acceptance of the service performed by the Grantee. The Commonwealth reserves the right to conduct further testing and inspection after payment, but within a reasonable time after performance, and to reject the service if such post payment testing or inspection discloses a defect or a failure to meet specifications. The Grantee agrees that the Commonwealth may set off the amount of any state tax liability or other obligation of the Grantee or its subsidiaries to the Commonwealth against any payments due the Grantee under any Grant with the Commonwealth.

b. The Commonwealth shall have the option of using the Commonwealth purchasing card to make purchases under the Grant or purchase order. The Commonwealth's purchasing card is similar to a credit card in that there will be a small fee which the Grantee will be required to pay and the Grantee will receive payment directly from the card issuer rather than the Commonwealth. Any and all fees related to this type of payment are the responsibility of the Grantee. In no case will the Commonwealth allow increases in prices to offset credit card fees paid by the Grantee or any other charges incurred by the Grantee, unless specifically stated in the terms of the Grant or purchase order.

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 Grantee 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 Grant.

10. WARRANTY

The Grantee warrants that all services performed by the Grantee, its agents and subGrantees shall be free and clear of any defects in workmanship or materials. Unless otherwise stated in the Grant, all services and parts are warranted for a period of one year following completion of performance by the Grantee and acceptance by the Commonwealth. The Grantee shall correct any problem with the service and/or replace any defective part with a part of equivalent or superior quality without any additional cost to the Commonwealth.

11. PATENT, COPYRIGHT, AND TRADEMARK INDEMNITY

The Grantee warrants that it is the sole owner or author of, or has entered into a suitable legal agreement concerning either: a) the design of any product or process provided or used in the performance of the Grant 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 under the Grant. The Grantee 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 Grant. This is upon condition that the Cornmonwealth 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 Grantee's written request, it shall be at the Grantee's expense, but the responsibility for such expense shall be only that within the Grantee's written authorization. The Grantee shall indemnify and hold the Commonwealth harmless from all damages, costs, and expenses, including attorney's fees that the Grantee or the Commonwealth may pay or incur by reason of any infringe1nent 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 Grant. If any of the products provided by the Grantee in such suit or proceeding are held to constitute infringement and the use is enjoined, the Grantee shall, at its own expense and at its option, either procure the right to continue use of such infringement products, replace them with non-infringement equal

performance products or modify them so that they are no longer infringing. If the Grantee is unable to do any of the preceding, the Grantee agrees to 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 Grantee under this paragraph continue without time limit. No costs or expenses shall be incurred for the account of the Grantee without its written consent.

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 Grant.

13. ASSIGNMENT OF ANTITRUST CLAIMS

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

14. HOLD HARMLESS PROVISION

The Grantee 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 Grantee and its employees and agents under this Grant 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

The Commonwealth shall have the right, at reasonable times and at a site designated by the Commonwealth, to audit the books, documents and records of the Grantee to the extent that the books, documents and records relate to costs or pricing data for the Grant. The Grantee agrees to maintain records which will support the prices charged and costs incurred for the Grant. The Grantee shall preserve books, documents, and records that relate to costs or pricing data for the Grant for a period of three (3) years from date of final payment. The Grantee shall give full and free access to all records to the Commonwealth and/or their 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 Grant, declare the Grantee in default by written notice thereof to the Grantee, and terminate (as provided in Paragraph 18, Termination Provisions) the whole or any part of this Grant for any of the following reasons:

1) Failure to begin work within the time specified in the Grant or as otherwise specified;
2) Failure to perform the work with sufficient labor, equipment, or material to insure the completion of the" specified work in accordance with the Grant terms;
3) Unsatisfactory performance of the work;
4) Failure or refusal to remove material, or remove and replace any work rejected as defective or unsatisfactory;
5) Discontinuance of work without approval;
6) Failure to resume work, which has been discontinued, within a reasonable time after notice to do so;
7) Insolvency or bankruptcy;
8) Assignment made for the benefit of creditors;
9) Failure or refusal within 10 days after written notice by the Granting Officer, 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;
10) Failure to protect, to repair, or to make good any damage or injury to property; or
11) Breach of any provision of this Grant.

b. In the event that the Commonwealth terminates this Grant in whole or in part as provided in Subparagraph a. above, the Commonwealth may procure, upon such terms and in such manner as it determines, services similar or identical to those so terminated,

and the Grantee shall be liable to the Commonwealth for any reasonable excess costs for such similar or identical services included within the terminated part of the Grant.

c. If the Grant js terminated as provided in Subparagraph a. above, the Commonwealth, in addition to any other rights provided in this paragraph, may require the Grantee to transfer title and deliver immediately to the Commonwealth in the manner and to the extent directed by the Issuing Office, such partially completed work, including, where applicable, reports, working papers and other documentation, as the Grantee has specifically produced or speclflcally acquired for the performance of such part of the Grant as has been terminated. Except as provided below, payment for completed work accepted by the Commonwealth shall be at the Grant price. Except as provided below, payment for partially completed work including, where applicable, reports and working papers, delivered to and accepted by the Commonwealth shall be in an amount agreed upon by the Grantee and Granting Officer. The Commonwealth may withhold from amounts otherwise due the Grantee for such completed or partially completed works, such sum as the Granting Officer determines to be necessary to protect the Commonwealth against loss.

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

e. The Commonwealth's failure to exercise any rights or remedies provided in this paragraph shall not be construed to be a waiver by the Commonwealth of its rights and remedies in regard to the event of default or any succeeding event of default.

f. Following exhaustion of the Grantee's administrative remedies as set forth in Paragraph 19, the Grantee's exclusive remedy shall be to seek damages in the Board of Claims.

17. FORCE MAJEURE

Neither party will incur any liability to the other if Its performance of any obligation under this Grant 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 Grantee shall notify the Commonwealth orally within five (5) days and in writing within ten (10) days of the date on which the Grantee becomes aware, or should have reasonably become aware, that such cause would prevent or delay its performance. Such notification shall (i) describe fully such cause(s) and its effect on performance, (ii) state whether performance under the Grant is prevented or delayed and (iii) if performance is delayed, state a reasonable estimate of the duration of the delay. The Grantee shall have the burden of proving that such cause(s) delayed or prevented its performance despite its diligent efforts to perform and shalt produce such supporting documentation as the Commonwealth may reasonably request. After receipt of such notification, the Commonwealth may elect either to cancel the Grant or to extend the time for performance as reasonably necessary to compensate for the Grantee's delay.

In the event of a declared emergency by competent governmental authorities, the Commonwealth by notice to the Grantee, may suspend all or a portion of the Grant.

18. TERMINATION PROVISIONS

The Commonwealth has the right to terminate this Grant for any of the following reasons. Termination shall be effective upon written notice to the Grantee.

a. TERMINATION FOR CONVENIENCE: The Commonwealth shall have the right to terminate the Grant for its convenience if the Commonwealth determines termination to be in its best interest. The Grantee shall be paid for work satisfactorily completed prior to the effective date of the termination, but in no event shall the Grantee be entitled to recover loss of profits.

b. NON-APPROPRIATION: The Commonwealth's obligation to make payments during any Commonwealth fiscal year succeeding the current fiscal year shall be subject to

availability and appropriation of funds. When funds (state 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 Grant. The Grantee 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 Grant. 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

c. TERMINATION FOR CAUSE: The Commonwealth shall have the right to terminate the Grant for Grantee default under Paragraph 16, Default, upon written notice to theGrantee. The Commonwealth shall also have the right, upon written notice to the Grantee, to terminate the Grant for other cause as specified In this Grant or by !aw. If it is later determined that the Commonwealth erred in terminating the Grant for cause, then, at the Commonwealth's discretion, the Grant shall be deemed to have been terminated for convenience under the Subparagraph 18.a.

19. GRANT CONTROVERSIES

a. In the event of a controversy or claim arising from the Grant, the Grantee must, within six months after the cause of action accrues, file a written claim with the Granting officer for a determination. The claim shall state all grounds upon which the Grantee asserts a controversy exists. If the Grantee fails to file a clairn or files an untimely claim, the Grantee is deemed to have waived its right to assert a claim in any forum.

b. The Granting officer shall review timely-filed claims and issue a final determination, in writing, regarding the claim. The final determination shall be issued within 120 days of the receipt of the claim, unless extended by consent of the Granting officer and the Grantee. The Granting officer shall send his/her written determination to the Grantee. If the Granting officer fails to issue a final determination within the 120 days (unless extended by consent of the parties), the claim shall be deemed denied. The Granting officer's determination shall be the final order of the purchasing agency.

c. Within fifteen (15) days of the mailing date of the determination denying a claim or within 135 days of filing a claim if, no extension is agreed to by the parties, whichever occurs first, the Grantee may file a statement of claim with the Commonwealth Board of Claims. Pending a final judicial resolution of a controversy or claim, the Grantee shall proceed diligently with the performance of the Grant in a manner consistent with the determination of the Granting officer and the Commonwealth shall compensate the Grantee pursuant to the terms of th€ Grant.

20. **ASSIGNABILITY AND SUBGRANTING**

a. Subject to the terms and conditions of this Paragraph 20, this Grant shall be binding upon the parties and their respective successors and assigns.

b. The Grantee shall not subGrant with any person or entity to perform all or any part of the work to be performed under this Grant without the prior written consent of the Granting Officer, which consent may be withheld at the sole and absolute discretion of the Granting Officer.

c. The Grantee may not assign, in whole or in part, this Grant or its rights, duties, obligations, or responsibilities hereunder without the prior written consent of the Granting Officer, which consent may be withheld at the sole and absolute discretion of the Granting Officer.

d. Notwithstanding the foregoing, the Grantee may, without the consent of the Granting Officer, assign its rights to payment to be received under the Grant, provided that the Grantee provides written notice of such assignment to the Granting Officer together with a written acknowledgement from the assignee that any such payments are subject to all of the terms and conditions of this Grant.

e. For the purposes of this Grant, the term "assign" shall include, but shall not be limited to, the sale, gift, assignment, pledge, or other transfer of any ownership interest in the

Grantee 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 Granting Officer shall be evidenced by a written assignment agreement executed by the Grantee and its assignee in which the assignee

agrees to be legally bound by all of the terms and conditions of the Grant and to assume the duties, obligations, and responsibilities being assigned.

g. A change of name by the Grantee, following which the Grantee's federal identification number remains unchanged, shall not be considered to be an assignment hereunder. The Grantee shall give the Granting Officer written notice of any such change of name.

21. **NONDISCRIMINATION/SEXUAL HARASSMENT** CLAUSE

During the term of the Grant, the Grantee 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 grant agreement or any subgrant agreement, contract, or subcontract, the Grantee, a subgrantee, a contractor, a subcontractor, or any person acting on behalf of the Grantee shall not discriminate in violation of the Pennsylvania Human Relations Act (PHRA) and applicable federal laws against any dizen of this Commonwealth who is qualified and available to perform the work to which the employment relates.

b. The Grantee, 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 Grantee, any subgrantee, contractor or any subcontractor shall establish and maintain a written nondiscrimination and sexual harassment policy and shall infoITTl 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 Grantee, 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 grant relates.

e. The Grantee and each subgrantee, contractor and subcontractor represents that rt is presently in co1npliance with and will maintain compliance with all applicable federal, state, and local laws and regulations relating to nondiscrimination and sexual harassment. The Grantee and each subgrantee, contractor and subcontractor further represents that it has filed a Standard Form 1OD Employer Information Report ("EE0-1") with the U.S. Equal Employment Opportunity Commission ("EEOC") and shall file an annual EE0-1 report with the EEOC as required for employers subject to Title VII of the Civil Rights Act of 1964, as amended, that have 100 or more employees and employers that have federal government contracts or first-tier subcontracts and have 50 or more employees. The Grantee, 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 EE0-1 reports, and peITTlit 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 Grantee, any subgrantee, contractor or any subcontractor shall include the provisions of this Nondiscrimination/Sexual Harassment Clause in every subgrant agreement, contract or subcontract so that those provisions applicable to subgrantees, contractors or subcontractors will be binding upon each subgrantee, contractor or subcontractor.

g. The Granter's and each subgrantee's, contractor's and subcontractor's obligations pursuant to these provisions are ongoing rrom and after the effective date of the grant agreement through the termination date thereof. Accordingly, the Grantee and each subgrantee, contractor and subcontractor shall have an obligation to inform the Commonwealth if, at any time during the term of the grant agreement, it becomes aware of any actions or occurrences that would result in violation of these provisions.

h. The Comrnonwealth may cancel or terminate the grant agreement and all money due or to become due under the grant agreement may be forfeited for a violation of the terms and conditions of this Nondiscrimination/Sexual Harassment Clause. In addition, the granting agency may proceed with debarment or suspension and may place the Grantee, subgrantee, contractor, or subcontractor inthe Contractor Responsibility File.

22. CONTRACTOR INTEGRITY PROVISIONS

It is essential that those who seek to contract with the Commonwec:ilth of Pennsylvania ("Commonwealth") observe high standards of honesty and integrity. They must conduct themselves in a manner that fosters public confidence in the integrity of the Com1nonwealth contracting and procurement process.

1. DEFINITIONS. For purposes of these Contractor Integrity Provisions, the following terms shall have the meanings found in this Section:

a. [11]**Affiliate"** means two or more eritities 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 prequahfication, 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 contract 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. iiFinancial 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 Q_ondui;;J,_ Executive Order 1980-18,* the *4* Pa. *Code §7.153(b),* shall apply.

g. uNon-bid Basis" means a contract 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 contract 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 contracting or 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 Contractor Integrity Provisions conspicuously in easily-accessible and well-lighted places customarily frequented by employees and at or near where the contract 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 contract, except as provided in this contract.

d. Contractor shall not have a financial interest in any other contractor, subcontractor, or supplier providing services, labor, or material under this contract, 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 contract. Contractor shall disclose the financial interest to the Commonwealth at the time of bid or proposal submission, or if no bids or proposals are solicited, no later than Contractor's submission of the contract 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 contract a written explanation of why such certification cannot be made and the Commonwealth will determine whether a contract 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 contract 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 contract 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 contract for cause if it learns that any of the certifications made herein are currently false due to intervening factual circurnstances or were false or should have been known to be false when entering into the contract.

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 contract 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 Contractor 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 Commonwealth contracting officer or the Office of the State Inspector General in writing.

g. Contractor, by submission of its bid or proposal and/or execution of this contract and by the submission of any bills, invoices or requests for payment pursuant to the contract, certifies and represents that it has not violated any of these Contractor Integrity Provisions in connection with the submission of the bid or proposal, during any contract negotiations or during the term of the contract, 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 Contractor 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 Contractor 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 contract/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 Contractor Integrity Provisions, the Commonwealth may terminate this and any other contract with Contractor, claim liquidated damages in an amount equal to the value of anything received in breach of these Provisions, claim damages for al! additional costs and expenses incurred in obtaining another contractor to complete performance under this contract, 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. GRANTEE RESPONSIBILITY PROVISIONS

a. The Grantee certifies, for itself and all its sub Grantees, that as of the date of its execution of this Bid/Grant, that neither the Grantee, nor any subGrantees, nor any suppliers are under suspension or debarment by the Commonwealth or any governmental entity, instrumentality, or authority and, if the Grantee cannot so certify, then it agrees to submit, along with its Bid, a written explanation of why such certification cannot be made.

b. The Grantee also certifies, that as of the date of its execution of this Bid/Grant, it has no tax liabilities or other Commonwealth obligations.

c. The Grantee's obligations pursuant to these provisions are ongoing from and after the effective date of the Grant through the termination date thereof. Accordingly, the Grantee shall have an obligation to inform the Commonwealth if, at any time during the term of the Grant, it becomes delinquent in the payment of taxes, or other Commonwealth obligations, or if it or any of its subGrantees are suspended or debarred by the Commonwealth, the federal government, or any other state or governmental entity. Such notification shall be made within 15 days of the date of suspension or debarment.

d. The failure of the Grantee to notify the Commonwealth of its suspension or debarment by the Commonwealth, any other state, or the federal government shall constitute an event of default of the Grant with the Commonwealth.

e. The Grantee agrees to reimburse the Commonwealth for the reasonable costs of investigation incurred by the Office of State Inspector General for Investigations of the Grantee's compliance with the terms of this or any other agreement between the Grantee and the Commonwealth, which results in the suspension or debarment of the Grantee. Such costs shall include, but shall not be limited to, salaries of investigators, including overtime; travel and lodging expenses; and expert witness and documentary fees. The Grantee shall not be responsible for investigative costs for investigations that do not result in the Grantee's suspension or debarment.

f. The Grantee may obtain a current list of suspended and debarred Commonwealth Grantees by either searching the internet at htfp://www.dgs.state. pa.us or contacting the:

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

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 Grantee understands and agrees that it shall not cause any individual with a disability to be excluded from participation in this Grant or from activities provided for under this Grant on the basis of the disability. As a condition of accepting this Grant, the Grantee agrees to comply with .the "General Prohibitions Against Discrimination," 28 C.F.R. § 35.130, and all other regulations promulgated under Title II of The Americans With Disabilities Act which are applicable to all benefits, services, programs, and activities provided by the Cornmonwealth of Pennsylvania through Grants with outside Grantees.

b. The Grantee 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 Grantee's failure to comply with the provisions of subparagraph a above.

25. HAZARDOUS SUBSTANCES

The Grantee shall provide information to the Commonwealth about the identity and hazards of hazardous substances supplied or used by the Grantee in the performance of the Grant. The Grantee must comply with Act 159 of October 5, 1984, known as the 'Worker and Community Right to Know Act" (the "Act") and the regulations promulgated pursuant thereto at 4 Pa. Code Section 301.1 et seq.

a. Labeling. The Grantee shall insure that each individual product (as well as the carton, container or package in which the product is shipped) of any of the following substances (as defined by the Act and the regulations) supplied by the Grantee is clearly labeled, tagged or marked with the information listed in Paragraph (1) through (4):

1) Hazardous substances:

a) The chemical name or common name,

b) A hazard warning, and

c) The name, address, and telephone number of the manufacturer.

2) Hazardous mixtures:

a) The common name, but if none exists, then the trade name,

b) The chemical or common name of special hazardous substances comprising .01 o/o or more of the mixture,

c) The chemical or common name of hazardous substances consisting 1.0% or more of the mixture,

d) A hazard warning, and

e) The name, address, and telephone number of the manufacturer.

3) Single chemicals:

a) The chemical name or the common name,A hazard warning, if appropriate, and

b) The name, address, and telephone number of the manufacturer.

4) Chemical Mixtures:

a) The common name, but if none exists, then the trade name,

b) A hazard warning, if appropriate,

c) The name, address, and telephone number of the manufacturer, and

d) The chemical name or common name of either the top five substances by volume or those substances consisting of 5.0o*b* or rnore of the mixture.

A common name or trade name may be used only if the use of the name more easily or readily identifies the true nature of the hazardous substance, hazardous mixture, single chemical, or mixture involved.

Container labels shall provide a warning as to the specific nature of the hazard arising from the substance in the container.

The hazard warning shall be given in conformity with one of the nationally recognized and accepted systems of providing warnings, and hazard warnings shall be consistent with one or more of the recognized systems throughout the workplace. Examples are:

- NFPA 704, Identification of the Fire Hazards of Materials.
- National Paint and Coatings Association: Hazardous Materials Identification System.

American Society for Testing and Materials, Safety Alert Pictorial Chart.

- American National Standard Institute, Inc., for the Precautionary Labeling of Hazardous Industrial Chemicals.

Labels must be legible and prominently affixed to and displayed on the product and the carton, container, or package so that employees can easily identify the substance or mixture present therein.

b. Material Safety Data Sheet. The Grantee shall provide Material Safety Data Sheets (MSDS) with the information required by the Act and the regulations for each hazardous substance or hazardous mixture. The Commonwealth must be provided an appropriate MSOS with the initial shipment and with the first shipment after an MSDS is updated or product changed. For any other chemical, the Grantee shall provide an appropriate MSDS, if the manufacturer, importer, or supplier produces or possesses the MSDS. The Grantee shall also notify the Commonwealth when a substance or mixture is subject to the provisions of the Act. Material Safety Data Sheets may be attached to the carton, container, or package mailed to the Commonwealth at the time of shipment.

26. COVENANT AGAINST CONTINGENT FEES

The Grantee warrants that no person or selling agency has been employed or retained to solicit or secure the Grant 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 Grantee for the purpose of securing business. For breach or violation of this warranty, the Commonwealth shall have the right to terminate the Grant without liability or in its discretion to

deduct from the Grant price or consideration, or otherwise recover the full amount of such commission, percentage, brokerage, or contingent fee.

27. **AP.PLICABLE LAW**

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

28. **INTEGRATION**

The Grant, including all referenced documents, constitutes the entire agreement between the parties. No agent, representative, employee or officer of either the Commonwealth or the Grantee has authority to make, or has made, any statement, agreement or representation, oral or written, in connection with the Grant, which in any way can be

deemed to modify, add to or detract frorn, 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 Grant. No modifications, alterations, changes, or waiver to the Grant or any of its terms shall be valid or binding unless accomplished by a written amendment signed by both parties. All such amendments will be made using the appropriate Commonwealth form.

29. CHANGE ORDERS

The Commonwealth reserves the right to issue change orders at any time during the term of the Grant or any renewals or extensions thereof: 1) to increase or decrease the quantities resulting frorn variations between any estimated quantities in the Grant and actual quantities; 2) to make changes to the services within the scope of the Grant; 3) to notify the Grantee that the Commonwealth is exercising any Grant renewal or extension option; or 4) to modify the time of performance that does not alter the scope of the Grant to extend the completion date beyond the Expiration Date of the Grant or any renewals or extensions thereof. Any such change order shall be in writing signed by the Granting 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 Grant, nor, if performance security is being furnished in conjunction with the Grant, release the security obligation. The Grantee agrees to provide the service in accordance with the change order. Any dispute by the Grantee in regard to the performance required under any change order shall be handled through Paragraph 19, "Grant Controversies".

For purposes of this Grant, "change order" is defined as a written order signed by the Granting Officer directing the Grantee to make changes authorized under this clause.

30. RIGHT TO KNOW LAW 8-K-1580

a. Grantee or Subgrantee understands that this Grant Agreement and records related to or arising out of the Grant 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 granting Commonwealth agency.

b. If the Con1monwealth needs the Grantee's or Subgrantee's assistance in any matter arising out of the RTKL related to this Grant Agreement, it shall notify the Grantee or Subgrantee using the legal contact information provided In the Grant Agreement. The Grantee or Subgrantee, 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 Grantee's or Subgrantee's assistance in responding to a request under the RTKL for information related to this Grant Agreement that may be in Grantee's or Subgrantee's possession, constituting, or alleged to constitute, a public record in accordance with the RTKL ("Requested Information"), Grantee or Subgrantee 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 Grantee's or Subgrantee's possession arising out of this Grant 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 Grant Agreement.

d. Jf Grantee or Subgrantee 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 Grantee or Subgrantee considers exempt from production under the RTKL, Grantee or Subgrantee must notify the Commonwealth and provide, within seven (7) calendar days of receiving the written notification, a written statement signed by a representative of Grantee or Subgrantee explaining why the requested material is exempt from public disclosure under .the RTKL.

e. The Commonwealth will rely upon the written statement from Grantee or Subgrantee 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, Grantee or Subgrantee shall provide the Requested Information within five (5) business days of receipt of written notification of the Commonwealth's determination.

f. If Grantee or Subgrantee fails to provide the Requested Information within the time period required by these provisions, Grantee or Subgrantee shall indemnify and hold the Commonwealth harmless for any damages, penalties, costs, detriment or harm that the Commonwealth may incur as a result of Grantee's or Subgrantee's failure, including any statutory damages assessed against the Commonwealth.

g. The Commonwealth will reimburse Grantee or Subgrantee for any costs associated with cotnp!ying 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. Grantee or Subgrantee 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, Grantee or Subgrantee 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 Grantee's or Subgrantee's failure, including any statutory damages assessed against the Commonwealth, regardless of the outcome of such legal challenge. As between the parties, Grantee or Subgrantee agrees to waive all rights or remedies that may be available to it as a result of the Commonwealth's disclosure of Requested Information pursuant to the RTKL.

i. The Grantee's or Subgrantee's duties relating to the RTKL are continuing duties thcit survive the expiration of this Grant Agreement and shall continue as long as the Grantee or Subgrantee has Requested Information in its possession.

DEPARTMENT OF PUBLIC WELFARE ADDENDUM TO
STANDARD CONTRACT TERMS AND CONDITIONS

A. **APPLICABILITY**

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

B. **CONFIDENTIALITY**

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

C. **INFORMATION**

During the period of this contract, all information obtained by the Contractor through work on the project will be made available to the Department immediately upon demand. If requested, the Contractor shall deliver to the Department background material prepared or obtained by the Contractor incident to the performance of this agreement. Background material is defined as original work, papers, notes and drafts prepared by the Contractor to support the data and conclusions in final reports, and includes completed questionnaires, materials in electronic data processing form, computer programs, other printed materials, pamphlets, maps, drawings and all data directly related to the services being rendered.

D. **CERTIFICATION AND LICENSING**

Contractor agrees to obtain all licenses, certifications and permits from Federal, State and Local authorities permitting it to carry on its activities under this contract.

E. **PROGRAM SERVICES**

Definitions of service, eligibility of recipients of service and other limitations in this contract are subject to modification by amendments to Federal, State and Local laws, regulations and program requirements without further notice to the Contractor hereunder.

F. **CHILD PROTECTIVE SERVICE LAWS**

In the event that the contract calls for services to minors, the contractor shall comply with the provisions of the Child Protective Services Law (Act of November 26, 1975, P.L. 438, No. 124; 23 P.S. SS 6301-6384, as amended by Act of July 1, 1985, P.L. 124, No. 33) and all regulations promulgated thereunder (55Pa. Code, chapter 3490).

G. **PRO-CHILDREN ACT OF 1994**

The Contractor agrees to comply with the requirements of the Pro-Children Act of 1994; Public Law 103-277, Part C-Environment Tobacco Smoke (also known as the Pro-Children Act of 1994) requires that smoking not be permitted in any portion of any indoor facility owned or leased or contracted by an entity and used routinely or regularly for the provision of health care services, day care and education to children under the age of 18, if the services are funded by Federal programs whether directly or through State and Local governments. Federal programs include grants, cooperative agreements, loans or loan guarantees and contracts. The law does not apply to children's services provided in private residences, facilities funded solely by Medicare or Medicaid funds, and portions of facilities used for impatient drug and alcohol treatment.

H. **MEDICARE/MEDICAID REIMBURSEMENT**

1. To the extent that services are furnished by contractors, subcontractors, or organizations related to the contractor/subcontractor and such services may in whole or in part be claimed by the

Commonwealth for Medicare/Medicaid reimbursements, contractor/subcontractor agrees to comply with 42 C.F.R.,Part 420, including:

a. Preservation of books, documents and records until the expiration of four (4) years after the services are furnished under the contract.

b. Full and free access to (i) the Commonwealth, (ii) the U.S. Comptroller General, (iii) the U.S. Department of Health and Human Services, and their authorized representatives.

2. Your signature on the proposal certifies under penalty of law that you have not been suspended/terminated from the Medicare/Medicaid Program and will notify the contracting DPW Facility or DPW Program Office immediately should a suspension/termination occur during the contract period.

I. **TRAVEL AND PER DIEM EXPENSES**

Contractor shall not be allowed or paid travel or per diem expenses except as provided for in Contractor's Budget and included in the contract amount. Any reimbursement to the Contractor for travel, lodging or meals under this contract shall be at or below state rates as provided in Management Directive 230.10, Commonwealth Travel Policy, as may be amended, unless the Contractor has higher rates which have been established by its offices/officials, and published prior to entering into this contract. Higher rates must be supported by a copy of the minutes or other official documents, and submitted to the Department. Documentation in support of travel and per diem expenses will be the same as required of state employees.

J. **INSURANCE**

1. The contractor shall accept full responsibility for the payment of premiums for Workers' Compensation, Unemployment Compensation, Social Security, and all income tax deductions required by law for its employees who are performing services under this contract. As required by law, an independent contractor is responsible for Malpractice Insurance for health care personnel. Contractor shall provide insurance Policy Number and Provider'' Name, or a copy of the policy with all renewals for the entire contract period.

2. The contractor shall, at its expense, procure and maintain during the term of the contract, the following types of insurance, issued by companies acceptable to the Department and authorized to conduct such business under the laws of the Commonwealth of Pennsylvania:

   a. Worker's Compensation Insurance for all of the Contractor's employees and those of any subcontractor, engaged in work at the site of the project as required by law.

   b. Public liability and property damage insurance to protect the Commonwealth, the Contractor, and any and all subcontractors from claim for damages for personal injury (including bodily injury), sickness or disease, accidental death and damage to property, including loss of use resulting from any property damage, which may arise from the activities performed under this contract or the failure to perform under this contract whether such performance or nonperformance be by the contractor, by any subcontractor, or by anyone directly or indirectly employed by either. The limits of such insurance shall be in an amount not less than $500,000 each person and $2,000,000 each occurrence, personal injury and property damage combined. Such policies shall be occurrence rather than claims-made policies and shall name the Commonwealth of Pennsylvania as an additional insured. The insurance shall not contain any endorsements or any other form designated to limit or restrict any action by the Commonwealth, as an additional insured, against the insurance coverage in regard to work performed for the Commonwealth.

Prior to commencement of the work under the contract and during the term of the contract, the Contractor shall provide the Department with current certificates of insurance. These certificates shall contain a provision that the coverages afforded under the policies will not be cancelled or changed until at least thirty (30) days' written notice has been given to the Department.

K. **PROPERTY AND SUPPLIES**

1. Contractor agrees to obtain all supplies and equipment for use in the performance of this contract at the lowest practicable cost and to purchase by means of competitive bidding whenever required by law.

2. Title to all property furnished in-kind by the Department shall remain with the Department.

3. Contractor has title to all personal property acquired by the contractor, including purchase by lease/purchase agreement, for which the contractor is to be reimbursed under this contract. Upon cancellation or termination of this contract, disposition of such purchased personal property which has a remaining useful life shall be made in accordance with the following provisions.

    a. The contractor and the Department may agree to transfer any item of such purchased property to another contractor designated by the Department. Cost of transportation shall be born by the contractor receiving the property and will be reimbursed by the Department. Title to all transferred property shall vest in the designated contractor. The Department will reimburse the Contractor for its share, if any, of the value of the remaining life of the property in the same manner as provided under subclause b of this paragraph.

    b. If the contractor wishes to retain any items of such purchased property, depreciation tables shall be used to ascertain the value of the remaining useful life of the property. The contractor shall reimburse the Department in the amount determined from the tables.

    c. When authorized by the Department in writing, the contractor may sell the property and reimburse the Department for its share. The Department reserves the right to fix the minimum sale price it will accept.

4. All property furnished by the Department or personal property acquired by the contractor, including purchase by lease-purchase contract, for which the contractor is to be reimbursed under this contract shall be deemed "Department Property" for the purposes of subsection 5, 6 and 7 of this section.

5. Contractor shall maintain and administer in accordance with sound business practice a program for the maintenance, repair, protection, preservation and insurance of Department Property so as to assure its full availability and usefulness.

6. Department property shall, unless otherwise approved in writing by the Department, be used only for the performance of this contract.

7. In the event that the contractor is indemnified, reimbursed or otherwise compensated for any loss, destruction or damage to Department Property, it shall use the proceeds to replace, repair or renovate the property involved, or shall credit such proceeds against the cost of the work covered by the contract, or shall reimburse the Department, at the Department's direction.

L. <u>DISASTERS</u>

If, during the terms of this contract, the Commonwealth's premises are so damaged by flood, fire or other Acts of God as to render them unfit for use; then the Agency shall be under no liability or obligation to the contractor hereunder during the period of time there is no need for the services provided by the contractor except to render compensation which the contractor was entitled to under this agreement prior to such damage.

M. <u>SUSPENSION OR DEBARMENT</u>

In the event of suspension or debarment, 4 Pa Code Chapter 60.1 through 60.7, as it may be amended, shall apply.

N. <u>COVENANT AGAINST CONTINGENT FEES</u>

The contractor warrants that no person or selling agency has been employed or retained to solicit or secure this contract upon an agreement or understanding for a commission, percentage, brokerage or contingent fee (excepting bona fide employees or bona fide established commercial or selling agencies maintained by the contractor for the purpose of securing business). For breach or violation of this warranty, the Department shall have the right to annul this contract without liability or, in its discretion, to deduct from

the consideration otherwise due under the contract, or otherwise recover, the full amount of such commission, percentage, and brokerage or contingent fee.

O. CONTRACTOR'S CONFLICT OF INTEREST

The contractor hereby assures that it presently has not interest and will not acquired any interest, direct or indirect, which would conflict in any manner or degree with the performance of its services hereunder. The contractor further assures that in the performance of this contract, it will not knowingly employ any person having such interest. Contractor hereby certifies that no member of the Board of the contractor or any of its officers or directors has such an adverse interest.

P. INTEREST OF THE COMMONWEALTH AND OTHERS

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

Q. CONTRACTOR RESPONSIBILITY TO EMPLOY WELFARE CLIENTS

(Applicable to contracts $25,000 or more)

1. The contractor, within 10 days of receiving the notice to proceed, must contact the Department of Public Welfare's Contractor Partnership Program (CPP) to present, for review and approval, the contractor's plan for recruiting and hiring recipients currently receiving cash assistance. If the contract was not procured via Request for Proposal (RFP); such plan must be submitted on Form PA-778. The plan must identify a specified number (not percentage) of hires to be made under this contract. If no employment opportunities arise as a result of this contract, the contractor must identify other employment opportunities available within the organization that are not a result of this contract. The entire completed plan (Form PA-778) must be submitted to the Bureau of Employment and Training Programs (BETP)**:** Attention CPP Division. (Note: Do not keep the pink copy of Form PA-778). The approved plan will become a part of the contract.

2. The contractor's CPP approved recruiting and hiring plan shall be maintained throughout the term of the contract and through any renewal or extension of the contract. Any proposed change must be submitted to the CPP Division which will make a recommendation to the Contracting Officer regarding course of action. If a contract is assigned to another contractor, the new contractor must maintain the CPP recruiting and hiring plan of the original contract.

3. The contractor, within 10 days of receiving the notice to proceed, must register in the Commonwealth Workforce Development System (CWDS). In order to register the selected contractor must provide business, location and contact details by creating an Employer Business Folder for review and approval, within CWDS at HTTPS://WWW.CWDS.State.PA.US . Upon CPP review and approval of Form PA-778 and the Employer Business Folder in CWDS, the Contractor will receive written notice (via the pink Contractor's copy of Form PA-778) that the plan has been approved.

4. Hiring under the approved plan will be monitored and verified by Quarterly Employment Reports (Form PA-1540); submitted by the contractor to the Central Office of Employment and Training – CPP Division. A copy of the submitted Form PA-1540 must also be submitted (by the contractor) to the DPW Contract Monitor (i.e. Contract Officer). The reports must be submitted on the DPW Form PA-1540. The form may not be revised, altered, or re-created.

5. If the contractor is non-compliant, CPP Division will contact the Contract Monitor to request corrective action. The Department may cancel this contract upon thirty (30) days written notice in the event of the contractor's failure to implement or abide by the approved plan.

R. TUBERCULOSIS CONTROL

As recommended by the Centers for Disease Control and the Occupational Safety and Health Administration, effective August 9, 1996, in all State Mental Health and Mental Retardation Facilities, all full-time and part-time employees (temporary and permanent), including contract service providers, having direct patient contact or providing service in patient care areas, are to be tested serially with PPD by Mantoux skin tests. PPD testing will be provided free of charge from the state MH/MR facility. If the contract service provider has written proof of a PPD by Mantoux method within the last six months, the MH/MR facility will accept this documentation in lieu of administration of a repeat test. In addition, documented results of a PPD by Mantoux method will be accepted by the MH/MR facility. In the event that a contractor is unwilling to submit to the test due to previous positive reading, allergy to PPD material or refusal, the risk assessment questionnaire must be completed. If a contractor refuses to be tested in accordance with this new policy, the facility will not be able to contract with this provider and will need to procure the services from another source.

S. ACT 13 APPLICATION TO CONTRACTOR

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

1. Pursuant to 18 Pa.C.S. Ch. 91(relating to criminal history record information) a report of criminal history information from the Pennsylvania State Police or a statement from the State Police that their central repository contains no such information relating to that person. The criminal history record information shall be limited to that which is disseminated pursuant to 18 Pa.C.S. 9121(b)(2) (relating to general regulations).

2. Where the applicant is not, and for the two years immediately preceding the date of application has not been a resident of this Commonwealth, the Department shall require the applicant to submit with the application a report of Federal criminal history record information pursuant to the Federal Bureau of Investigation's under Department of State, Justice, and Commerce, the Judiciary, and Related Agencies Appropriation Act, 1973 (Public Law 92-544, 86 Stat. 1109). For the purpose of this paragraph, the applicant shall submit a full set of fingerprints to the State Police, which shall forward them to the Federal Bureau of Investigation for a national criminal history check. The information obtained from the criminal record check shall be used by the Department to determine the applicant's eligibility. The Department shall insure confidentially of the information.

3. The Pennsylvania State Police may charge the applicant a fee of not more than $10 to conduct the criminal record check required under subsection 1. The State Police may charge a fee of not more than the established charge by the Federal Bureau of Investigation for the criminal history record check required under subsection 2.

The Contractor shall apply for clearance using the State Police Background Check (SP4164) at their own expense. The forms are available from any State Police Substation. When the State Police Criminal History Background Report is received, it must be forwarded to the Department. State Police Criminal History Background Reports not received within sixty (60) days may result in cancellation of the contract.

T. LOBBYING CERTIFICATION AND DISCLOUSRE

(applicable to contracts $100,000 or more)

Commonwealth agencies will not contract with outside firms or individuals to perform lobbying services, regardless of the source of funds. With respect to an award of a federal contract, grant, or cooperative agreement exceeding $100,000 or an award of a federal loan or a commitment providing for the United States to insure or guarantee a loan exceeding $150,000 all recipients must certify that they will not use federal funds for lobbying and must disclose the use of non-federal funds for lobbying by filing required documentation. The contractor will be required to complete and return a "Lobbying Certification Form" and a "Disclosure of Lobbying Activities form" with their signed contract, which forms will be made attachments to the contract.

U. <u>AUDIT CLAUSE</u>
(applicable to contracts $100,000 or more)

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

AUDIT CLAUSE A – SUBRECIPIENT
Local Governments and Nonprofit Organizations

The Commonwealth of Pennsylvania, Department of Public Welfare (DPW), distributes federal and state funds to local governments, nonprofit, and for-profit organizations. Federal expenditures are subject to federal audit requirements, and federal and state funding passed through DPW are subject to DPW audit requirements. If any federal statute specifically prescribes policies or specific requirements that differ from the standards provided herein, the provisions of the subsequent statute shall govern. The DPW provides the following audit requirements in accordance with the Commonwealth of Pennsylvania, Governor's Office, Management Directive 325.9, as amended August 20, 2009.

Subrecipient means an entity that expends federal awards received from a pass-through entity to carry out a federal program, but does not include an individual that is a beneficiary of such a program. A subrecipient may also be a recipient of other federal awards directly from a federal awarding agency. For purposes of this audit clause, a subrecipient **is not** a vendor that receives a procurement contract to provide goods or services that are required to provide the administrative support to carry out a federal program.

A. Federal Audit Requirements – Local Governments and Nonprofit Organizations

A local government and nonprofit organization must comply with all federal audit requirements, including: the Single Audit Act, as amended; the revised Office of Management and Budget (OMB) Circular A-133, *Audits of States, Local Government, and Non-Profit Organizations*; and any other applicable law or regulation, as well as any other applicable law or regulation that may be enacted or promulgated by the federal government.

A local government or nonprofit organization that expends federal awards of $500,000 or more during its fiscal year, received either directly from the federal government, indirectly from a pass-through entity, or a combination of both, to carry out a federal program, **is required** to have an audit made in accordance with the provisions of OMB Circular A-133, as revised.

If a local government or nonprofit organization expends **total federal awards of less than $500,000** during its fiscal year, it is exempt from these **federal** audit requirements, but is required to maintain auditable records of federal or state funds that supplement such awards. Records must be available for review by appropriate officials. **Although an audit may not be necessary under the federal requirements, DPW audit requirements may be applicable.**

B. Department of Public Welfare Audit Requirements

A local government or nonprofit provider must meet the DPW audit requirements.

Where a Single Audit or program-specific audit is conducted in accordance with the federal audit requirements detailed above, such an audit will be accepted by the DPW provided that:

1. A full copy of the audit report is submitted as detailed below; **and**

2. The subrecipient shall ensure that the audit requirements are met for the terms of this contract; i.e., the prescribed Attestation Report and applicable schedule

requirement(s). The incremental cost for preparation of the Attestation Report and the schedule cannot be charged to the federal funding stream.

AUDIT CLAUSE A – SUBRECIPIENT
Local Governments and Nonprofit Organizations

The local government or nonprofit organization must comply with all federal and state audit requirements including: the Single Audit Act Amendments of 1996; Office of Management and Budget (OMB) Circular A-133, Audits of States, Local Governments, and Non-Profit Organizations, as amended; and any other applicable law or regulation and any amendment to such other applicable law or regulation which may be enacted or promulgated by the federal government. **In the absence of a federally required audit**, the entity is responsible for the following annual audit requirements, which are based upon the program year specified in this agreement.

Institutions that **expends $500,000 or more in combined state and federal funds** during the program year is required to have an audit of those funds made in accordance with generally accepted *Government Auditing Standards* (The Yellow Book), revised, as published by the Comptroller General of the United States. Where such an audit is not required to meet the federal requirements, the costs related to DPW audit requirements may not be charged to federal funding streams.

If in connection with the agreement, a local government or nonprofit organization **expends $300,000 or more in combined state and federal funds** during the program year, the subrecipient shall ensure that, for the term of the contract, an independent auditor conducts annual examinations of its compliance with the terms and conditions of this contract, as well as applicable program regulations. These examinations shall be conducted in accordance with the American Institute of Certified Public Accountants' Statements on Standards for Attestation Engagements (SSAE), Section 601, *Compliance Attestation*, and shall be of a scope acceptable to the DPW. The initial Section 601 compliance examination shall be completed for the program year specified in the contract and conducted annually thereafter. The independent auditor shall issue a report on its compliance examination as defined in SSAE, Section 601. The incremental cost for preparation of the SSAE cannot be charged to federal funding streams.

The subrecipient shall submit the SSAE, Section 601, audit report (if applicable) to the DPW within 90 days after the program year has been completed. When SSAE, Section 601, audit reports are other than unqualified, the subrecipient shall submit to the DPW, in addition to the audit reports, a plan describing what actions the subrecipient will implement to correct the situation that caused the auditor to issue a qualified report, a timetable for implementing the planned corrective actions, a process for monitoring compliance with the timetable, and a contact person who is responsible for the resolution of the situation.

If the subrecipient enters into an agreement with a subcontractor(s) for the performance of any primary contractual duties, the audit requirements are applicable to the subcontractor(s) with whom the subrecipient has entered into an agreement. Consequently, the audit requirements should be incorporated into the sub-contractual document as entered by the subrecipient.

A local government or nonprofit entity that **expends less than $300,000 combined state and federal funds** during the program year is exempt from DPW audit requirements, but is required to maintain auditable records for each contract year. Records must be available for review by appropriate officials of the DPW or a pass-through entity.

AUDIT CLAUSE A – SUBRECIPIENT
Local Governments and Nonprofit Organizations

GENERAL AUDIT PROVISIONS

A local government or nonprofit organization is responsible for obtaining the necessary audit and securing the services of a certified public accountant or other independent governmental auditor. Federal regulations preclude public accountants licensed in the Commonwealth of Pennsylvania from performing audits of federal awards.

The Commonwealth reserves the right for federal and state agencies, or their authorized representatives, to perform additional audits of a financial and/or performance nature, if deemed necessary by Commonwealth or federal agencies. Any such additional audit work will rely on the work already performed by the subrecipient's auditor, and the costs for any additional work performed by the federal or state agency will be borne by those agencies at no additional expense to the subrecipient.

The Commonwealth reserves the right for state and federal agencies, or their authorized representatives, to perform financial and/or performance audits if deemed necessary. If it is decided that an audit of this contract will be performed, the subrecipient will be given advance notice. The subrecipient shall maintain books, records, and documents that support the services provided, that the fees earned are in accordance with the contract, and that the subrecipient has complied with the contract terms and conditions. The subrecipient agrees to make available, upon reasonable notice, at the office of the subrecipient, during normal business hours, for the term of this contract and the retention period set forth in this Audit Clause, any of the books, records, and documents for inspection, audit, or reproduction by any state or federal agency or its authorized representative.

The subrecipient shall preserve all books, records, and documents related to this contract for a period of time that is the greater of five years from the contract expiration date, until all questioned costs or activities have been resolved to the satisfaction of the Commonwealth, or as required by applicable federal laws and regulations, whichever is longer. If this contract is completely or partially terminated, the records relating to the work terminated shall be preserved and made available for a period of five years from the date of any resulting final settlement.

Audit documentation and audit reports must be retained by the subrecipient's auditor for a minimum of five years from the date of issuance of the audit report, unless the subrecipient's auditor is notified in writing by the Commonwealth or the cognizant or oversight federal agency to extend the retention period. Audit documentation will be made available upon request to authorized representatives of the Commonwealth, the cognizant or oversight agency, the federal funding agency, or the Government Accountability Office.

Records that relate to litigation of the settlement of claims arising out of performance or expenditures under this contract to which exception has been taken by the auditors shall be retained by the subrecipient or provided to the Commonwealth at the DPW's option until such litigation, claim, or exceptions have reached final disposition.

Except for documentary evidence delivered pursuant to litigation or the settlement of claims arising out of the performance of the contract, the subrecipient may, in fulfillment of his obligation to retain records as required by this Audit Clause, substitute photographs, microphotographs, or other authentic reproductions of such records after the expiration of two years following the last day of the month of reimbursement to the contractor of the

invoice or voucher to which such records relate, unless a shorter period is authorized by the Commonwealth.

AUDIT CLAUSE A – SUBRECIPIENT
Local Governments and Nonprofit Organizations

SUBMISSION OF AUDIT REPORTS TO THE COMMONWEALTH

A. Federally Required Audit Reports

Submit an electronic copy of federally required audit reports to the Commonwealth, which shall include:

1. Auditor's reports

   a. Independent auditor's report on the financial statements, which expresses an opinion on whether the financial statements are presented fairly in all material respects in conformity with the stated accounting policies.

   b. Independent auditor's report on the supplementary Schedule of Expenditures of Federal Awards (SEFA), which should determine and provide an opinion on whether the SEFA is presented fairly in all material respects in relation to the subrecipient's financial statements taken as a whole. This report can be issued separately or combined with the independent auditor's report on the financial statements.

   c. Report on internal control over financial reporting, compliance and other matters based on an audit of financial statements performed in accordance with Government Auditing Standards.

   d. Report on compliance with requirements applicable to each major program and report on internal control in accordance with the circular.

   e. Schedule of findings and questioned costs.

2. Financial statements and notes to the financial statements

3. SEFA and notes to the SEFA

4. Summary schedule of prior audit findings

5. Corrective action plan (if applicable)

6. Data collection form

7. Management letter (if applicable)

In instances where a federal program-specific audit guide is available, the audit report package for a program-specific audit may be different and should be prepared in accordance with the audit guide and OMB Circular A-133.

Effective July 1, 2009, the Office of the Budget, Office of Comptroller Operations, Bureau of Audits will begin accepting electronic submission of single audit/program-specific audit reporting packages. Electronic submission is required for the fiscal year ending December 31, 2008 and subsequent years. Instructions and information regarding submission of the single audit/program-specific audit reporting package are available to the public on Single Audit Submissions page of the Office of the Budget website (http://www.budget.state.pa.us). The

reporting package must be submitted electronically in single Portable Document Format (PDF) file to RA-BOASingleAudit@state.pa.us.

Steps for submission:

1. Complete the Single Audit/Program Specific Audit Reporting Package Checklist available on the Single Audit Submissions page of the Office of the Budget website (http://www.budget.state.pa.us). The Single Audit/Program Specific Audit Reporting Package Checklist ensures the subrecipient's reporting package contains all required elements.

2. Upload the completed Single Audit/Program-Specific Audit Reporting Package along with the Single Audit/Program Specific Audit Reporting Package Checklist in a single PDF file to an e-mail addressed to RA-BOASingleAudit@state.pa.us. In the subject line of the e-mail the subrecipient must identify the exact name on the Single Audit/Program-Specific Audit Reporting Package and the period end date to which the reporting package applies.

The subrecipient will receive an e-mail to confirm the receipt of the Single Audit/Program-Specific Audit Reporting Package, including the completed Single Audit/Program Specific Audit Reporting Package Checklist.

B. DPW Required Audit Reports and Additional Submission by Subrecipients

Submit **three copies** of the DPW required audit report package.

1. Independent Accountant's Report – on the Attestation of an entity's compliance with specific requirements during a period of time in accordance with the contract and the appropriate schedule, as required.

2. In addition, if OMB Circular A-133, §__.320 (e), *Submission by Subrecipients*, applies, please submit the audit requirements directly to:

U.S. Postal Service: Department of Public Welfare
Bureau of Financial Operations
Division of Financial Policy and Operations
Audit Resolution Section
3rd Floor, Bertolino Building
P. O. Box 2675
Harrisburg, Pennsylvania 17102-2675

Special Deliveries: 3rd Floor, Bertolino Building
1401 North Seventh Street
Harrisburg, Pennsylvania 17102
Phone: (717) 787-8890 Fax: (717) 772-2522

AUDIT CLAUSE A – SUBRECIPIENT
Local Governments and Nonprofit Organizations

PERIOD SUBJECT TO AUDIT

A federally required audit, made in accordance with OMB Circular A-133, encompasses the fiscal period of the provider. **Therefore, the period of the federally required audit may differ from the official reporting period as specified in this agreement.** Where these periods differ, the required supplement schedule(s) and Independent Auditor's Report on the Attestation must be completed for the official annual reporting period of this agreement that ended during the period under audit and shall accompany the federally required audit.

CORRECTIVE ACTION PLAN

The provider shall prepare a corrective action plan (CAP) to address all findings of noncompliance, internal control weaknesses, and/or reportable conditions disclosed in the audit report. For each finding noted, the CAP should include: (1) a brief description identifying the findings; (2) whether the provider agrees with the finding; (3) the specific steps to be taken to correct the deficiency or specific reasons why corrective action is not necessary; (4) a timetable for completion of the corrective action steps; and (5) a description of monitoring to be performed to ensure that the steps are taken (6) the responsible party for the CAP.

REMEDIES FOR NONCOMPLIANCE

The provider's failure to provide an acceptable audit, in accordance with the requirements of the Audit Clause Requirements, may result in the DPW's not accepting the report and initiating sanctions against the provider that may include the following:

- Disallowing the cost of the audit.
- Withholding a percentage of the contract funding pending compliance.
- Withholding or disallowing administrative costs.
- Suspending subsequent contract funding pending compliance.

TECHNICAL ASSISTANCE

Technical assistance on the DPW's audit requirements, and the integration of those requirements with the federal Single Audit requirements, will be provided by:

Department of Public Welfare
Bureau of Financial Operations
Division of Financial Policy and Operations
Audit Resolution Section
3rd Floor, Bertolino Building
P.O. Box 2675
Harrisburg, Pennsylvania 17105-2675
Phone: (717) 787-8890 FAX: (717) 772-2522

AUDIT CLAUSE A – SUBRECIPIENT
Local Governments and Nonprofit Organizations
ENCLOSURE I

The Department of Public Welfare (DPW) requires an Independent Accountant's Report on the Attestation to be in the format described by the American Institute of Certified Public Accountants (AICPA). The following is the form of report an Independent Accountant should use when expressing an opinion on an entity's compliance with specified requirements during a period of time. For further guidance, refer to the AICPA guidelines.

Independent Accountant's Report

[Introductory Paragraph]

We have examined [*name of entity*]'s compliance with [*list specific compliance requirement*] during the [*period*] ended [*date*]. Management is responsible for [*name of entity*]'s compliance with those-requirements. Our responsibility is to express an opinion on [*name of entity*]'s compliance based on our examination.

[Scope Paragraph]

Our examination was conducted in accordance with attestation standards established by the American Institute of Certified Public Accountants and, accordingly, included examining, on a test basis, evidence about [*name of entity*]'s compliance with those requirements and performing such other procedures as we considered necessary in the circumstances. We believe that our examination provides a reasonable basis for our opinion. Our examination does not provide a legal determination on [*name of en*tity]'s compliance with specified requirements.

[Opinion Paragraph]

In our opinion, [*name of* entity] complied, in all material respects, with the aforementioned requirements for the year ended December 31, 20XX.

[DATE] [SIGNATURE]

AUDIT CLAUSE B – SUBRECIPIENT
For-Profit Organizations

The Commonwealth of Pennsylvania, Department of Public Welfare (DPW), distributes federal and state funds to local governments, nonprofit, and for-profit organizations. Federal expenditures are subject to federal audit requirements, and federal and state funding passed through DPW are subject to DPW audit requirements. If any federal statute specifically prescribes policies or specific requirements that differ from the standards provided herein, the provisions of the subsequent statute shall govern. The DPW provides the following audit requirements in accordance with the Commonwealth of Pennsylvania, Governor's Office, Management Directive 325.9, as amended August 20, 2009.

Subrecipient means an entity that expends federal awards received from a pass-through entity to carry out a federal program, but does not include an individual that is a beneficiary of such a program. A subrecipient may also be a recipient of other federal awards directly from a federal awarding agency. For purposes of this audit clause, a subrecipient **is not** a vendor that receives a procurement contract to provide goods or services that are required to provide the administrative support to carry out a federal program.

A. Federal Audit Requirements – For- Profit Organizations

The for-profit organization must comply with all federal and state audit requirements including: the Single Audit Act Amendments of 1996; Office of Management and Budget (OMB) Circular A-133, Audits of States, Local Governments, and Non-Profit Organizations, as amended; and any other applicable law or regulation and any amendment to such other applicable law or regulation which may be enacted or promulgated by the federal government.

A for-profit organization **is required** to have an audit if it expends a total of $500,000 or more in federal funds under one or more Department of Health and Human Services (DHHS) federal awards. Title 45, CFR 74.26, incorporates the thresholds and deadlines of the Office of Management and Budget (OMB) Circular A-133, *Audits of States, Local Government, and Non-Profit Organizations*, but provides for-profit organizations with two options regarding the type of audit that will satisfy the audit requirements:

1. An audit made in accordance with generally accepted *Government Auditing Standards* (The Yellow Book), revised; or

2. An audit that meets the requirements contained in OMB Circular A-133.

A for-profit organization **is required** to have an audit, in accordance with the above audit requirements, if it expends a total of $500,000 or more of federal awards directly or indirectly during its fiscal year.

If a for-profit organization expends **total federal awards of less than $500,000** during its fiscal year, it is exempt from these **federal** audit requirements, but is required to maintain auditable records of federal or state funds that supplement such awards. Records must be available for review by appropriate officials. **Although an audit may not be necessary under the federal requirements, DPW audit requirements may be applicable.**

AUDIT CLAUSE B – SUBRECIPIENT
For-Profit Organizations

B. Department of Public Welfare Audit Requirements

A for-profit provider must meet the DPW audit requirements.

Where a Single Audit or program-specific audit is conducted in accordance with the federal audit requirements detailed above, such an audit will be accepted by the DPW provided that:

1. A full copy of the audit report is submitted as detailed below; **and**

2. The subrecipient shall ensure that the audit requirements are met for the terms of this contract; i.e., the prescribed Attestation Report and applicable schedule requirement(s). The incremental cost for preparation of the Attestation Report and the schedule cannot be charged to the federal funding stream.

In the absence of a federally required audit, the entity is responsible for the following annual audit requirements, which are based upon the program year specified in this agreement.

If in connection with the agreement, a for-profit organization **expends $300,000 or more in combined state and federal funds** during the program year, the subrecipient shall ensure that, for the term of the contract, an independent auditor conducts annual examinations of its compliance with the terms and conditions of this contract. These examinations shall be conducted in accordance with the American Institute of Certified Public Accountants' Statements on Standards for Attestation Engagements (SSAE), Section 601, *Compliance Attestation*, and shall be of a scope acceptable to the DPW. The initial Section 601 compliance examination shall be completed for the program year specified in the contract and conducted annually thereafter. The independent auditor shall issue a report on its compliance examination as defined in SSAE, Section 601. The incremental cost for preparation of the SSAE cannot be charged to federal funding streams.

The subrecipient shall submit the SSAE, Section 601, audit reports (if applicable) to the DPW within 90 days after the program year has been completed. When the SSAE, Section 601, audit reports are other than unqualified, the subrecipient shall submit to the DPW, in addition to the audit reports, a plan describing what actions the subrecipient will implement to correct the situation that caused the auditor to issue a qualified report, a timetable for implementing the planned corrective actions, and a process for monitoring compliance with the timetable and a contact person who is responsible for the resolution of the situation.

If the subrecipient enters into an agreement with a subcontractor(s) for performance of any primary contractual duties, the audit requirements are applicable to the subcontractor(s) with whom the subrecipient has entered into an agreement. Consequently, the audit requirements should be incorporated into the sub-contractual document as entered by the subrecipient.

A for-profit entity that **expends less than $300,000 combined state and federal funds** during the program year is exempt from DPW audit requirements, but is required to maintain auditable records for each contract year. Records must be available for review by appropriate officials of the DPW or a pass-through entity.

AUDIT CLAUSE B – SUBRECIPIENT
For-Profit Organizations

GENERAL AUDIT PROVISIONS

A for-profit organization is responsible for obtaining the necessary audit and securing the services of a certified public accountant or other independent governmental auditor. Federal regulations preclude public accountants licensed in the Commonwealth of Pennsylvania from performing audits of federal awards.

The Commonwealth reserves the right for state and federal agencies, or their authorized representatives, to perform financial and/or performance audits if deemed necessary by the Commonwealth or federal agencies. Any such additional audit work will rely on the work already performed by the subrecipient's auditor, and the costs for any additional work performed by the federal or state agency will be borne by those agencies at no additional expense to the subrecipient.

The Commonwealth reserves the right for state and federal agencies, or their authorized representatives, to perform financial and/or performance audits if deemed necessary. If it is decided that an audit of this contract will be performed, the subrecipient will be given advance notice. The subrecipient shall maintain books, records, and documents that support the services provided, that the fees earned are in accordance with the contract, and that the subrecipient has complied with the contract terms and conditions. The subrecipient agrees to make available, upon reasonable notice, at the office of the subrecipient, during normal business hours, for the term of this contract and the retention period set forth in this Audit Clause, any of the books, records, and documents for inspection, audit, or reproduction by any state or federal agency or its authorized representative.

The subrecipient shall maintain books, records, and documents related to this contract for a period of five years from the contract expiration date, until all questioned costs or activities have been resolved to the satisfaction of the Commonwealth, or as required by applicable federal laws and regulations, whichever is longer. Any records that support the services provided, that the fees earned are in accordance with the contract, and that the subrecipient has complied with contract terms and conditions must be maintained The subrecipient agrees to make available, upon reasonable notice, at the office of the subrecipient, during normal business hours, for the term of this contract and the retention period set forth in this Audit Clause, any of the books, records, and documents for inspection, audit, or reproduction by any state or federal agency or its authorized representative.

Audit documentation and audit reports must be retained by the subrecipient's auditor for a minimum of five years from the date of issuance of the audit report, unless the subrecipient's auditor is notified in writing by the Commonwealth or the cognizant or oversight federal agency to extend the retention period. Audit documentation will be made available upon request to authorized representatives of the Commonwealth, the cognizant or oversight agency, the federal funding agency, or the Government Accountability Office.

Records that relate to litigation of the settlement of claims arising out of performance or expenditures under this contract to which exception has been taken by the auditors shall be retained by the subrecipient or provided to the Commonwealth at the DPW's option until such litigation, claim, or exceptions have reached final disposition.

AUDIT CLAUSE B – SUBRECIPIENT
For-Profit Organizations

Except for documentary evidence delivered pursuant to litigation or the settlement of claims arising out of the performance of the contract, the subrecipient may, in fulfillment of his obligation to retain records as required by this Audit Clause, substitute photographs, microphotographs, or other authentic reproductions of such records after the expiration of two years following the last day of the month of reimbursement to the contractor of the invoice or voucher to which such records relate, unless a shorter period is authorized by the Commonwealth.

SUBMISSION OF AUDIT REPORT TO THE COMMONWEALTH

A. Federally Required Audit Reports

Submit an electronic copy of federally required audit reports to the Commonwealth, which shall include:

1. Auditor's reports

   a. Independent auditor's report on the financial statements, which expresses an opinion on whether the financial statements are presented fairly in all material respects in conformity with the stated accounting policies.

   b. Independent auditor's report on the supplementary Schedule of Expenditures of Federal Awards (SEFA), which should determine and provide an opinion on whether the SEFA is presented fairly in all material respects in relation to the subrecipient's financial statements taken as a whole. This report can be issued separately or combined with the independent auditor's report on the financial statements.

   c. Report on internal control over financial reporting, compliance and other matters based on an audit of financial statements performed in accordance with Government Auditing Standards.

   d. Report on compliance with requirements applicable to each major program and report on internal control in accordance with the circular.

   e. Schedule of findings and questioned costs.

2. Financial statements and notes to the financial statements

3. SEFA and notes to the SEFA

4. Summary schedule of prior audit findings

5. Corrective action plan (if applicable)

6. Data collection form

7. Management letter (if applicable)

SUBRECIPIENT AUDIT CLAUSE B
For-Profit Organization

In instances where a federal program-specific audit guide is available, the audit report package for a program-specific audit may be different and should be prepared in accordance with the audit guide and OMB Circular A-133.

Effective July 1, 2009, the Office of the Budget, Office of Comptroller Operations, Bureau of Audits will begin accepting electronic submission of single audit/program-specific audit reporting packages. Electronic submission is required for the fiscal year ending December 31, 2008 and subsequent years. Instructions and information regarding submission of the single audit/program-specific audit reporting package are available to the public on Single Audit Submissions page of the Office of the Budget website (http://www.budget.state.pa.us). The reporting package must be submitted electronically in single Portable Document Format (PDF) file to RA-BOASingleAudit@state.pa.us.

Steps for submission:

1. Complete the Single Audit/Program Specific Audit Reporting Package Checklist available on the Single Audit Submissions page of the Office of the Budget website (http://www.budget.state.pa.us). The Single Audit/Program Specific Audit Reporting Package Checklist ensures the subrecipient's reporting package contains all required elements.

2. Upload the completed Single Audit/Program-Specific Audit Reporting Package along with the Single Audit/Program Specific Audit Reporting Package Checklist in a single PDF file to an e-mail addressed to RA-BOASingleAudit@state.pa.us. In the subject line of the e-mail the subrecipient must identify the exact name on the Single Audit/Program-Specific Audit Reporting Package and the period end date to which the reporting package applies.

The subrecipient will receive an e-mail to confirm the receipt of the Single Audit/Program-Specific Audit Reporting Package, including the completed Single Audit/Program Specific Audit Reporting Package Checklist.

B. DPW Required Audit Reports and Additional Submission by Subrecipients

Submit **three copies** of the DPW required audit report package.

1. Independent Accountant's Report – on the Attestation of an entity's compliance with specific requirements during a period of time in accordance with the contract and the appropriate schedule, as required.

2. In addition, if OMB Circular A-133, §__.320 (e), *Submission by Subrecipients*, applies, please submit the audit requirements directly to:

   U.S. Postal Service: Department of Public Welfare
   Bureau of Financial Operations
   Division of Financial Policy and Operations
   Audit Resolution Section
   3rd Floor, Bertolino Building

P. O. Box 2675
Harrisburg, Pennsylvania 17102-2675

SUBRECIPIENT AUDIT CLAUSE B
For-Profit Organization

Special Deliveries 3rd Floor, Bertolino Building
1401 North Seventh Street
Harrisburg, Pennsylvania 17102
Phone: (717) 787-8890 Fax: (717) 772-2522

PERIOD SUBJECT TO AUDIT

A federally required audit, made in accordance with OMB Circular A-133, encompasses the fiscal period of the auditee. **Therefore, the period of the federally required audit may differ from the official reporting period as specified in this agreement.** Where these periods differ, the required supplement schedule and an Independent Auditor's Report on the Attestation must be completed for the official annual reporting period of this agreement that ended during the period under audit and shall accompany the federally required audit.

CORRECTIVE ACTION PLAN

The provider shall prepare a corrective action plan (CAP) to address all findings of noncompliance, internal control weaknesses, and/or reportable conditions disclosed in the audit report. For each finding noted, the CAP should include: (1) a brief description identifying the findings; (2) whether the auditee agrees with the finding; (3) the specific steps to be taken to correct the deficiency or specific reasons why corrective action is not necessary; (4) a timetable for completion of the corrective action steps; and (5) a description of monitoring to be performed to ensure that the steps are taken. (6) the responsible party for the CAP.

REMEDIES FOR NONCOMPLIANCE

The provider's failure to provide an acceptable audit, in accordance with the requirements of the Audit Clause Requirements, may result in the DPW's not accepting the report and initiating sanctions against the Provider that may include the following:

- Disallowing the cost of the audit.
- Withholding a percentage of the contract funding pending compliance.
- Withholding or disallowing administrative costs.
- Suspending subsequent contract funding pending compliance.

TECHNICAL ASSISTANCE

Technical assistance on the DPW's audit requirements, and the integration of those requirements with the federal Single Audit requirements, will be provided by:

Department of Public Welfare
Bureau of Financial Operations
Division of Financial Policy and Operations
Audit Resolution Section
3rd Floor, Bertolino Building
P.O. Box 2675
Harrisburg, Pennsylvania 17105-2675

Phone: (717) 787-8890 FAX: (717) 772-2522

AUDIT CLAUSE B
For-Profit Organization
ENCLOSURE I

Independent Accountant's Report

The Department of Public Welfare (DPW) requires an Independent Accountant's Report on the Attestation to be in the format described by the American Institute of Certified Public Accountants (AICPA). The following is the form of report an Independent Accountant should use when expressing an opinion on an entity's compliance with specified requirements during a period of time. For further guidance, refer to the AICPA guidelines.

Independent Accountant's Report

[Introductory Paragraph]

We have examined [*name of entity*]'s compliance with [*list specific compliance requirement*] during the [*period*] ended [*date*]. Management is responsible for [*name of entity*]'s compliance with those-requirements. Our responsibility is to express an opinion on [*name of entity*]'s compliance based on our examination.

[Scope Paragraph]

Our examination was conducted in accordance with attestation standards established by the American Institute of Certified Public Accountants and, accordingly, included examining, on a test basis, evidence about [*name of entity*]'s compliance with those requirements and performing such other procedures as we considered necessary in the circumstances. We believe that our examination provides a reasonable basis for our opinion. Our examination does not provide a legal determination on [*name of en*tity]'s compliance with specified requirements.

[Opinion Paragraph]

In our opinion, [*name of* entity] complied, in all material respects, with the aforementioned requirements for the year ended December 31, 20XX.

[DATE] [SIGNATURE]

AUDIT CLAUSE C – VENDOR
Service Organizations

The Commonwealth of Pennsylvania, Department of Public Welfare (DPW), distributes federal and state funds to local governments, nonprofit, and for-profit organizations. Federal expenditures are subject to federal audit requirements, and federal funding and state funding passed through DPW are subject to DPW audit requirements. If any federal statute specifically prescribes policies or specific requirements that differ from the standards provided herein, the provisions of the subsequent statute shall govern.

Vendor means a dealer, distributor, merchant, or other seller providing goods or services to an auditee that are required for the **administrative support** of a program. These goods or services may be for an organization's own use or for the use of beneficiaries of the federal program. The vendor's responsibility is to meet the requirements of the procurement contract.

Department of Public Welfare Audit Requirements

If in connection with the agreement, an entity **expends $300,000 or more in combined state and federal funds** during the program year, the entity shall ensure that, for the term of the contract, an independent auditor conducts annual examinations of its compliance with the terms and conditions of this contract. These examinations shall be conducted in accordance with the American Institute of Certified Public Accountants' Statements on Standards for Attestation Engagements (SSAE), Section 601, *Compliance Attestation*, and shall be of a scope acceptable to the DPW. The contractor shall also ensure that an independent auditor performs an audit of its policies and procedures applicable to the processing of transactions. These audits shall be performed in accordance with the Statement on Auditing Standards 70 (SAS 70), *Reports on the Processing of Transactions by Service Organizations.* The initial SAS 70 audit shall be completed for the official annual reporting period of this agreement and conducted annually thereafter. The independent auditor shall issue reports on its compliance examination, as defined in the SSAE, Section 601, and on the policies and procedures placed in operation and the tests of operating effectiveness, as defined in SAS 70.

The Commonwealth reserves the right for state and federal agencies, or their authorized representatives, to perform financial and performance audits if deemed necessary. If it is decided that an audit of this contract will be performed, the contractor will be given advance notice. The contractor shall maintain books, records, and documents that support the services provided, that the fees earned are in accordance with the contract, and that the contractor has complied with contract terms and conditions. The contractor agrees to make available, upon reasonable notice, at the office of the contractor, during normal business hours, for the term of this contract and the retention period set forth in this Audit Clause, any of the books, records, and documents for inspection, audit, or reproduction by any state or federal agency or its authorized representative.

The contractor shall preserve all books, records, and documents related to this contract for a period of time that is the greater of five years from the contract expiration date, until all questioned costs or activities have been resolved to the satisfaction of the Commonwealth, or as required by applicable federal laws and regulations, whichever is longer. If this contract is completely or partially terminated, the records relating to the work terminated shall be preserved and made available for a period of five years from the date of any resulting final settlement.

Records that relate to litigation or the settlement of claims arising out of performance or expenditures under this contract to which exception has been taken by the auditors, shall be retained by the contractor or provided to the Commonwealth at the DPW's option until such litigation, claim, or exceptions have reached final disposition.

Except for documentary evidence delivered pursuant to litigation or the settlement of claims arising out of the performance of this contract, the contractor may, in fulfillment of his obligation to retain records as required by this Audit Clause, substitute photographs, microphotographs, or other authentic reproductions of such records, after the expiration of two years following the last day of the month of reimbursement to the contractor of the invoice or voucher to which such records relate, unless a shorter period is authorized by the Commonwealth.

DPW Required Audit Report Submission

The contractor shall submit the SSAE, Section 601, and SAS 70 audit reports to the DPW within 90 days after the required period of audit has ended. When either the SSAE, Section 601, or SAS 70 audit reports are other than unqualified, the contractor shall submit to the DPW, in addition to the audit reports, a plan describing what actions the contractor will implement to correct the situation that caused the auditor to issue a qualified report, a timetable for implementing the planned corrective actions, and a process for monitoring compliance with the timetable and the contact person who is responsible for resolution.

Submit **two copies** of the DPW required audit report package.

1. Independent Accountant's Report – on the Attestation of an entity's compliance with specific requirements during a period of time in accordance with the contract and the appropriate schedule, as required.

2. Submit the audit report directly to the program office.

REMEDIES FOR NONCOMPLIANCE

The provider's failure to provide an acceptable audit, in accordance with the requirements of the Audit Clause Requirements, may result in the DPW's not accepting the report and initiating sanctions against the contractor that may include the following:

- Disallowing the cost of the audit.
- Withholding a percentage of the contract funding pending compliance.
- Suspending subsequent contract funding pending compliance.

TECHNICAL ASSISTANCE

Technical assistance on the DPW's audit requirements, will be provided by:

Department of Public Welfare
Bureau of Financial Operations
Division of Financial Policy and Operations
Audit Resolution Section
3rd Floor, Bertolino Building
P.O. Box 2675
Harrisburg, Pennsylvania 17105-2675
Phone: (717) 787-8890 FAX: (717) 772-2522

AUDIT CLAUSE C – VENDOR
Service Organizations
ENCLOSURE I

The Department of Public Welfare (DPW) requires an Independent Accountant's Report on the Attestation to be in the format described by the American Institute of Certified Public Accountants (AICPA). The following is the form of report an Independent Accountant should use when expressing an opinion on an entity's compliance with specified requirements during a period of time. For further guidance, refer to the AICPA guidelines.

Independent Accountant's Report

[Introductory Paragraph]

We have examined [*name of entity*]'s compliance with [*list specific compliance requirement*] during the [*period*] ended [*date*]. Management is responsible for [*name of entity*]'s compliance with those-requirements. Our responsibility is to express an opinion on [*name of entity*]'s compliance based on our examination.

[Scope Paragraph]

Our examination was conducted in accordance with attestation standards established by the American Institute of Certified Public Accountants and, accordingly, included examining, on a test basis, evidence about [*name of entity*]'s compliance with those requirements and performing such other procedures as we considered necessary in the circumstances. We believe that our examination provides a reasonable basis for our opinion. Our examination does not provide a legal determination on [*name of en*tity]'s compliance with specified requirements.

[Opinion Paragraph]

In our opinion, [*name of* entity] complied, in all material respects, with the aforementioned requirements for the year ended December 31, 20XX.

[DATE] [SIGNATURE]

AUDIT CLAUSE D – VENDOR

The Commonwealth of Pennsylvania, Department of Public Welfare (DPW), distributes federal and state funds to local governments, nonprofit, and for-profit organizations. Federal expenditures are subject to federal audit requirements, and federal funding and state funding passed through DPW are subject to DPW audit requirements. If any federal statute specifically prescribes policies or specific requirements that differ from the standards provided herein, the provisions of the subsequent statute shall govern.

Vendor means a dealer, distributor, merchant, or other seller providing goods or services to an auditee that are required for the **administrative support** of a program. These goods or services may be for an organization's own use or for the use of beneficiaries of the federal program. The vendor's responsibility is to meet the requirements of the procurement contract.

Department of Public Welfare Audit Requirement

If in connection with the agreement, an entity **expends $300,000 or more in combined state and federal funds** during the program year, the entity shall ensure that, for the term of the contract, an independent auditor conducts annual examinations of its compliance with the terms and conditions of this contract. These examinations shall be conducted in accordance with the American Institute of Certified Public Accountants' Statements on Standards for Attestation Engagements (SSAE), examinations, Section 601, *Compliance Attestation*, and shall be of a scope acceptable to the DPW. The initial SSAE, Section 601, compliance examination shall be completed for the official annual reporting period of this agreement and conducted annually thereafter. The independent auditor shall issue a report on its compliance examination, as defined in the SSAE, Section 601.

The Commonwealth reserves the right for state and federal agencies, or their authorized representatives, to perform financial and performance audits if deemed necessary. If it is decided that an audit of this contract will be performed, the contractor will be given advance notice. The contractor shall maintain books, records, and documents that support the services provided, that the fees earned are in accordance with the contract, and that the contractor has complied with contract terms and conditions. The contractor agrees to make available, upon reasonable notice, at the office of the contractor, during normal business hours, for the term of this contract and the retention period set forth in this Audit Clause, any of the books, records, and documents for inspection, audit, or reproduction by any state or federal agency or its authorized representative.

The contractor shall preserve all books, records, and documents related to this contract for a period of time that is the greater of five years from the contract expiration date, until all questioned costs or activities have been resolved to the satisfaction of the Commonwealth, or as required by applicable federal laws and regulations, whichever is longer. If this contract is completely or partially terminated, the records relating to the work terminated shall be preserved and made available for a period of five years from the date of any resulting final settlement.

Records that relate to litigation or the settlement of claims arising out of performance or expenditures under this contract to which exception has been taken by the auditors, shall be retained by the contractor or provided to the Commonwealth at the DPW's option until such litigation, claim, or exceptions have reached final disposition.

AUDIT CLAUSE D – VENDOR

Except for documentary evidence delivered pursuant to litigation or the settlement of claims arising out of the performance of this contract, the contractor may, in fulfillment of his obligation to retain records as required by this Audit Clause, substitute photographs, microphotographs, or other authentic reproductions of such records, after the expiration of two years following the last day of the month of reimbursement to the contractor of the invoice or voucher to which such records relate, unless a shorter period is authorized by the Commonwealth

.

DPW Required Audit Report Submission

The contractor shall submit the SSAE, Section 601 audit report to the DPW within 90 days after the required period of audit has ended. When the SSAE, Section 601, audit report is other than unqualified, the contractor shall submit to the DPW, in addition to the audit reports, a plan describing what actions the contractor will implement to correct the situation that caused the auditor to issue a qualified report, a timetable for implementing the planned corrective actions, and a process for monitoring compliance with the timetable.

Submit **two copies** of the DPW required audit report package.

1. Independent Accountant's Report – on the Attestation of an entity's compliance with specific requirements during a period of time in accordance with the contract and the appropriate schedule, as required.

2. Submit the audit report directly to the program office.

REMEDIES FOR NONCOMPLIANCE

The provider's failure to provide an acceptable audit, in accordance with the requirements of the Audit Clause Requirements, may result in the DPW's not accepting the report and initiating sanctions against the contractor that may include the following:

- Disallowing the cost of the audit.
- Withholding a percentage of the contract funding pending compliance.
- Suspending subsequent contract funding pending compliance.

TECHNICAL ASSISTANCE

Technical assistance on the DPW's audit requirements, will be provided by:

Department of Public Welfare
Bureau of Financial Operations
Division of Financial Policy and Operations
Audit Resolution Section
3rd Floor, Bertolino Building
P.O. Box 2675
Harrisburg, Pennsylvania 17105-2675
Phone: (717) 787-8890 FAX: (717) 772-2522

AUDIT CLAUSE D – VENDOR
ENCLOSURE I

The Department of Public Welfare (DPW) requires an Independent Accountant's Report on the Attestation to be in the format described by the American Institute of Certified Public Accountants (AICPA). The following is the form of report an Independent Accountant should use when expressing an opinion on an entity's compliance with specified requirements during a period of time. For further guidance, refer to the AICPA guidelines.

Independent Accountant's Report

[Introductory Paragraph]

We have examined [*name of entity*]'s compliance with [*list specific compliance requirement*] during the [*period*] ended [*date*]. Management is responsible for [*name of entity*]'s compliance with those-requirements. Our responsibility is to express an opinion on [*name of entity*]'s compliance based on our examination.

[Scope Paragraph]

Our examination was conducted in accordance with attestation standards established by the American Institute of Certified Public Accountants and, accordingly, included examining, on a test basis, evidence about [*name of entity*]'s compliance with those requirements and performing such other procedures as we considered necessary in the circumstances. We believe that our examination provides a reasonable basis for our opinion. Our examination does not provide a legal determination on [*name of en*tity]'s compliance with specified requirements.

[Opinion Paragraph]

In our opinion, [*name of* entity] complied, in all material respects, with the aforementioned requirements for the year ended December 31, 20XX.

[DATE] [SIGNATURE]

AUDIT CLAUSE E – VENDOR
Exceptions

NOTE: This Audit Clause should not be used in most instances – only for instances when no specific audit requirement is warranted.

The Commonwealth reserves the right for state and federal agencies, or their authorized representatives, to perform financial and performance audits if deemed necessary. If it is decided that an audit of this contract will be performed, the contractor will be given advance notice. The contractor shall maintain books, records, and documents that support the services provided, that the fees earned are in accordance with the contract, and that the contractor has complied with contract terms and conditions. The contractor agrees to make available, upon reasonable notice, at the office of the contractor, during normal business hours, for the term of this contract and the retention period set forth in this Audit Clause, any of the books, records, and documents for inspection, audit, or reproduction by any state or federal agency or its authorized representative.

The contractor shall preserve all books, records, and documents related to this contract for a period of time that is the greater of five years from the contract expiration date, until all questioned costs or activities have been resolved to the satisfaction of the Commonwealth, or as required by applicable federal laws and regulations, whichever is longer. If this contract is completely or partially terminated, the records relating to the work terminated shall be preserved and made available for a period of four years from the date of any resulting final settlement.

Records that relate to litigation or the settlement of claims arising out of performance or expenditures under this contract to which exception has been taken by the auditors, shall be retained by the contractor or provided to the Commonwealth at the Department of Public Welfare's option until such litigation, claim, or exceptions have reached final disposition.

Except for documentary evidence delivered pursuant to litigation or the settlement of claims arising out of the performance of this contract, the contractor may, in fulfillment of his obligation to retain records as required by this Audit Clause, substitute photographs, microphotographs, or other acceptable reproductions of such records, after the expiration of two years following the last day of the month of reimbursement to the contractor of the invoice or voucher to which such records relate, unless a shorter period is authorized by the Commonwealth.

LOBBYING CERTIFICATION AND DISCLOSURE OF LOBBYING ACTIVITIES

Certification for Contracts, Grants, Loans, and Cooperative Agreements

The undersigned certifies, to the best of his/her knowledge and belief, that:

(1) No Federal appropriated funds have been paid or will be paid by or on behalf of the undersigned, to any person for influencing or attempting to influence an officer or employees of any agency, a member of Congress, an officer or employee of Congress, or an employee of a member of Congress in connection with the awarding of any Federal contract, the making of any federal grant, the making of any federal loan, the entering into any cooperative agreement, and the extension, continuation, renewal, amendment, or modification of any Federal contract, grant, loan, or cooperative agreement.

(2) If any funds other than Federally appropriated funds have been paid or will be paid to any person for influencing or attempting to influence an officer or employee of any agency, a member of Congress, an officer or employee of Congress, or an employee of a member of Congress in connection with this Federal contract, grant, loan, or cooperative agreement, the undersigned shall complete and submit Standard Form-LLL, "Disclosure of Lobbying Activities" in accordance with its instructions.

(3) The undersigned shall require that the language of this certification be included in the award documents for all sub-awards at all times including subcontracts, sub-grants, and contracts under grants, loans, and cooperative agreements, and that all sub-recipients shall certify and disclose accordingly.

This certification is a material representation of fact upon which reliance was placed when this transaction was made or entered into. Submission of this certification is a prerequisite for making or entering into this transaction imposed under Section 1352, Title 31, and U.S. Code. Any person who fails to file the required certification shall be subject to a civil penalty of not less than $10,000 and not more than $100,000 for such failure.

SIGNATURE: _____

TITLE: _____

DATE: _____

INSTRUCTIONS FOR COMPLETION OF DISCLOSURE OF LOBBYING ACTIVITIES

This disclosure form shall be completed by the reporting entity, whether sub-awardee or prime federal client, at the initiation or receipt of a covered federal action, or a material change to a previous filing, pursuant to Title 31 U.S.C., Section 1352. The filing of a form is required for each payment or agreement to make payment to any lobbying entity for influencing or attempting to influence an office or employee of any agency, a Member of Congress, an office or employee of Congress, or an employee of Member of Congress in connection with a covered federal action. Use the Standard Form-LLL-A, "Continuation Sheet," for additional information if the space on the form is inadequate. Complete all items that apply for both the initial filing and material change report. Refer to the implementing guidance published by the Office of Management and Budget for additional information.

1. Identify the type of covered federal action for which lobbying activity is and/or has been secured to influence the outcome of a covered federal action.

2. Identify the status of the covered federal action.

3. Identify the appropriate classification of this report. If this is a follow-up report caused by a material change to the information previously reported, enter the year and quarter in which the change occurred. Enter the date of the last previously submitted report by this reporting entity for this covered federal action.

4. Enter the full name, address, city, state and zip code of the reporting entity. Include Congressional District, if known. Check the appropriate classification of the reporting entity that designates if it is, or expects to be, a prime or sub-award client. Identify the tier of the sub-awardee, e.g., the first sub-awardee of the prime is the 1st tier. Sub-awards include but are not limited to subcontracts, sub-grants and contract awards under grants.

5. If the organization filing the report in item 4 checks "Sub-awardee," then enter the full name, address, city, state, and zip code of the prime federal client. Include Congressional District, if known.

6. Enter the name of the federal agency making the award or loan commitment. Include at least one organizational level below agency name, if known. For example, Department of Transportation, United States Coast Guard.

7. Enter the federal program name or description for the covered federal action (Item 1). If known, enter the full Catalog of Federal Domestic Assistance (CFDA) number for grants, cooperative agreements, loans, and loan commitments.

8. Enter the most appropriate federal identifying number available for the federal action identified in Item 1, e.g., Request for Proposal (RFP) number, Invitation for Bid (IFB) number; grant announcement number; the contract, grant, or loan award number; the application/proposal control number assigned by the Federal agency. Include prefixes, e.g., "RFP-DE-80-001."

9. For a covered federal action where there has been an award or loan commitment by the federal agency, enter the federal amount of the award loan commitment for the prime entity identified in Item 4 or 5.

10. A. Enter the full name, address, city, state, and zip code of the lobbying entity engaged by the reporting entity identified in item 4 to influence the covered federal action.

    B. Enter the full names of the individual(s) performing services, and include full address if different from 10(a). Enter Last Name, First Name, and Middle Initial (MI).

11. Enter the amount of compensation paid or reasonably expected to be paid by the reporting entity (Item 4) to the lobbying entity (item 10). Indicate whether the payment has been made (actual) or will be made (planned). Check all boxes that apply. If this is a material change report, enter the cumulative amount of payment made or planned to be made.

12. Check the appropriate box(es). Check all boxes that apply. If payment is made through an in-kind contribution, specify the rate and value of the in-kind payment.

13. Check the appropriate box(es). Check all boxes that apply. If other, specify nature.

14. Provide a specific and detailed description of the services that the lobbyist has performed, or will be expected to perform, and the date(s) of any services rendered. Include all preparatory and related activity, not just time spent in actual contract with federal officials. Identify the federal official(s) or employee(s) contacted or the officer(s), employee(s), or Member(s) of Congress that were contacted.

15. Check whether or not a Standard Form-LLL-A Continuation Sheet(s) is attached.

16. The certifying official shall sign and date the form, print his/her name, title, and telephone number.

Public reporting burden for this collection of information is estimated to average 30 minute per reports, including time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. Send comments regarding the burden estimate or any other aspect of the collection of information, including suggestions for reducing the burden, to the Office of Management and Budget, Paperwork Reduction Project (CC-48-004), Washington, D.C., 30603.

DISCLOSURE OF LOBBYING ACTIVITIES

Complete this form to disclose lobbying activities pursuant to 31 U.S.C. 1352

1. Type of Federal Action: Contract a. Grant b. Cooperative Agreement c. Loan d. Loan Guarantee e. Loan Insurance	2. Status of Federal Action: Bid/Offer Application a. Initial Award b. Post-Award	3. Report Type: a. Initial Filing b. Material Change For Material Change: Year_____Quarter _____ Date of last report _____

4. Name and Address of Reporting Entity: Prime Subawardee Tier_____if known: Congressional District, if known	5. If Reporting Entity in No. 4 is Subawardee, Enter Name and Address of Prime: Congressional District, if known
6. Federal Department/Agency:	7. Federal Program Name/Description: CFDA Number, if applicable:
8. Federal Action Number, if known:	9. Award Amount, if known: $
10. a. Name and Address of Lobbying Entity (if individual, last name, first name, MI): (attach Continuation Sheet(s)	b. Individuals Performing Services (including address if different from No. 10a) (last name, first name, MI) SF-LLL-A, if necessary
11. Amount of Payment (check all that apply): $_____ actual planned	13. Type of Payment a. retainer b. one-time fee c. commission d. contingent fee e. deferred f. other; specify: _____
12. Form of Payment (check all that apply): a. Cash b. In-kind: Specify: Nature _____ Value	

14. Brief Description of Services Performed or to be Performed and Date(s) of Service, including officer(s), employe(s) or Member(s) contacted, for payment indicated in Item 11: (attach Continuation Sheet(s) SF-LLL-A, if necessary)
15. Continuation Sheet(s) SF-LLL-A attached: Yes No

16. Information required through this form is authorized by Title 31 U.S.C., Section 1352. This disclosure of lobbying activities is a material representation of fact upon which reliance was placed by the above when this transaction was made or entered into. This disclosure is required pursuant to 31 U.S.C. 1352. This information will be reported to the Congress semiannually and will be available for public inspection. Any person who fails to file the required disclosure shall be subject to a civil penalty of not less than $10,000 and no more than $100,000 for each such failure.	Signature: Print Name: Title: Telephone No.: Date:
Federal Use Only:	Authorized for Local Reproduction Standard Form - LLL

DISCLOSURE OF LOBBYING ACTIVITIES
Continuation Sheet

Reporting Entry:_____Page _____of _____

PAY FOR PERFORMANCE PROGRAM: Integrated Care Plan (ICP) Program

A. OVERVIEW

The Department is implementing a Pay for Performance Program (P4P) beginning January 1, 2016 for all Primary Contractors per HEDIS 2017 and select Pennsylvania Performance Measures (PAPMs) as defined in this document below. This P4P program is aligned with the Departmental goal for greater integration and coordination of behavioral health and physical health services. The Department expects this ICP Program to improve the quality of health care and reduce Medical Assistance (MA) expenditures through enhanced coordination of care between the Physical Health-MCOs (PH-MCO), Behavioral Health-MCOs (BH-MCO), Primary Contractors (PC) and providers.

The Department will provide a funding pool from which dollars will be paid to the Primary Contractor on a weighted basis based on combined PH/BH-MCO performance measures outlined in this Appendix

The Primary Contractor, who subcontracts with a BH-MCO to administer the HealthChoices Behavioral Health (HC BH) program, shall implement a shared saving methodology with the BH-MCO within sixty (60) days of implementation of this program that shall be reviewed and approved by the Department's Office of Mental Health and Substance Abuse Services (OMHSAS).

In order to be eligible for payments under the ICP, the BH-MCO must provide an Integrated Care Plan Program Report for Calendar Year (CY) 2016 that contains the following specific data requirements for individuals with serious and persistent mental illness (SPMI). SPMI is identified through the following ICD-9 codes and future ICD-10 codes:

295.xx - Schizophrenic Disorders
296.xx - Episodic Mood Disorders (i.e. Bipolar, Manic Affective Disorder, Major Depressive Affective Disorder)
298.9x - Other Nonorganic Psychoses
301.83 – Borderline Personality Disorder

1. **Member stratification**- An initial baseline stratification shall be conducted on all members in the targeted PSMI population at the start of the program. New members shall have an initial stratification level established within sixty (60) days of the date of enrollment. The BH-MCO will report on the member ID, initial stratification level, and six (6) month re-stratification level. Members will be stratified as follows:

    a. Four (4) = high PH/high BH needs
    b. Three (3) = high PH/low BH needs
    c. Two (2) = low PH/high BH needs
    d. One (1) = low PH/low BH needs

2. **Integrated Care Plan/Member Profile**- At least **.25%** of the Primary Contractor's **total** membership must receive an ICP that has been used in care management activity by both the PH and BH MCO. For purposes of this requirement, the Department considers an ICP or member profile, to be the collection, integration and documentation of key physical and behavioral health information that is easily accessible in a timely manner to persons with designated access.

3. **Hospitalization Notification and Coordination**- Each BH-MCO and PH-MCO will jointly share responsibility for notification of a hospital admission and will coordinate discharge and follow-up. This includes but is not limited to, sharing discharge instructions, medications, and recommended follow-up appointments to respective BH-MCO, PH-MCO as appropriate per HIPAA and regulatory standards. Notification to the partner MCO of hospital admissions shall occur within one (1) business day of when the responsible MCO partner learns of the admission (e.g., if the BH-MCO knows of an admission, it will notify the PH-MCO within one (1) business day and vice versa). Each BH-MCO will attest on the Integrated Care Plan Program Report that 90% of the admission notifications occurred within one (1) business day of the PH-MCO learning of the admission. The BH-MCO must maintain documentation to support the attestation of 90% admissions notifications.

4. The Integrated Care Plan Program Report will be audited to verify the accuracy of the stratification, integrated care plan and hospital notification information.

B. PERFORMANCE MEASURES

The following performance measures for the 2016 ICP Program include:

1. Initiation and Engagement of Alcohol and Other Drug Dependence Treatment *
   a. Initiation rate*
   b. Engagement rate*

2. Adherence to Antipsychotic Mediations for Individuals with Schizophrenia *

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

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

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

C. PERFORMANCE INCENTIVES

Ten million dollars ($10M) will be allocated statewide to a funding pool for the ICP Program in CY 2016 for Behavioral Health. The funding will be allocated to each HC BH Primary Contractor according to its overall percent of HealthChoices members for CY 2014.

Each of the measures defined below will be weighted equally and receive 20% of the allocated funding. Each component of the Initiation and Engagement of Alcohol and Other Drug Dependence Treatment will receive 10% of the allocated funding. Payments will be based on incremental improvement calculated from the base clinical care measurement year of 2015 (HEDIS/PAPM 2016) to the initial intervention year of 2016 (HEDIS/PAPM 2017).

1. Initiation and Engagement of Alcohol and Other Drug Dependence Treatment - **20%***
   a. Initiation rate-10%
   b. Engagement rate- 10%

2. Adherence to Antipsychotic Mediations for Individuals with Schizophrenia-**20%** *

3. Combined BH-PH Inpatient 30 Day Readmission Rate for Individuals with Serious and Persistent Mental Illness (SPMI)-**20**%**

4. Emergency Department Utilization for Individuals with Serious and Persistent Mental Illness (SPMI)- **20**%**

5. Combined BH-PH Inpatient Admission Utilization for Individuals with Serious and Persistent Mental Illness (SPMI)-**20**%**

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

D. METHODOLOGY FOR IMPROVEMENT INCENTIVES

1. **Performance Target**

The incremental payments will be based on the following scale for measures 1, 2 and 3.

Incremental Improvement	**% Payout**
≥ 3 Percentage Point Improvement	100.0%
≥ 2 and < 3 Percentage Point Improvement	85.0%
≥ 1 and < 2 Percentage Point Improvement	75.0%
0.5 - < 1 Percentage Point Improvement	50.0%

For measures 4 and 5, 100% payout will be made if there is a reduction of ≤3.0 events per 1000 member months and a 75% payout if there is a reduction in ≤2.0 events per 1000 member months.

E. Payment for Performance Incentives

The Department will make a payment, as provided by this Appendix, only to the extent that adequate funds are included for the purpose of Appendix payments to all Primary Contractors and PH-MCOs in the Commonwealth enacted budget for fiscal year 2017-18 within the capitation appropriation. If the Department has an obligation to the BH-MCO and PH-MCO, the Department will issue the payment by August 31, 2018.

The P4P Program is effective only if the BH-MCO and PH-MCO operate a HC program in the HC zone under this Agreement in the month of December 2016. If the BH-MCO or PH-MCO does not operate a HC program in the HC zone under this Agreement in the month of December 2016, the Department has no obligation under this Appendix.

All incentives will be developed and administered in accordance with 42 CFR 438.6, Contract Requirements. Financial incentives available through P4P will be paid in addition to the actuarially sound capitation rates to be paid by the Department to each Primary Contractor. Agreements with incentive arrangements may not provide for total payment in excess of 105% of the approved Capitation payments, nor will they be conditioned on an Intergovernmental Transfer, in accordance with federal regulations. Incentive payments can be made to both public and private providers.

The parties will be notified 120 days prior to the start of each measurement period with respect to renewal and related modifications of the P4P, as funds are available.

Fraud, Waste and Abuse Program Requirements

Definitions:

Abuse –*Per §42 CFR Part 455.2,- Provider practices that are inconsistent with sound fiscal, business, or medical practices, and result in an unnecessary cost to the Medicaid program, or in reimbursement for services that are not medically necessary or that fail to meet professionally recognized standards for health care. It also includes recipient practices that result in unnecessary costs to the Medicaid program.*

This includes any practices in a capitated MCO, Primary Care Case Management (PCCM) program, or other managed care setting that are inconsistent with sound fiscal, business, or medical practice and which result in unnecessary cost to the MA Program, or in reimbursement for services that are not medically necessary or that fail to meet professionally recognized standards or contractual obligations (including the terms of the PSR, contracts, and requirements of state or federal regulations) for health care in the managed care setting. The abuse can be committed by an MCO, contractor, Subcontractor, Provider, State employee, MA beneficiary or MA managed care enrollee, among others. It also includes beneficiary practices in a capitated MCO, PCCM program, or other managed care setting that result in unnecessary costs to the MA program or MCO, contractor, Subcontractor, or Provider. A Provider can be described as any individual or entity that receives MA funds in exchange for providing a service (MCO, contractor or Subcontractor).

Fraud –*Per §42 CFR Part 455.2 – An intentional deception or misrepresentation made by a person with the knowledge that the deception could result in some unauthorized benefit to himself or some other person. It includes any act that constitutes fraud under applicable Federal or State law.*

This includes any intentional deception or misrepresentation made by an entity or person in a capitated MCO, PCCM program, or other managed care setting with the knowledge that the deception could result in an unauthorized benefit to the entity, him/herself or another responsible person in a managed care setting.

Waste – (as defined by CMS for Medicare Part D) – *Overutilization of services, or other practices that result in unnecessary costs. Generally not considered caused by criminally negligent actions but rather the misuse of resources.*

1. Primary Contractor's Responsibility for Fraud, Waste and Abuse Requirements of the HealthChoices Contract

Per §42 CFR 438.608, the Primary Contractor must develop or require the BHMCO to develop a written compliance plan that must contain the following elements:

- Written policies, procedures and standards of conduct that articulate the Primary Contractor and/or its BH-MCO's commitment to comply with all Federal and State standards related to Medicaid managed care organizations;
- The designation of a compliance officer and a compliance committee that is accountable to senior management;
- Effective training and education for the compliance officer and MCO employees;
- Effective lines of communication between the compliance officer and MCO employees;
- Enforcement of standards through well publicized disciplinary guidelines;
- Provisions for internal monitoring and auditing; and
- Provisions for prompt response to detected offenses and the development of corrective action initiatives.
- The Primary Contractor and its BH-MCO must comply with the Department's MA Bulletin #99-11-05 "Provider Screening of Employees and Contractors for Exclusion from Participation in Federal Health Care Programs and the Effect of Exclusion on Participation" and must check providers against the National Plan and Provider Enumeration System (NPPES) (effective for rating periods starting on or after July 1, 2017), the System for Award Management (SAM) at www.sam.gov; the Excluded Individuals and Entities (LEIE) and the Medicheck databases for screening to determine exclusion status at the time of hire or contracting and thereafter on an ongoing monthly basis.
- Effective for rating periods starting on or after July 1, 2017, the Primary Contractor must comply with Federal database check as per 42 CFR 455.436 which requires that the Social Security Death Master File (DMF) be checked monthly. Providers who have enrolled or re-enrolled since the date of implementation must have their Social Security numbers compared to the DMF.

The Primary Contractor must designate a full-time Fraud Waste and Abuse Coordinator who will be dedicated to preventing, detecting, investigating, and referring suspected Fraud, Waste and Abuse in the HealthChoices Behavioral Health program to the Department. The Fraud, Waste and Abuse Coordinator will act as a direct contact with the Department in matters relating to Fraud, Waste and Abuse. The Primary Contractor shall submit the title, address, and contact information of the Coordinator to the Department

The Primary Contractor may designate the BH-MCO to fulfill the function of managing the HealthChoices Fraud, Waste and Abuse requirements and, in this event, the Primary Contractor will submit policies and procedures to the Department for approval describing the measures taken to ensure that the BH-MCO complies with all requirements related to Fraud, Waste and Abuse including but not limited to §42 CFR 455.104, 105 and 106. In this instance the Primary Contractor must provide oversight of the BH-MCO and will require the BH-MCO to report all cases of suspected Fraud, Waste or Abuse to the Primary Contractor and the Department. The Primary Contractor and its BH-MCO must cooperate with any Federal, State and local law enforcement investigation.

2. Fraud, Waste and Abuse Requirements for HealthChoices

a. Corporate Integrity / Compliance / Fraud, Waste and Abuse Staff

The Primary Contractor and its BH-MCO must have Fraud, Waste and Abuse staff in sufficient numbers that will prevent, detect, investigate, and report suspected Fraud, Waste and Abuse that may be committed by network Providers, members, employees, and subcontracted parties.

b. Written Policies

The Primary Contractor and its BH-MCO will maintain and comply with written policies and procedures for the prevention, detection, and reporting of suspected Fraud, Waste and Abuse, which are subject to the approval of the Department's Bureau of Program Integrity.

The Department will require policies and procedures before implementation of the HealthChoices Behavioral Health Agreement and an annual review of policies and procedures during the course of the Agreement period. The policies and procedures will contain the following:

- The title and contact information of the Fraud, Waste and Abuse Coordinator and staff.
- A description of specific controls in place for Fraud, Waste and Abuse detection, including an explanation of the technology used to identify aberrant billing patterns, procedures for claims edits and post processing review of claims, review of complaints and grievances, and other means of identifying Fraud , Waste and Abuse.
- A description of the methodology and standard operating procedures used to investigate Fraud, Waste and Abuse, such as on-site visits and record reviews.

- Explanation of the process for referring suspected Fraud, Waste and Abuse to the Department within thirty (30) business days of identification of the problem/issue. This explanation must state that the MCO will gather and send to BPI any and all documentation supporting the referral. Such information will include, but will not be limited to, the items listed on the "Checklist of Supporting Documentation for Referrals" (Attachment 2).
- Methodology for recovering overpayments or otherwise sanctioning Providers.
- Process for reporting in writing any Providers who are suspended, resign, or voluntarily withdraw after initiation of Fraud, Waste and Abuse review.
- A statement outlining an educational plan for staff relating to Fraud, Waste and Abuse.
- Statement ensuring full cooperation with State and Federal oversight agencies including, but not limited to, the Department's Bureau of Program Integrity, the Office of Attorney General's Medicaid Fraud Control Section, The Pennsylvania Office of the Inspector General, and the US Justice Department.
- A statement that the Department's Medicheck List and the Federal Office of Inspector General's List of Excluded Individuals and Entities (LEIE) are used to verify that Providers sanctioned by the State or Federal government are not participating in HealthChoices.
- A statement that the System for Award Management (SAM) at www.sam.gov, is used to verify Providers that are excluded from receiving Federal contracts, certain subcontracts and certain Federal financial and non-financial assistance and benefits are excluded from participating in HealthChoices.
- A method to verify whether services reimbursed by the Primary Contractor and/or its BH-MCO were actually furnished to recipients.
- A statement that provide for the imposition of payment suspension at the request of the Department and the MFCS.
- A statement that requires compliance with MA Bulletin 99-11-05 upon hire and monthly screening and ensure all Providers in the network are in compliance.
- A certification that the policies and procedures were reviewed and approved by the Primary Contractor and/or its BH-MCO.

c. Duty to Report Suspected Fraud, Waste and Abuse to the Department

The Fraud, Waste and Abuse Coordinator shall be required to report all suspected Fraud, Waste and Abuse to the Department within thirty (30) business days of the identification of the problem/issue or pattern of abuse. The Fraud, Waste and Abuse Coordinator is responsible for assembling all documentation supporting the referral and sending it to BPI. "MCO Fraud and Abuse Reporting Requirements" (Attachment 1) provides examples of Fraud and Abuse, as well as reporting information to the Department. The "Checklist of Supporting Documentation for Referrals" (Attachment 2) includes examples of the

information that the MCO must gather and send to BPI in order to support a referral. The Fraud, Waste and Abuse Coordinator should check the appropriate boxes on the "Checklist of Supporting Documentation for Referrals" form indicating the supporting documentation information that is sent with each referral. A copy of the completed checklist and all supporting documentation should accompany each referral. All suspected Fraud, Waste and Abuse must be reported prior to any internal sanctioning, including corrective actions by the Primary Contractor or BH-MCO.

The Fraud, Waste and Abuse Coordinator must submit to the Department quarterly statistical reports which detail its Fraud, Waste and Abuse detection and sanctioning activities regarding Providers. Depending on the nature or extent of the problem, it may also be advisable to place the individual Provider on prepayment review to avoid unnecessary expenditures during the review process.

The quarterly report must include information for all situations where a Provider action caused an overpayment to occur. The quarterly report will identify cases under review (including approximate dollar amounts), Providers terminated due to Medicare /Medicaid preclusion, and overpayments recovered. **The "MCO Quarterly Compliance Report" and instructions for completion are located online at:** https://dpwintra.dpw.state.pa.us/HEALTHCHOICES/custom/program/fraud/fraud.asp

Upon completion of the Quarterly Compliance Report copy the spreadsheets and attach them to your secure email and send it to the email address provided in the instructions. The MCO must provide a quarterly certification statement signed by the Chief Executive Officer, the Chief Financial Officer or the Chief Operations Officer and the SIU Manager/Compliance Officer with every reporting package being submitted. If revisions are made to any report, an additional quarterly certification statement must accompany the revised report being sent to the Department of Human Services. .

d. Duty to Cooperate with Oversight Agencies

The Primary Contractor and/or its BH-MCO must cooperate fully with State detection and prosecution activities. Such agencies include, but are not limited to, the Department's Bureau of Program Integrity, Governor's Office of the Budget, Office of Attorney General's Medicaid Fraud Control Section, the Pennsylvania State Inspector General, the Federal Office of Inspector General, and the United States Justice Department.

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

The Primary Contractor and/or its BH-MCO must immediately notify the Department, Bureau of Program Integrity, when a Provider, as well as other parties associated with Provider entity, has disclosed information regarding a criminal conviction related to Medicare, Medicaid, or Title XX when making an application to be credentialed as a BH-MCO network Provider or upon renewal of their credentialing, or is identified due to required monthly screening. The Primary Contractor or its BH-MCO must also notify the Department, Bureau of Program Integrity of an adverse action, such as convictions, exclusions, revocations, and suspensions, taken on Provider applications, including denial of initial enrollment. Disclosure includes the following information:

- Identity of any person or entity having an ownership or control interest in the Provider and who has been convicted of a criminal offense related to that person's involvement in any program under Medicare, Medicaid or the Title XX services program since the inception of those programs.

- Identity of any person who is a managing employee of the Provider and who has been convicted of a crime related to Federal health care programs.

- Identity of any person who is an agent of the Provider and who has been convicted of a crime related to Federal health care programs. The Primary Contractor and/or its BH-MCO must supply updated disclosure to the Department within fifteen (15) days upon request.

e. Fraud and Abuse Hotline

The Primary Contractor and/or its BH-MCO must also ensure that the Department's toll-free Fraud and Abuse hotline and accompanying explanatory statement (Attachment 3) is distributed to Members and Providers through Member and Provider handbooks. Notwithstanding this requirement, the Primary Contractor or BH-MCO will not be required to re-print handbooks for the sole purpose of revising them to include Fraud and Abuse hotline information. The Primary Contractor and/or its BH-MCO must, however, include such information in any new version of these documents to be distributed to Members and Providers.

f. Precluded Providers

The Primary Contractor, its BH-MCO and their employees are prohibited from affiliating with individuals who have been debarred from such Federal agencies as Medicaid, Medicare and SCHIP. Federal Financial Participation (FFP) is not available to pay for services from the Primary Contractor's BH-MCO, Providers or their employees who are excluded from these programs, except for emergency services.

The Department shall notify Primary Contractors when actions are taken to terminate behavioral health Providers from participation in the Medicaid and Medicare Programs. The notification will not include the basis for the departmental action, due to confidentiality issues. Upon notification from the Department that a Provider is suspended or terminated from participation in the Medicaid or Medicare Programs, BH-MCO shall immediately act to terminate the Provider from participation. Terminations for loss of licensure and criminal convictions must coincide with the MA effective date of the action.

g. Duty to Notify Department

The Department recommends that the Primary Contractor / BH-MCO access the Office of Medical Assistance Program's Medicheck List for information on Providers who have been precluded from the MA Program. The Federal List of Excluded Individuals and Entities (LEIE) must be checked monthly.

The Primary Contractor or BH-MCO must immediately notify the Department in writing if a Provider, Subcontractor , or employee resigns, is suspended, terminated, decredentialed or voluntarily withdraws from participation in the network as a result of suspected or confirmed Fraud, Waste or Abuse. The notification must contain the reason for the action.

Provider agreements shall carry notification of the prohibition and sanctions for submission of false claims and statements. Primary Contractor and/or BH-MCOs who fail to report such information are subject to sanctions, penalties, or other actions.

h. Audit Protocol

The BH-MCO must inform all Network Providers of the Pennsylvania Medical Assistance Provider Self Audit Protocol which allows Providers to voluntarily disclose overpayments or improper payments of MA Funds.

The protocol is available on the Department's website under "Fraud and Abuse".

i. Sanctions

The Department reserves the right to impose sanctions, penalties, or take other actions if it determines that a Primary Contractor, BH-MCO, network Provider, employee, or Subcontractor has committed Fraud, Waste or Abuse or has otherwise violated applicable law.

j. Subcontracts

The Primary Contractor and BH-MCO agree to ensure that all Subcontractors comply with the Fraud, Waste and Abuse requirements listed in this Agreement. All health care Providers with whom the Primary Contractor and BH-MCO subcontracts are enrolled in the MA program and subject to MA regulations. The Primary Contractor and BH-MCO agrees to ensure, via the HC BH Agreement, that such health care Providers comply with MA regulations, and understand and agree that they are subject to enforcement actions directly initiated by the Department under its regulations, including termination and restitution actions, among others.

Attachment 1

MCO FRAUD AND ABUSE REPORTING REQUIREMENTS

1. Examples of Suspected Fraud and Abuse: The following are examples of suspected fraud and abuse that must be reported. The Primary Contractor or BH-MCO may reference 55 Pa. Code Section 1101 et seq. and the specific regulations relating to each provider type for further guidance.

Billing / Record Keeping Issues
Falsifying/altering claims/ encounters/records
Upcoding / Incorrect coding
Double billing / Unbundling
Billing for services/ supplies not rendered
Failing to maintain appropriate records
Any issue that could result in collection of overpayment

Suspected Member Fraud / Abuse
Prescription alteration or forgery
Inappropriate use of member's card
Duplication of medications/services
Frequent ER visits; physician, pharmacy, or hospital "shopping"

Abuse of a Member
Physical, mental, sexual
Discrimination

Employee / Subcontractor Theft or Embezzlement

2. Reporting Suspected Provider Fraud and Abuse: The Primary Contractor or BH-MCO fraud and abuse unit must report suspected provider fraud and abuse within 30 business days.

Reports are to be submitted online using the "MCO Referral Form". The instructions and form template are located at:

https://dpwintra.dpw.state.pa.us/HealthChoices/custom/general/forms/forms.asp .

Once completed, the form should be submitted electronically to BPI by clicking the "Submit" button. The "Checklist" (outlined on the "MCO Referral Form"), a copy of the confirmation page (which will appear after "Submit" button is clicked submitting the "MCO Referral Form") and all supporting documentation must be faxed to BPI at 717- 772-4655 (Attn: MCO Unit) or by mail to:

DHS Bureau of Program Integrity
Managed Care Unit
PO Box 2675
Harrisburg, PA 17105-2675

3. Reporting Suspected Member Fraud and Abuse and requesting recipient restriction (lock-in) action: Report to:

DHS Bureau of Program Integrity
Recipient Restriction Program
PO Box 2675
Harrisburg, PA 17105-2675
717-772-4627 (office)
717-772-4655 (fax)

4. Reporting Suspected Member Fraud and Abuse and not requesting recipient restriction (lock-in) action: Report to:

DHS Bureau of Program Integrity
Managed Care Unit
PO Box 2675
Harrisburg, PA 17105-2675
717-772-4655 (fax)

Attachment 2

Checklist of Supporting Documentation for Referrals

- All referrals should have the confirmation page from online referral attached.
- Please check the appropriate boxes that indicate the supporting documentation included with your referral.

Example of materials for provider or staff person referrals –

- ☐ confirmation page from online referral
- ☐ encounter forms (lacking signatures or forged signatures)
- ☐ timesheets
- ☐ attendance records of recipient
- ☐ written statement from parent, provider, school officials or client that services were not rendered or a forged signature
- ☐ progress notes
- ☐ internal audit report
- ☐ interview findings
- ☐ sign-in log sheet
- ☐ complete medical records
- ☐ resume and supporting resume documentation (college transcripts, copy of degree)
- ☐ credentialing file (DEA license, CME, medical license, board certification)
- ☐ copies of complaints filed by members
- ☐ admission of guilty statement
- ☐ other:_____

Example of materials for pharmacy referrals-

- ☐ paid claims
- ☐ prescriptions
- ☐ signature logs
- ☐ encounter forms
- ☐ purchase invoices
- ☐ EOB's
- ☐ delivery slips
- ☐ licensing information
- ☐ other: _____

Example of materials for RTF referrals-

- ☐ complete medical records
- ☐ discharge summary
- ☐ progress notes from providers, nurses, other staff
- ☐ psychological evaluation
- ☐ other: _____

Example of materials for behavioral health referrals-

- ☐ complete medical and mental health record
- ☐ results of treatment rendered/ ordered, including the results of all lab tests and diagnostic studies
- ☐ summaries of all hospitalizations
- ☐ all psychiatric examinations
- ☐ all psychological evaluations
- ☐ treatment plans
- ☐ all prior authorizations request packets and the resultant prior authorization number
- ☐ encounter forms (lacking signatures or forged signatures)
- ☐ plan of care summaries
- ☐ documentation of treatment team or Interagency Service Planning Team meetings
- ☐ progress notes
- ☐ other: _____

Example of materials for DME referrals-

- ☐ orders, prescriptions, and/or certificates of medical necessity (CMN0 for the equipment
- ☐ delivery slips and/or proof of delivery of equipment
- ☐ copies of checks or proof of copay payment by recipient
- ☐ diagnostic testing in the records
- ☐ copy of company's current licensure
- ☐ copy of the Policy and Procedure manual applicable to MDE items
- ☐ other: _____

Department of Human Services' (DHS) Toll-Free Fraud and Abuse Hotline Information for Inclusion in MCO Member and Provider Manuals

For Member Handbooks:

DHS Fraud and Abuse Hotline:

The Department of Public Welfare has a hotline if you want to report a medical provider (for example a doctor, dentist, therapist, hospital) or business (medical supplier) for suspected fraud or abuse for services provided to anyone with an ACCESS card). The hotline number is 1-866-DPW-TIPS (1-866-379-8477).

Some common examples of **fraud and abuse** are:
Billing or charging you for services that your health plan covers
Offering you gifts or money to receive treatment or services
Offering you free services, equipment, or supplies in exchange for your ACCESS number
Giving you treatment or services that you don't need
Physical, mental, or sexual abuse by medical staff

You can call the Hotline and speak to someone Monday through Friday, 8:30AM to 3:30PM. You may leave a voice mail message at other times. If you don't speak English an interpreter will be made available. If you are hearing impaired you can call the hotline using your TTY device.

You do not have to give your name and if you do, the provider will not be told you called.

You can also report suspected fraud and abuse by using the website:

http://www.dhs.state.pa.us/learnaboutdhs/fraudandabuse/maprovidercompliancehotlineresponseform/index.htm

This has been set up so you do not have to give your name also.

For Provider Handbooks:

The Department of Human Services has established a hotline to report suspected fraud and abuse committed by any entity providing services to Medical Assistance recipients.

The hotline number is 1-866-DPW-TIPS (1-866-379-8477) and operates between the hours of 8:30 AM and 3:30 PM, Monday through Friday. Voice mail is available at all other times. Callers may remain anonymous and may call after hours and leave a voice mail if they prefer.

Some common examples of fraud and abuse are:
Billing or charging Medical Assistance recipients for covered services
Billing more than once for the same service
Dispensing generic drugs and billing for brand name drugs
Falsifying records
Performing inappropriate or unnecessary services

Suspected fraud and abuse may also be reported via the website at:

http://www.dhs.pa.gov/learnaboutdhs/fraudandabuse/maprovidercompliancehotlineresponseform/index.htm

Information reported via the website or email can also be done anonymously. The website contains additional information on reporting fraud and abuse.

HEALTHCHOICES ENROLLMENT PROGRAM

The HealthChoices Enrollment Program contracts with an enrollment broker that is responsible for enrollment activities within all HealthChoices Zones. The enrollment broker employs trained professional staff called Enrollment Specialists (ESs) that are supervised by Special Needs Enrollment Coordinators (SNECs). The enrollment broker is responsible for educating the consumer, which enables them to make an informed choice of a physical health plan that best serves their medical needs and to assist with selecting a primary care physician (PCP).

The enrollment broker offers MA consumers several convenient methods of enrolling into the HealthChoices Program. All eligible Medicaid consumers have the opportunity to meet face-to-face with an ES with County Assistance Offices (CAOs). Other methods of enrolling include attending community presentations, using the HealthChoices Smart phone installed at the CAO which connects directly with an ES at the HC hotline, calling the toll-free HealthChoices hotline or by completing an enrollment form and returning it in the mail.

The enrollment broker will have Special Needs Coordinator (SNEC) serve as liaisons and work with County and State children and youth agencies; children in substitute care, county and state mental retardation agencies, aging, social programs, maternal and child health; and physical and behavioral health plans. The SNECS will assist Medicaid consumers who encounter obstacles enrolling into HealthChoices

Once the Medicaid consumer enrolls into HealthChoices, the enrolment broker will enter this data onto their system and will submit on a weekly basis an enrollment/disenrollment file to the Department. The Department will send weekly enrollment/plan transfer reconciliation files to the enrollment broker and to the physical health plans.

The enrollment broker will be responsible for maintaining an on-line provider directory. This directory contains the provider network submitted by the physical health plans and is updated weekly.

Responsibilities of the enrollment broker include, but are not limited to the following:

- To help increase public awareness of the HealthChoices Program through conducting the CLIC and by coordinating efforts of the Public Information Campaign which provides general information to Medicaid consumers on mandatory managed care in Pennsylvania.

- To ensure that outreach efforts are specifically targeted to the various populations and needs of the Medicaid consumers in all HC-zones.

- To provide education and information to Medicaid consumers to enable them to make informed decisions on which physical health plans meets their needs in order to decrease plan transfers and encourage continuity of care.

- To ensure objective awareness of choices available for physical health care services.

- To provide information on the HC-BH-MCOs and how to access these services.

- To minimize the number of Medicaid consumers assigned to a physical health plan through automatic assignment.

- To complete enrollments and ensure that they are processed accurately, timely, efficiently, and effectively.

- To ensure the appropriate identification and referral of individuals with special needs or circumstances.

APPENDIX H
Complaint, Grievance, and Fair Hearing Processes

A. General Requirements

1. The BH-MCO must have written policies and procedures for registering, responding to and resolving complaints and grievances (at all levels) as they relate to the MA population.

2. All complaint, grievance, and fair hearing policies and procedures developed by a BH-MCO must be approved in writing by the Department prior to their implementation.

3. The complaint and grievance processes must be fair, easy to understand, easy to follow, easily accessible and respectful of individual rights.

4. The BH-MCO policies and procedures regarding member complaints and grievances must be provided to members in written form:

    a. Upon enrollment into the BH-MCO,
    b. Upon member request, and
    c. At least 30 calendar days before a Department-approved change becomes effective.

5. Information regarding the complaint and grievance procedures and how to file a complaint or grievance must be available within public view at all network provider offices.

6. Notification that a member will not incur a fee for filing a complaint or grievance at any level of the process must be available within public view at all network provider offices

7. The BH-MCO must operate a toll-free telephone service for members to file complaints and grievances and to follow up on complaints and grievances filed by members. The phone service must be operated 24 hours a day, 7 days a week with appropriately trained staff. Answering machines or taped messages are not acceptable.

8. The BH-MCO must designate and train sufficient staff to be responsible for receiving, processing, and responding to member complaints and grievances in accordance with the requirements in this Appendix.

9. All County and BH-MCO staff involved in the complaint and grievance processes and all review committee members must receive training in the areas related to their responsibility at least annually or more frequently, if needed.

10. All County and BH-MCO staff involved in the complaint and grievance processes and all review committee members must have the necessary orientation, clinical training and experience to make an informed and impartial determination(s) regarding issues assigned to them.

    a. Informed: having knowledge of the circumstances and issues that are the subject of the review.
    b. Impartial: a demonstrated ability to analyze information and resolve disputed issues in a fair and nondiscriminatory manner.

11. All review committee proceedings shall be conducted in a manner that is informal and impartial to avoid intimidating the member or the member's representative.

12. The BH-MCO must identify a lead person responsible for overall coordination of the complaint and grievance processes, including the provision of information and instructions to members.

13. The BH-MCO must maintain a log of all complaints and grievances, which includes, at a minimum, identifying information about the member, the nature of the complaint or grievance, and the date received.

14. The BH-MCO must ensure that members have access to all relevant documentation pertaining to the subject of the complaint or grievance and may not charge members for copies of the documentation. If the member requests the documentation pertaining to the subject of the complaint or grievance it must be provided to the member sufficiently in advance of the review to allow the member time to review it.

15. The BH-MCO must ensure that there is a link between the complaint and grievance processes and the Quality Management and Utilization Management programs.

16. The BH-MCO may not use the timeframes or procedures of the complaint and grievance processes to avoid the medical decision process or to discourage or prevent the member from receiving medically necessary care in a timely manner.

17. The BH-MCO must accept complaints and grievances from individuals who have disabilities which are in alternative formats including: TTD/TTY for telephone inquiries and complaints and grievances from members who are hearing impaired; Braille; tape; or computer disk; and other commonly accepted alternative forms of communication. BH-MCO employees who receive telephone complaints and grievances should also be aware of the speech limitation of some members who have disabilities so they can treat these individuals with patience, understanding, and respect.

18. The BH-MCO must recognize that members, who have disabilities, may need assistance to prepare and present their case at complaint or grievance reviews. Assistance shall be offered by the BH-MCO at no cost to the member and may include:

    a. Providing qualified sign language interpreters for members who are severely hearing impaired;
    b. Providing information submitted on behalf of the BH-MCO at the complaint or grievance review in an alternative format accessible to the member filing the complaint or grievance. The alternative format version should be supplied to the member before the review and at the review, so the member can discuss and/or refute the content during the review; and
    c. Providing personal assistance to members with other physical limitations in copying and presenting documents and other evidence.

19. The BH-MCO must provide language interpreter services when requested by a member at no cost to the member.

20. The BH-MCO must offer members, at no cost to the member, the assistance of a BH-MCO staff member throughout the complaint and grievance processes. The BH-MCO staff member cannot have had previous involvement with the issue in dispute.

21. The BH-MCO must ensure that anyone who participates in making the decision on a complaint or grievance has not participated in any previous decision by the BH-MCO related to the same complaint or grievance.

22. Upon receipt of a complaint or grievance, the BH-MCO must provide members with names and contact information of advocacy organizations available to assist members.

23. If the outcome of a member's complaint or grievance indicates that a corrective plan of action and/or follow-up is needed to address quality of care concerns that were discovered at any time, the BH-MCO must implement the corrective plan of action and/or follow-up.

24. The BH-MCO must retain all complaint and grievance records to include the log of the complaint and grievance for a period of no less than 10 years.

25. The BH-MCO must notify the member when the BH-MCO fails to decide a 1st level complaint or 1st level grievance within the timeframes specified in this Appendix, using the template supplied by the Department as **Attachment 1a** of this Appendix. This notice must be mailed on the date the timeframe for making a decision on the 1st level complaint or 1st level grievance expire.

26. The BH-MCO must notify the member when it denies payment after a service(s) has been delivered because the service(s) was provided without authorization by a provider not enrolled in the Pennsylvania Medical Assistance Program, using the template supplied by the Department as **Attachment 1b** of this Appendix. The notice must be mailed to the member on the day that the decision is made to deny payment.

27. The BH-MCO must notify the member when it denies payment after a service(s) has been delivered because the service provided is not a covered benefit, using the template supplied by the Department as **Attachment 1c** of this Appendix. The notice must be mailed to the member on the day that the decision is made to deny payment.

28. The BH-MCO must notify the member when it denies payment after a service(s) has been delivered because the BH-MCO determined that the service(s) was not medically necessary, using the template supplied by the Department as **Attachment 1d** of this Appendix. This notice must be mailed to the member on the day the decision is made to deny payment.

B. Complaints

1. Definition**:** A complaint is a dispute or objection filed with the BH-MCO regarding a participating health care provider or the coverage, operations, or management policies of a BH-MCO.

   Note: Complaints do not include requests for review of a decision concerning the medical necessity and appropriateness of a health care service.

   a. A complaint may be filed about the following, but can also address other issues:

      i. a denial because the requested service is not a covered benefit;
      ii. failure of the BH-MCO to meet the required timeframes for providing a service, which includes the BH-MCO failure to deliver all services as authorized;
      iii. failure of the BH-MCO to decide a complaint or grievance within the specified timeframes;
      iv. a denial of payment after a service(s) has been delivered because the service(s) was provided without authorization by a provider not enrolled in the Pennsylvania Medical Assistance Program;
      v. a denial of payment after a service(s) has been delivered because the service is not a covered benefit; and
      vi. a member's dissatisfaction with the BH-MCO or a provider.

2. First Level Complaint Process

   a. A BH-MCO must permit a member to designate a representative, which may include the member's provider, if the member provides the BH-MCO with written authorization that indicates that the representative may be involved and/or take action on the member's behalf. Failure to provide written authorization of representation may not delay the complaint process.

   b. A member or member's representative (if designated) may file a complaint either orally or in writing. An oral complaint filed about the following:

      i. a denial because the requested service is not a covered benefit, or
      ii. the failure of the BH-MCO to meet the required timeframes for providing a service, which includes the BH-MCO failure to deliver all services as authorized; or
      iii. the failure of the BH-MCO to decide a complaint or a grievance within the specified timeframes, or

iv. a denial of payment after a service has been delivered because the service(s) was provided without authorization by a provider not enrolled in the Pennsylvania Medical Assistance Program, or
v. a denial of payment after a service has been delivered because the service is not a covered benefit.

must be committed to writing by the BH-MCO and must be provided to the member for signature. The member's signature may be obtained at any point in the process, and failure to obtain a signed complaint may not delay the complaint process.

c. If the complaint is about the following:

i. a denial because the requested service is not a covered benefit, or
ii. the failure of the BH-MCO to meet the required timeframes for providing a service, which includes the BH-MCO failure to deliver all services as authorized; or
iii. the failure of the BH-MCO to decide a complaint or a grievance within the specified timeframes, or
iv. a denial of payment after a service(s) has been delivered because the service(s) was provided without authorization by a provider not enrolled in the Pennsylvania Medical Assistance Program, or
v. a denial of payment after a service(s) has been delivered because the service is not a covered benefit.

the member must file the complaint within 45 calendar days from the date of the incident complained of or the date the member receives written notice of the decision. For all other complaints, there is no time limit for filing a complaint.

d. If a member files a complaint, which constitutes as filing for a continuation of benefits, to dispute a decision to discontinue, reduce, or change a service that the member has been receiving on the basis that the service is not a covered benefit, the member must continue to receive the disputed service at the previously authorized level pending resolution of the complaint, if the complaint is filed orally, hand delivered or post-marked within one calendar day from the date on the written notice of decision if inpatient services are being discontinued, reduced, or changed or within ten calendar days from the date on the written notice of decision for all other services.

e. Upon receiving the complaint, the BH-MCO must assign an Investigator who has not had any previous involvement with the issue in dispute or is supervised by any person who has had any previous involvement with the issue in dispute and who will not benefit financially from the resolution of the complaint. The Investigator must treat all parties involved equally and be respectful of the member. The Investigator cannot be involved in making the decision on the member's complaint.

f. The Investigator is responsible for obtaining from all individuals involved all relevant documentation pertaining to the subject of the complaint. The Investigator must attend the review and provide the information obtained as part of the investigation to the first level complaint review committee. The Investigator must also provide all information provided to the first level complaint review committee to the member and the member's representative, if designated.

g. The BH-MCO must send the member and member's representative (if designated), an acknowledgment letter within five business days of receiving the complaint using the template supplied by the Department as **Attachment 2a** of this Appendix or, if the complaint is about the following:

   i. a denial because the requested service is not a covered benefit, or
   ii. the failure of the BH-MCO to meet the required timeframes for providing a service, which includes the BH-MCO failure to deliver all services as authorized; or
   iii. the failure of the BH-MCO to decide a complaint or a grievance within the specified timeframes, or
   iv. a denial of payment after a service has been delivered because the service(s) was provided without authorization by a provider not enrolled in the Pennsylvania Medical Assistance Program, or
   v. a denial of payment after a service has been delivered because the service is not a covered benefit

   using the template supplied by the Department as **Attachment 2b** of this Appendix.

h. The first level complaint review for complaints **not involving** a clinical issue must be performed by a first level complaint review committee, which must include one or more employees of the BH-MCO who were not involved in any previous level of review or decision making on the issue that is the subject of the complaint.

i. The first level complaint review for complaints **involving** a clinical issue must be performed by a first level complaint review committee, which must include one or more employees of the BH-MCO who were not involved in any previous level or review or decision making on the issue that is the subject of the complaint. At least one member of the committee must meet the qualifications required of an individual who makes a medical necessity decision as described in Appendix AA; section C.3, and this individual must decide the complaint.

j. If the complaint is about the following:

   i. a denial because the requested service is not a covered benefit, or
   ii. the failure of the BH-MCO to meet the required timeframes for providing a service, which includes the BH-MCO failure to deliver all services as authorized; or
   iii. the failure of the BH-MCO to decide a complaint or a grievance within the specified timeframes, or
   iv. a denial of payment after a service has been delivered because the service(s) was provided without authorization by a provider not enrolled in the Pennsylvania Medical Assistance Program, or
   v. a denial of payment after a service has been delivered because the service is not a covered benefit

   the member must be afforded a reasonable opportunity to present evidence, and allegations of fact or law, in person as well as in writing. The BH-MCO must be flexible when scheduling the review to facilitate the member's attendance. If the member cannot appear in person at the review, an opportunity to communicate with the first level complaint review committee by telephone or videoconference must be provided. The member may elect not to attend the first level complaint meeting but the meeting must be conducted with the same protocols as if the member was present. The member and/or anyone the member chooses may present the member's position to the first level complaint review committee.

k. The member's provider may be present at the first level complaint review if the member consents to the provider being present. The BH-MCO must document the member's consent in the complaint record.

l. The first level complaint review committee must complete its review of the complaint as expeditiously as the member's health condition requires, but no more than 30 calendar days from receipt of the complaint, unless an extension of up to 14 calendar days was requested by the member.

m. The first level complaint review committee must prepare a summary of the issues presented and decisions made, which must be maintained as part of the complaint record.

n. The BH-MCO must send a written notice of the first level complaint decision to the member and member's representative (if designated), service provider and the prescribing provider(if applicable), within five business days of the first level complaint review committee's decision, using the template supplied by the Department as **Attachment 3a** of this Appendix or, if the complaint is about the following:

   i. a denial because the requested service is not a covered benefit, or
   ii. the failure of the BH-MCO to meet the required timeframes for providing a service, which includes the BH-MCO failure to deliver all services as authorized; or
   iii. the failure of the BH-MCO to decide a complaint or a grievance within the specified timeframes, or
   iv. a denial of payment after a service has been delivered because the service(s) was provided without authorization by a provider not enrolled in the Pennsylvania Medical Assistance Program, or
   v. a denial of payment after a service has been delivered because the service is not a covered benefit.

   using the template supplied by the Department as **Attachment 3b** of this Appendix.

o. If the complaint is about the following:

   i. a denial because the requested service is not a covered benefit, or
   ii. the failure of the BH-MCO to meet the required timeframes for providing a service, which includes the BH-MCO failure to deliver all services as authorized; or
   iii. the failure of the BH-MCO to decide a complaint or a grievance within the specified timeframes, or
   iv. a denial of payment after a service has been delivered because the service(s) was provided without authorization by a provider not enrolled in the Pennsylvania Medical Assistance Program, or
   v. a denial of payment after a service has been delivered because the service is not a covered benefit.

the member may file a request for a fair hearing within 30 calendar days from the date on the written notice of the BH-MCO's first level complaint decision.

3. Second Level Complaint Process

   a. A BH-MCO must permit a member to designate a representative, which may include the member's provider, if the member provides the BH-MCO with written authorization that indicates that the representative may be involved and/or take action on the member's behalf. Failure to provide written authorization of representation may not delay the complaint process.

   b. The member or the member's representative (if designated) may file a request for a second level complaint review ("second level complaint"), within 45 calendar days from the date the member receives written notice of the BH-MCO's first level complaint decision.

   c. The BH-MCO must send the member and member's representative (if designated), an acknowledgment letter within five business days of receiving the second level complaint using the template supplied by the Department as **Attachment 4** of this Appendix.

   d. If a member files a second level complaint, which constitutes as filing for a continuation of benefits, to dispute a decision to discontinue, reduce, or change a service that the member has been receiving on the basis that the service is not a covered benefit, the member must continue to receive the disputed service at the previously authorized level pending resolution of the second level complaint if the second level complaint is filed orally, hand delivered or post-marked within one calendar day from the date on the written notice of the BH-MCO's first level complaint decision if inpatient services are being discontinued, reduced, or changed or within ten calendar days from the date on the written notice of the BH-MCO's first level complaint decision for all other services.

   e. The second level complaint review must be performed by a second level complaint review committee made up of three or more individuals who were not involved in any previous level of review or decision making on the matter under review.

   f. If the complaint involves a service for an adult, at least one third of the committee member(s) must be an adult who is enrolled in the BH-MCO and has received or is currently receiving services (mental health services if the issue is a mental health complaint; substance abuse services if the issue is a substance abuse complaint) through the BH-MCO.

g. If the complaint involves a service for a child or adolescent, at least one third of the committee member(s) must be a parent or guardian of a child or adolescent who has received or is currently receiving services (mental health services if the issue is a mental health complaint; substance abuse services if the issue is a substance abuse complaint) through the BH-MCO.

h. A committee member who does not personally attend the review meeting may not be part of the decision making process unless that person actively participates in the review by telephone or videoconference and has the opportunity to review any information introduced at the meeting.

i. The second level complaint review committee may not discuss the case to be reviewed prior to the second level review meeting.

j. The member must be provided the opportunity to appear before the second level complaint review committee. The BH-MCO must be flexible when scheduling the second level complaint review to facilitate the member's attendance.

k. The member must be given at least 15 calendar days advance written notice of the review date. The BH-MCO must document in the complaint record the date that it notified the member of the review date.

l. The review must be conducted at a time and place convenient to the member. If the member cannot appear in person at the second level complaint review, an opportunity to communicate with the second level complaint review committee by telephone or videoconference must be provided. The member may elect not to attend the second level complaint meeting but the meeting must be conducted with the same protocols as if the member was present. The member and/or anyone the member chooses may present the member's position to the second level complaint review committee.

m. The member's provider may be present at the second level complaint review if the member consents to the provider being present. The BH-MCO must document the member's consent in the complaint record.

n. The decision of the committee must be based solely on the information presented at the second level complaint review committee meeting.

o. The committee may question the member and the member's representative (if designated), BH-MCO staff representing the BH-MCO's position, and the provider (if attending).

p. Testimony taken by the second level complaint review committee (including the member's comments) and the discussion of the decision by the complaint review committee must be either tape-recorded and a summary prepared or transcribed verbatim and a summary prepared and maintained as part of the complaint record.

q. The second level complaint review committee must complete the second level complaint review and reach a decision within 30 calendar days from the BH-MCO's receipt of the member's second level complaint, unless an extension of up to 14 calendar days was requested by the member.

r. The BH-MCO must send a written notice of the second level complaint decision to the member and member's representative (if designated), service provider and prescribing provider (if applicable), within five business days of the second level complaint review committee's decision using the template supplied by the Department as **Attachment 5a** of this Appendix or, if the complaint is about the following:

   i. a denial because the requested service is not a covered benefit, or
   ii. the failure of the BH-MCO to meet the required timeframes for providing a service, which includes the BH-MCO failure to deliver all services as authorized; or
   iii. the failure of the BH-MCO to decide a complaint or a grievance within the specified timeframes, or
   iv. a denial of payment after a service has been delivered because the service(s) was provided without authorization by a provider not enrolled in the Pennsylvania Medical Assistance Program, or
   v. a denial of payment after a service has been delivered because the service is not a covered benefit.

   using the template supplied by the Department as **Attachment 5b** of this Appendix.

s. If the complaint is about the following:

   i. a denial because the requested service is not a covered benefit, or
   ii. the failure of the BH-MCO to meet the required timeframes for providing a,service, which includes the BH-MCO failure to deliver all services as authorized; or
   iii. the failure of the BH-MCO to decide a complaint or a grievance within the specified timeframes, or
   iv. a denial of payment after a service has been delivered because the service(s) was provided without authorization by a provider not enrolled in the Pennsylvania Medical Assistance Program, or

v. a denial of payment after a service has been delivered because the service is not a covered benefit.

the member may file a request for a fair hearing within 30 calendar days from the date on the written notice of the BH-MCO's second level complaint decision.

4. External Review of Second Level Complaint Review Decision

a. The member or the member's representative (if designated), which may include the member's provider, with proof of the member's written authorization for the representative to be involved and/or take action on the member's behalf, may file a request for an external review of the second level complaint decision with either the Department of Health or the Insurance Department within 15 calendar days from the date the member receives the written notice of the BH-MCO's second level complaint decision.

b. If a member files a request for an external review of a second level complaint decision to dispute a decision to discontinue, reduce, or change a service that the member has been receiving on the basis that the service is not a covered benefit, the member must continue to receive the disputed service at the previously authorized level pending resolution of the external review, if the request for external review is filed orally, hand delivered or post-marked within one calendar day from the date on the written notice of the BH-MCO's second level complaint decision if inpatient services are being discontinued, reduced, or changed or within ten calendar days from the date on the written notice of the BH-MCO's second level complaint decision for all other services.

c. Upon the request of either the Department of Health or the Insurance Department, all records from the first level review and second level review must be transmitted to the appropriate department by the BH-MCO within 30 calendar days from the request in the manner prescribed by that department. The member, the health care provider or the BH-MCO may submit additional materials related to the complaint.

d. The Department of Health and the Insurance Department will determine the appropriate agency for the review.

5. Expedited Complaint Process

a. The BH-MCO must conduct expedited review of a complaint at any point prior to the second level complaint decision, if a member or the member's representative, which may include the member's provider, with proof of the member's written authorization for the representative to be involved and/or

take action on the member's behalf, provides the BH-MCO with a certification from his or her provider that the member's life, health or ability to attain, maintain or regain maximum function would be placed in jeopardy by following the regular complaint process. This certification is necessary even when the member's request for the expedited complaint is made orally. The certification must include the provider's signature.

b. A request for an expedited review of a complaint may be filed either in writing or orally. Oral requests must be committed to writing by the BH-MCO. The member's signature is not required.

c. Upon receipt of an oral or written request for expedited review, the BH-MCO must inform the member of the right to present evidence and allegations of fact or of law in person as well as in writing and of the limited time available to do so.

d. If the provider certification is not included with the request for an expedited review, the BH-MCO must inform the member that the provider must submit a certification as to the reason why the expedited review is needed. The BH-MCO must make a reasonable effort to obtain the certification from the provider. If the provider certification is not received within three business days from the member's request for an expedited review, the BH-MCO shall decide the complaint within the standard timeframes as set forth in this Appendix. The BH-MCO must make a reasonable effort to give the member prompt oral notice that the complaint is to be decided within the standard timeframe, and must send written notice within two business days of the decision to deny expedited review, using the template supplied by the Department as **Attachment 5c** of this Appendix.

e. If a member files a request for expedited review of a complaint, which constitutes as filing for a continuation of benefits, to dispute a decision to discontinue, reduce, or change a service that the member has been receiving on the basis that the service is not a covered benefit, the member must continue to receive the disputed service at the previously authorized level pending resolution of the complaint, if the request for expedited review is filed orally, hand delivered or post-marked within one calendar day from the date on the written notice of the BH-MCO's decision if inpatient services are being discontinued, reduced, or changed or within ten calendar days from the date on the written notice of the BH-MCO's decision for all other services.

f. Complaints requiring expedited review must be decided by an individual who meets the qualifications required of an individual who makes a medical necessity decision as described in Appendix AA, Section C.3 and who has not been involved in any previous level of review or decision making on the issue under review.

g. The BH-MCO must issue the decision resulting from the expedited review in person or by phone to the member, the member's representative (if designated), and the member's provider within either 48 hours from receiving the provider's certification or three business days from receiving the member's request for an expedited review, whichever is shorter. In addition, the BH-MCO must mail written notice of the decision to the member, the member's representative (if designated), and the member's provider within two business days of the decision using the template supplied by the Department **(Attachment 6).**

h. A summary of the issues presented and decisions made must be maintained as part of the complaint record.

i. The member or the member's representative with proof of the member's written authorization for the representative to be involved and/or take action on the member's behalf, may file a request for an expedited external complaint review with the BH-MCO within two business days from the date the member receives the written notice of the BH-MCO's expedited complaint decision.

j. The BH-MCO must follow Department of Health guidelines relating to submission of requests for expedited external reviews.

k. The member may file a request for a fair hearing within 30 calendar days from the date on the written notice of the BH-MCO's expedited complaint decision.

l. The BH-MCO must ensure that punitive action is not taken against a provider who either requests an expedited resolution of a complaint or supports a member's request for an expedited review of a complaint.

C. <u>Grievances</u>

1. Definition: A grievance is a request to have a BH-MCO or utilization review entity reconsider a decision solely concerning the medical necessity and appropriateness of a health care service.

a. A grievance may be filed regarding a BH-MCO decision to:

i. deny, in whole or in part, payment for a service if based on lack of medical necessity;
ii. deny or issue a limited authorization of a requested service, including the type or level of service;
iii. reduce, suspend, or terminate a previously authorized service;

iv. deny the requested service but approve an alternative service.

2. First Level Grievance Process

a. The BH-MCO must permit a member to designate a representative, which may include the member's provider, if the member provides the BH-MCO with written authorization that indicates that the representative may be involved and/or take action on the member's behalf.

b. A member or member's representative (if designated) may file a grievance either orally or in writing. An oral grievance must be committed to writing by the BH-MCO and must be provided to the member for signature. The member's signature may be obtained at any point in the process, and failure to obtain a signed grievance may not delay the grievance process.

c. The member or member's representative (if designated), will be given 45 calendar days from the date the written notice was received to file a grievance.

d. In order for the provider to represent the member in the filing of a grievance, the provider must obtain the written consent of the member. A provider may obtain the member's written permission at the time of treatment. A provider may NOT require a member to sign a document authorizing the provider to file a grievance as a condition of treatment. The written consent must include:

i. The name and address of the member, the member's date of birth and identification number,
ii. If the member is a minor, or is legally incompetent, the name, address and relationship to the member of the person who signed the consent,
iii. The name, address and plan identification number of the provider to whom the member is providing consent,
iv. The name and address of the plan to which the grievance will be submitted,
v. An explanation of the specific service for which coverage was provided or denied to the enrollee to which the consent will apply, and
vi. The following statement: "The member or the member's representative may not submit a grievance concerning the services listed in this consent form unless the member or the member's representative rescinds consent in writing. The member or member's representative has the right to rescind consent at any time during the grievance process."

e. A member who files a grievance, which constitutes as filing for a continuation of benefits, to dispute a decision to discontinue, reduce or change a service that the member has been receiving must continue to receive the disputed service at the previously authorized level pending resolution of the grievance, if the grievance is filed orally, hand delivered or post-marked within one calendar day from the date on the written notice of decision if inpatient services are being discontinued, reduced, or changed or within ten calendar days from the date on the written notice of decision for all other services.

f. The BH-MCO must send the member and member's representative (if designated) an acknowledgment letter within three business days of receiving the grievance using the template supplied by the Department as **Attachment 7** of this Appendix.

g. The first level grievance review must be performed by the first level grievance review committee, which must include one or more employees of the BH-MCO who were not involved in any previous level of review or decision making on the subject of the grievance. At least one member of the committee must meet the qualifications required of an individual who makes a medical necessity decision as described in Appendix AA, Section C.3, and this individual must decide the grievance.

h. The member must be afforded a reasonable opportunity to present evidence, and allegations of fact or law, in person as well as in writing. The BH-MCO must be flexible when scheduling the review to facilitate the member's attendance. If the member cannot appear in person at the review, an opportunity to communicate with the first level grievance review committee by telephone or videoconference must be provided. The member may elect not to attend the first level grievance meeting but the meeting must be conducted with the same protocols as if the member was present. The member and/or anyone the member chooses may present the member's position at the first level grievance review.

i. The member's provider may be present at the first level grievance review if the member consents to the provider being present. The BH-MCO must document the member's consent in the grievance record.

j. The first level grievance review committee must complete its review of the grievance and make a decision as expeditiously as the member's health condition requires, but no more than 30 calendar days from receipt of the grievance, unless an extension of up to 14 calendar days was requested by the member.

k. The first level grievance review committee must prepare a summary of the issues presented and decisions made, which must be maintained as part of the grievance record.

l. The BH-MCO must send a written notice of the first level grievance decision, using the appropriate template supplied by the Department as **Attachment 8a** (overturned decisions), **8b** (partially overturned decisions), and **8c** (upheld decisions) of this Appendix, to the member and member's representative (if designated), service provider and prescribing provider(if applicable), within five business days from the first level grievance review committee's decision.

   i. Overturned: The review committee determined that the evidence presented supports the reversal or alteration of a prior decision concerning the medical necessity and appropriateness of the health care service.
   ii. Upheld: The review committee determined that the evidence presented does not support the reversal or alteration of a prior decision concerning the medical necessity and appropriateness of the health care service.
   iii. Partially Overturned: The review committee determined that the evidence presented supports the partial reversal or alteration of a prior decision concerning the medical necessity and appropriateness of the health care service.

m. The member may file a request for a fair hearing within 30 calendar days from the date on the written notice of the BH-MCO's first level grievance decision.

3. Second Level Grievance Process

a. A BH-MCO must permit a member to designate a representative, which may include the member's provider, if the member provides the BH-MCO with written authorization that indicates that the representative may be involved and/or take action on the member's behalf.

b. The member or the member's representative (if designated) may file a request for a second level grievance review ("second level grievance") within 45 calendar days from the date the member receives the written notice of the BH-MCO's first level grievance decision.

c. The BH-MCO must send the member and the member's representative (if designated), an acknowledgment letter within three business days of receiving the second level complaint using the template supplied by the Department as **Attachment 9** of this Appendix.

d. A member who files a second level grievance, which constitutes as filing for a continuation of benefits, to dispute a decision to discontinue, reduce, or change a service that the member has been receiving must continue to receive the disputed service at the previously authorized level pending resolution of the second level grievance, if the second level grievance is filed orally, hand delivered or post-marked within one calendar day from the date on the written notice of the BH-MCO's first level grievance decision if inpatient services are being discontinued, reduced, or changed or within ten calendar days from the date on the written notice of the BH-MCO's first level grievance decision for all other services..

e. The second level grievance review must be performed by a second level grievance review committee made up of three or more individuals who were not involved in any previous level of review or decision making to deny coverage or payment for the requested service(s). At least one member of the committee must meet the qualifications required of an individual who makes a medical necessity decision as described in Appendix AA, Section C.3.

f. If the grievance involves a service for an adult, at least one third of the committee member(s) must be an adult who is enrolled in the BH-MCO and has received or is currently receiving services (mental health services if the issue is a mental health grievance; substance abuse services if the issue is a substance abuse grievance) through the BH-MCO.

g. If the grievance involves a service for a child or adolescent, at least one third of the committee member(s) must be a parent or guardian of a child or adolescent who has received or is currently receiving services (mental health services if the issue is a mental health grievance; substance abuse services if the issue is a substance abuse grievance) through the BH-MCO.

h. A committee member who does not personally attend the review meeting may not be part of the decision making process unless that person actively participates in the review by telephone or videoconference and has the opportunity to review any information introduced at the meeting.

i. The second level grievance review committee may not discuss the case to be reviewed prior to the second level review meeting.

j. The member must be provided the opportunity to appear before the second level grievance review committee. The BH-MCO must be flexible when scheduling the second level review to facilitate the member's attendance. The committee meeting must be conducted at a time and place convenient to the member.

k. The member must be given at least 15 calendar days advance written notice of the review date. The BH-MCO must document in the grievance record the date that it notified the member of the review date.

l. If the member cannot appear in person at the second level grievance review, an opportunity to communicate with the second level grievance review committee by telephone or videoconference must be provided. The member may elect not to attend the second level grievance meeting but the meeting must be conducted with the same protocols as if the member was present. The member and/or anyone the member chooses may present the member's position to the committee.

m. The member's provider may be present at the second level grievance review if the member consents to the provider being present. The BH-MCO must document the member's consent in the grievance record.

n. The committee may question the member and the member's representatives (if designated), BH-MCO staff representing the BH-MCO's position, and the provider (if attending).

o. The second level grievance review committee must complete the second level grievance review and reach a decision within 30 calendar days from receipt of the member's second level grievance, unless an extension of up to 14 calendar days was requested by the member.

p. The decision of the committee must be based solely on the information presented at the second level grievance review committee meeting

q. Testimony taken by the second level grievance review committee (including the member's comments) and the discussion of the decision by the grievance review committee must be either tape recorded and a summary prepared or transcribed verbatim and a summary prepared and maintained as part of the grievance record.

r. The BH-MCO must send a written notice of the second level grievance review committee decision, using the appropriate template supplied by the Department as **Attachment 10a** (overturned decisions), **10b** (partially overturned decisions), and **10c** (upheld decisions) of this Appendix, to the member, member's representative, if the member has designated one, service provider and prescribing provider, if applicable, within five business days of the second level grievance review committee's decision.
    i. Overturned: The review committee determined that the evidence presented supports the reversal or alteration of a prior decision concerning the medical necessity and appropriateness of the health care service.

ii. Upheld: The review committee determined that the evidence presented does not support the reversal or alteration of a prior decision concerning the medical necessity and appropriateness of the health care service.

iii. Partially Overturned: The review committee determined that the evidence presented supports the partial reversal or alteration of a prior decision concerning the medical necessity and appropriateness of the health care service.

s. The member may file a request for a fair hearing within 30 calendar days from the date on the written notice of the BH-MCO's second level grievance decision.

4. External Review of the Second Level Grievance Decision

a. The member or the member's representative (if designated), which may include the member's provider, with proof of the member's written authorization for the representative to be involved and/or take action on the member's behalf, may file a request with the BH-MCO for an external review of the second level grievance decision ("external grievance review") by the Department of Health. The request must be filed in writing within 15 calendar days from the date the member receives the written notice of the BH-MCO's second level grievance decision.

b. All requests for external grievance reviews are processed through the BH-MCO. The BH-MCO must follow the protocols established by the Department of Health to meet all timeframes and requirements necessary in coordinating the request and notification of the decision to the member, member's representative (if designated), service provider and prescribing provider.

c. A member who files a request for external grievance review, which constitutes as filing for a continuation of benefits, to dispute a decision to discontinue, reduce or change a service that the member has been receiving must continue to receive the disputed service at the previously authorized level pending resolution of the external grievance review, if the request for external grievance review is filed orally, hand delivered or post-marked within one calendar day from the date on the written notice of the BH-MCO's second level grievance decision if inpatient services are being discontinued, reduced, or changed or within ten calendar days from the date on the written notice of the BH-MCO's second level grievance decision for all other services.

d. Within five business days of receipt of the request for an external grievance review, the BH-MCO must notify the member, the member's representative (if designated), or the health care provider, and the Department of Health that the request for an external grievance review has been filed.

e. The external grievance review must be conducted by an independent utilization review entity not directly affiliated with the BH-MCO.

f. Within two business days from receipt of the request for external grievance review, the Department of Health will randomly assign a certified utilization review entity (CRE) to conduct the review. The BH-MCO and assigned CRE will be notified of this decision.

g. If the Department of Health fails to select a CRE within two business days of receipt of a request for an external grievance review, the BH-MCO may designate a CRE to conduct a review from the list of CREs approved by the Department of Health. The BH-MCO may not select a CRE that has a current contract or is negotiating a contract with the BH-MCO or its affiliates or is otherwise affiliated with the BH-MCO or its affiliates.

h. The BH-MCO must forward all documentation regarding the decision, including all supporting information, a summary of applicable issues, and the basis and clinical rationale for the decision, to the CRE conducting the external grievance review. This transmission of information must take place within 15 calendar days from receipt of the request for an external grievance review.

i. The BH-MCO must inform the member that within 15 calendar days from receipt of the request for an external grievance review by the BH-MCO, the member or the member's representative, which may include the member's provider, with proof of the member's written authorization, may supply additional information to the CRE conducting the external review for consideration. Copies must also be provided at the same time to the BH-MCO so that the BH-MCO has an opportunity to consider the additional information.

j. Within 60 calendar days from the filing of the request for the external grievance review, the CRE conducting the external grievance review must issue a written decision to the BH-MCO, the member, the member's representative and the provider (if the provider filed the grievance with the member's consent), that includes the basis and clinical rationale for the decision. The standard of review must be whether the service was medically necessary and appropriate under the terms of the BH-MCO contract.

k. The external grievance decision shall be subject to appeal to a court of competent jurisdiction within 60 calendar days from the date the member receives notice of the external grievance decision.

5. Expedited Grievance Process

a. The BH-MCO must conduct expedited review of a grievance at any point prior to the second level grievance decision, if a member or the member's representative, with proof of the member's written authorization for the representative to be involved and/or take action on the member's behalf, provides the BH-MCO with a certification from his or her provider that the member's life, health or ability to attain, maintain, or regain maximum function would be placed in jeopardy by following the regular grievance process. This certification is necessary even when the member's request for the expedited grievance is made orally. The certification must include the provider's signature.

b. A request for an expedited review of a grievance may be filed either in writing or orally. Oral requests must be committed to writing by the BH-MCO. The member's signature is not required.

c. Upon receipt of an oral or written request for expedited review, the BH-MCO must inform the member of the right to present evidence and allegations of fact or of law in person as well as in writing and of the limited time available to do so.

d. If the provider certification is not included with the request for an expedited grievance review, the BH-MCO must inform the member that the provider must submit a certification as to the reasons why the expedited review is needed. The BH-MCO must make a reasonable effort to obtain the certification from the provider. If the provider certification is not received within three business days from the member's request for an expedited review, the BH-MCO shall decide the grievance within the standard timeframes as set forth in this Appendix. The BH-MCO must make a reasonable effort to give the member prompt oral notice that the grievance is to be decided within the standard timeframe, and must send written notice within two business days of the decision to deny expedited review, using the template supplied by the Department as **Attachment 10d** of this Appendix.

e. A member who files a request for expedited review of a grievance, which constitutes as filing for a continuation of benefits, to dispute a decision to discontinue, reduce or change a service that the member has been receiving must continue to receive the disputed service at the previously authorized level pending resolution of the grievance, if the request for expedited review

of a grievance is filed orally, hand delivered or post-marked within one calendar day from the date on the written notice of the BH-MCO's decision if inpatient services are being discontinued, reduced, or changed or within ten calendar days from the date on the written notice of the BH-MCO's decision for all other services.

f. The expedited review process is bound by the same rules and procedures as the second level grievance review process with the exception of time frames, which are modified as specified in this section.

g. Grievances requiring expedited review must be decided by an individual who meets the qualifications required of an individual who makes a medical necessity decision as described in Appendix AA, Section C.3 and who was not involved in any previous level of review or decision making on the subject of the grievance.

h. The BH-MCO must issue the decision resulting from the expedited review in person or by phone to the member, the member's representative (if designated) and the member's provider within either 48 hours from receiving the provider's certification, or three business days from receiving the member's request for an expedited review, whichever is shorter. In addition, the BH-MCO must mail written notice of the decision to the member and, member's representative (if designated) and the member's provider within two business days of the decision using the template supplied by the Department as **Attachment 11** of this Appendix.

i. The member or the member's representative, with proof of the member's written authorization for the representative to be involved and/or take action on the member's behalf, may file a request for an expedited external grievance review with the BH-MCO within two business days from the date the member receives the written notice of the BH-MCO's expedited grievance decision.

j. The BH-MCO must follow Department of Health guidelines relating to submission of requests for expedited external reviews.

k. The member may file a request for a fair hearing within 30 calendar days from the date on the written notice of the BH-MCO's expedited grievance decision.

l. The BH-MCO must ensure that punitive action is not taken against a provider who either requests an expedited resolution of a grievance or supports a member's request for expedited review of a grievance.

D. Department's Fair Hearing Requirements

1. Department's Fair Hearing Process

   a. A member does not have to exhaust the complaint or grievance process prior to filing a request for a fair hearing.

   b. A member or the member's representative may request a fair hearing within 30 calendar days from the date on the initial written notice of decision or within 30 calendar days from the date on the written notice of the BH-MCO's first or second level grievance notice of decision, for any of the following:

      i. The denial, in whole or in part, of payment for a service if the denial is based on lack of medical necessity;

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

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

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

   c. A member, or the member's representative may request a fair hearing within 30 calendar days from the date of the incident complained of, or within 30 calendar days from the date on the initial written notice of decision, or within 30 calendar days from the date on the written notice of the BH-MCO's first or second level complaint notice of decision, for any of the following:

      i. The denial of a service because the requested service is not a covered benefit;

      ii. The failure of the BH-MCO to meet the required timeframes for providing a service, which includes the BH-MCO failure to deliver all services as authorized;

      iii. The failure of the BH-MCO to decide a complaint or grievance within the specified timeframes;

      iv. A denial of payment after a service(s) has been delivered because the service(s) was provided without authorization by a provider not enrolled in the Pennsylvania Medical Assistance Program;

      v. A denial of payment after a service(s) has been delivered because the service(s) is not a covered benefit.

d. The request for a fair hearing must include a copy of the written notice of decision that is the subject of the request. Requests should be sent to:

Department of Human Services
Office of Mental Health Substance Abuse Services
Division of Quality Management
Commonwealth Towers, 12th Floor
P.O. Box 2675
Harrisburg, PA 17101

e. A member who files a request for a fair hearing, which constitutes as filing for a continuation of benefits, to dispute a decision to discontinue, reduce or change a service that the member has been receiving must continue to receive the disputed service at the previously authorized level pending resolution of the fair hearing, if the request for a fair hearing is hand delivered or post-marked within one day from the date on the written notice of decision if inpatient services are being discontinued, reduced, or changed or within ten days from the date on the written notice of decision for all other services.

f. Upon the receipt of the request for a fair hearing, the Department's Bureau of Hearings and Appeals or a designee will schedule a hearing. The member and the BH-MCO will receive notification of the hearing date by letter at least ten calendar days in advance, or a shorter time if requested by the member. The letter will outline the type of hearing, the location of the hearing (if applicable), and the date and time of the hearing.

g. The BH-MCO is a party to the hearing and must be present. The BH-MCO, which may be represented by an attorney, must be prepared to explain and defend the issue on appeal. The Department's decision is based solely on the evidence presented at the hearing.

h. The BH-MCO must provide members, at no cost, with records, reports, and documents relevant to the subject of the fair hearing.

i. If the Bureau of Hearings and Appeals has not taken final administrative action within 90 calendar days of the receipt of the request for a fair hearing, the BH-MCO shall follow the requirements at 55 Pa. Code 275.4 regarding the provision of interim assistance upon the request for such by the member. When the member is responsible for delaying the hearing process the time limit for final administrative action will be extended by the length of the delay attributed to the member (55 Pa. Code 275.4).

j. The Bureau of Hearings and Appeals' adjudication is binding on the BH-MCO unless reversed by the Secretary of Human Services. Either party may request reconsideration from the Secretary within 15 days from the date of the adjudication. Only the member may appeal to Commonwealth Court within 30 calendar days from the date of adjudication (or from the Secretary's final order, if reconsideration was granted). The decisions of the Secretary and the Court are binding on the BH-MCO.

2. Expedited Fair Hearing Process

a. A request for an expedited fair hearing may be filed with the Department by a member or the member's representative, with proof of the member's written authorization for the representative to be involved and/or take action on the member's behalf, either orally or in writing.

b. A member does not have to exhaust the complaint or grievance process prior to filing a request for an expedited fair hearing.

c. An expedited fair hearing will be conducted if a member or a member's representative provides the Department with written certification from the member's provider that the member's life, health or ability to attain, maintain or regain maximum function would be placed in jeopardy by following the regular fair hearing process. This certification is necessary even when the member's request for the expedited fair hearing is made orally. The certification must include the provider's signature.

d. A member who files a request for an expedited fair hearing, which constitutes as filing for a continuation of benefits, to dispute a decision to discontinue, reduce or change a service that the member has been receiving must continue to receive the disputed service at the previously authorized level pending resolution of the fair hearing, if the request for an expedited fair hearing is hand delivered or post-marked within one calendar day from the date on the written notice of decision if inpatient services are being discontinued, reduced, or changed or within ten calendar days from the date on the written notice of decision for all other services.

e. Upon the receipt of the request for an expedited fair hearing, the Department's Bureau of Hearings and Appeals or a designee will schedule a hearing.

f. The BH-MCO is a party to the hearing and must participate in the hearing. The BH-MCO, which may be represented by an attorney, must be prepared to explain and defend the issue on appeal. The failure of the BH-MCO to participate in the hearing will not be reason to postpone the hearing.

g. The BH-MCO must provide members, at no cost, with records, reports, and documents, relevant to the subject of the fair hearing.

h. The Bureau of Hearings and Appeals has 3 business days from the receipt of the member's oral or written request for an expedited review to process final administrative action.

i. The Bureau of Hearings and Appeals' adjudication is binding on the BH-MCO unless reversed by the Secretary of Human Services. Either party may request reconsideration from the Secretary within 15 days from the date of the adjudication. Only the member may appeal to Commonwealth Court within 30 calendar days from the date of adjudication (or from the Secretary's final order, if reconsideration was granted). The decisions of the Secretary and the Court are binding on the BH-MCO.

E. Provision of and Payment for Services Following Decision

1. If the BH-MCO or the Bureau of Hearings and Appeals reverses a decision to deny, limit, or delay services that were not furnished during the complaint, grievance or fair hearing process, the BH-MCO must authorize or provide the disputed services within 72 hours and as expeditiously as the member's health condition requires.

2. If the BH-MCO or the Bureau of Hearings and Appeals reverses a decision to deny authorization of services, and the member received the disputed services during the complaint, grievance or fair hearing process, the BH- MCO must pay for those services.

F. Quality Review of Complaints and Grievances

1. The Primary Contractor is responsible for monitoring the complaint and grievance processes for compliance with Appendix H and the Program Evaluation Performance Summary (PEPS). The monitoring must include a review of the following:

   a. The Member Handbook to confirm that it describes the complaint, grievance and fair hearing processes in accurate and easy to understand language;
   b. Complaint and grievance decisions to determine if decisions were made within established timeframes;
   c. Written notification letters;
   d. Investigations of the complaint;
   e. Committee proceeding to ensure that they are accessible for the member to attend (if applicable);
   f. Complaint and grievance trainings and
   g. Involvement of the voting committee members.

2. The Primary Contractor and BH-MCO must provide the Department with evidence of the BH-MCO's compliance with Appendix H. This evidence must include the percentage of complaint and grievance cases, by level, reviewed by the Primary Contractor.

3. If as a result of the Primary Contractor's monitoring of the complaint and grievance processes for compliance with Appendix H and PEPS, the Primary Contractor discovers that corrective plans of action and/or follow up activities are needed, the BH-MCO must implement the corrective plans of action and/or follow up activities.

4. When reporting on complaint decisions, the Primary Contractor must include the following classifications:

    a. Substantiated: The available information supported the member's complaint and a corrective plan of action is needed.
    b. Unsubstantiated: The available information did not support the member's complaint.

ATTACHMENT 1a

Notice for Failure of BH-MCO to Meet Complaint or Grievance Time Frames

[Date the notice is mailed]
[Member or Parent/Guardian Name]
[Address]
[County]

RE: **[Member's name, DOB, and Member or Denial Identifier]**
Subject: Your **[Complaint][Grievance]**

Dear **[Member or Parent/Guardian Name]**:

[BH-MCO Name] has not decided your **[complaint][grievance]** about **[identify subject of complaint/grievance]**, filed on **[date]**, within **[number that is 30 days or fewer]** days, as required. We expect to be able to decide the **[complaint][grievance]** by **[date]**.

If you are unhappy that **[BH-MCO name]** has not decided your **[complaint/grievance]** within **[#]** days of receiving it, you can do one or both of the following:

1) File a Complaint

You may file a complaint with **[BH-MCO Name]** about the delay in deciding your **[complaint][grievance]**. You must file the complaint **within 45 calendar days from the date you get this notice.** A decision will be made on your complaint no later than **[30, unless the BH-MCO will be using a shorter time frame to decide first level complaints]** days from when we receive it.

To file a complaint:

- Call **[BH-MCO Name]** at **[#]**; **or**
- Send your complaint to **[BH-MCO Name]** at the following address:

[BH-MCO Address for filing complaint]

2) Request a Fair Hearing

You may ask for a fair hearing from the Department of Human Services. 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;
- The reason(s) you are asking for a fair hearing, or a copy of this notice.

Your request for a fair hearing must be sent to the following address:

Department of Human Services
Office of Mental Health Substance Abuse Services
Division of Quality Management
Commonwealth Towers, 12th Floor
P.O. Box 2675
Harrisburg, PA 17101

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

If you need help filing a complaint or request for a fair hearing, or have any other questions, you may call us at **[BH-MCO Phone #]**, the legal aid office at 1-800-322-7572 (www.palegalservices.org), or the Pennsylvania Health Law Project at 1-800-274-3258 (www.phlp.org).

Sincerely,

[BH-MCO Name]

cc: **[Member Representative, if designated]**
[Provider, if BBA Complaint or grievance]

[BH-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 about the [complaint][grievance] you filed with [BH-MCO Name]. It is available in other languages and formats by calling [BH-MCO Name] at [#].

ATTACHMENT 1b
Notice for Payment Denial Because the Service Was Provided Without Authorization by a Provider Not Enrolled in the Pennsylvania Medical Assistance Program

THIS IS NOT A BILL

[Date the notice is mailed]
[Member or Parent/Guardian Name]
[Address]
[County]

RE: [Member's name, DOB, and Member or Denial Identifier]

Dear **[Member or Parent/Guardian Name]**:

[BH-MCO Name] has reviewed the request for payment from **[provider's name]** for **[identify specific service]**, which you received on **[date]**. Your provider's request for payment has been denied because **[provider's name]** is not enrolled in the Pennsylvania Medical Assistance Program and did not ask **[BH-MCO Name]** for approval to provide the service to you.

[PROVIDER'S NAME] MAY BILL YOU FOR THIS SERVICE.

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

1) File a Complaint

You may file a complaint with **[BH-MCO name] within 45 calendar days from the date you get this notice**. A decision will be made on your complaint no later than **[30, unless the BH-MCO will be using a shorter time frame to decide first level complaints]** days from when we receive it.

To file a complaint:

- Call **[BH-MCO Name]** at **[#]**; **or**
- Send your complaint to **[BH-MCO Name]** at the following address:

[BH-MCO Address for filing complaint]

2) Request a Fair Hearing

You may ask for a fair hearing from the Department of Human Services. 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;
- The reason(s) you are asking for a fair hearing, or a copy of this notice.

Your request for a fair hearing must be sent to the following address:

Department of Human Services
Office of Mental Health Substance Abuse Services
Division of Quality Management
Commonwealth Towers, 12th Floor
P.O. Box 2675
Harrisburg, PA 17101

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 may appear in person or by telephone at both the complaint review and the fair hearing, and you may bring a family member, friend, lawyer or other person to help you.

If you file a complaint or a request for a fair hearing, you may ask to see all information relevant to this decision by sending a written request for the information to the following address:

[Address for records information]

If you need help filing a complaint or request for a fair hearing, or have any other questions, you may call us at **[BH-MCO Phone #]**, the legal aid office at 1-800-322-7572 (www.palegalservices.org), or the Pennsylvania Health Law Project at 1-800-274-3258 (www.phlp.org).

Sincerely,

[BH-MCO Name]

cc: **[Provider]**

[BH-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 about payment for medical services. It is available in other languages and formats by calling [BH-MCO Name] at [#].

ATTACHMENT 1c
Notice for Payment Denial Because the Service Was Not a Covered Service for the Member

THIS IS NOT A BILL

[Date the notice is mailed]
[Member or Parent/Guardian Name]
[Address]
[County]

RE: **[Member's name, DOB, and Member or Denial Identifier]**

Dear **[Member or Parent/Guardian Name]**:

[BH-MCO Name] has reviewed the request for payment from **[provider's name]** for **[identify specific service]**, which you received on **[date]**. Your provider's request for payment has been denied. The service you received is not a covered benefit because:

_____It is not covered under the Medical Assistance Program; **OR**

_____It is not part of your benefit package; **OR**

_____**[Provider's name]** is not in **[BH-MCO Name's]** provider network and provided this service without **[BH-MCO Name's]** authorization.

[PROVIDER'S NAME] MAY BILL YOU FOR THIS SERVICE ONLY IF [PROVIDER'S NAME] TOLD YOU THAT THE SERVICE WAS NOT COVERED FOR YOU BEFORE YOU GOT THE SERVICE.

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

1) File a Complaint

You may file a complaint with **[BH-MCO Name] within 45 calendar days from the date you get this notice**. A decision will be made on your complaint no later than **[30, unless the BH-MCO will be using a shorter time frame to decide first level complaints]** days from when we receive it.

To file a complaint:

- Call **[BH-MCO Name]** at **[#]**; **or**

- Send your complaint to **[BH-MCO Name]** at the following address:

[BH-MCO Address for filing complaint]

2) Request a Fair Hearing

You may ask for a fair hearing from the Department of Human Services. 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;
- The reason(s) you are asking for a fair hearing, or a copy of this notice.

Your request for a fair hearing must be sent to the following address:

Department of Human Services
Office of Mental Health Substance Abuse Services
Division of Quality Management
Commonwealth Towers, 12th Floor
P.O. Box 2675
Harrisburg, PA 17101

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 may appear in person or by telephone at both the complaint review and the fair hearing, and you may bring a family member, friend, lawyer or other person to help you.

If you file a complaint or a request for a fair hearing, you may ask to see all information relevant to this decision by sending a written request for the information to the following address:

[Address for records information]

If you need help filing a complaint or request for a fair hearing, or have any other questions, you may call us at **[BH-MCO Phone #]**, the legal aid office at 1-800-322-7572 (www.palegalservices.org), or the Pennsylvania Health Law Project at 1-800-274-3258 (www.phlp.org).

Sincerely,

[BH-MCO Name]

cc: **[Provider]**

[BH-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 about payment for medical services. It is available in other languages and formats by calling [BH-MCO Name] at [#].

Revised 10/15/15
Amended 09/19/16

ATTACHMENT 1d
Notice for Denial of Payment After a Service(s) Has Been Delivered Because the Emergency Room Service(s) Was Not Medically Necessary

THIS IS NOT A BILL

Date the notice is mailed]
[Member or Parent/Guardian Name]
[Address]
[County]

RE: **[Member's name, DOB, and Member or Denial Identifier]**

Dear **[Member or Parent/Guardian Name]:**

[BH-MCO Name] has reviewed the request for payment from **[provider's name]** for **[identify specific service]**, which you received on **[date]**. Your provider's request for payment has been denied.

The service you received was not medically necessary 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].

[PROVIDER'S NAME] MAY NOT BILL YOU FOR THIS SERVICE. YOU CAN SHOW THIS NOTICE TO [PROVIDER'S NAME] IF [PROVIDER'S NAME] SENDS YOU A BILL.

Sincerely,

[BH-MCO Name]

cc: **[Provider]**

[BH-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 about payment for medical services. It is available in other languages and formats by calling [BH-MCO Name] at [#].

ATTACHMENT 2a

First Level Complaint Acknowledgment Letter

MCO: Use this template for all complaints EXCEPT for those involving the following:

1. **A denial because the requested service is not a covered benefit.**
2. **Failure of the MCO to meet the required time frames for providing a service, which includes the BH-MCO's failure to deliver all services as authorized.**
3. **Failure of the MCO to decide a complaint or a grievance within the specified time frames.**
4. **A denial of payment after a service has been delivered because the service(s) was provided without authorization by a provider not enrolled in the Pennsylvania Medical Assistance Program.**
5. **A denial of payment after a service has been delivered because the service is not a covered benefit.**

[Date the letter is mailed]
[Member or Parent/Guardian Name]
[Address]
[County]

RE: **[Member's name, DOB, and Member or Complaint Identifier]**

Subject: Your Complaint

Dear **[Member or Parent/Guardian Name]**:

[BH-MCO Name] received your complaint about:

- **[list each complaint issue].**

The complaint was received on **[date of receipt]**.

The First Level Complaint Process

A committee of one or more **[BH-MCO Name]** staff members who have not been involved in the issue you filed your complaint about will make a decision about your complaint by **[date that is no more than 30 days from receipt of the complaint]**. This is called the "complaint review." A letter will be mailed to you within five business days after the decision is made, telling you each reason for the decision.

At any time during the complaint process, you can have someone you know represent you or act on your behalf. This person will be "your representative." If you decide to have someone represent you or act for you, tell **[BH-MCO Name]**, in writing, the name of that person and how we can reach him or her.

You or your representative may ask [**BH-MCO Name]** to see all information relevant to your complaint. You may also send information that you have about your complaint to **[BH-MCO Name]**:

[BH-MCO Address]

If you think your issue is really a grievance and should not be treated as a complaint, you may call or write to the Pennsylvania Department of Health:

Pennsylvania Department of Health
Bureau of Managed Care
Room 912, Health & Welfare Building
625 Forster Street
Harrisburg, PA 17120-0701
Telephone: 1-888-466-2787; Fax: 1-717-705-0947
AT&T Relay: 1-800-654-5984 (for persons with hearing impairments)

If you need more information on what a grievance is, you can read your member handbook or call us at **[BH-MCO Phone #]**.

To get help with your complaint

- If you need help with your complaint, call us at **[BH-MCO Phone #]** and **[BH-MCO Name]** will assign someone who has not been involved in the complaint issue to help you.
- If you have any other questions, you may call us at **[BH-MCO Phone #]**, the legal aid office at 1-800-322-7572 (www.palegalservices.org), or the Pennsylvania Health Law Project at 1-800-274-3258 (www.phlp.org).
- If you ask, **[BH-MCO Name]** will provide you with a list of advocacy organizations that may be able to assist you.
-

Sincerely,

[BH-MCO Name]

cc: **[Member Representative, if designated]**

[BH-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 letter is about the complaint you filed with [BH-MCO Name]. It is available in other languages and formats by calling [BH-MCO Name] at [#].

ATTACHMENT 2b
First Level Complaint Acknowledgment Letter

MCO: Use this template ONLY for complaints involving the following:

1. **A denial because the requested service is not a covered benefit.**
2. **Failure of the MCO to meet the required time frames for providing a service, which includes the BH-MCO's failure to deliver all services as authorized.**
3. **Failure of the MCO to decide a complaint or a grievance within the specified time frames.**
4. **A denial of payment after a service has been delivered because the service(s) was provided without authorization by a provider not enrolled in the Pennsylvania Medical Assistance Program.**
5. **A denial of payment after a service has been delivered because the service is not a covered benefit.**

[Date the letter is mailed]
[Member or Parent/Guardian Name]
[Address]
[County]

RE: **[Member's name, DOB, and Member or Complaint Identifier]**

Subject: Your Complaint

Dear **[Member or Parent/Guardian Name]**:

On **[date of complaint] [BH-MCO Name]** received your complaint that:

____ you have not received your **[type of services]** in the time you should have received them, or

____ you did not receive a decision on your complaint or grievance in the time you should have received it, or

____ you disagree with the decision to deny a service because the requested service is not a covered benefit, or

____ you disagree with the decision to deny payment to your provider because your provider is not enrolled in the Pennsylvania Medical Assistance Program and did not receive authorization to provide the service to you, or

____ you disagree with the decision to deny payment to your provider because the service you received is not a covered benefit.

The First Level Complaint Process

A committee of one or more **[BH-MCO Name]** staff members who have not been involved in the issue you filed your complaint about will make a decision about your complaint by **[date that is no more than 30 days from receipt of the complaint]**. This is called the "complaint review." A letter will be mailed to you within five business days after the decision is made, telling you each reason for the decision.

At any time during the complaint process, you can have someone you know represent you or act on your behalf. This person will be "your representative." If you decide to have someone represent you or act for you, tell **[BH-MCO Name]**, in writing, the name of that person and how we can reach him or her.

You or your representative may ask **[BH-MCO Name]** to see any information relevant to your complaint. You may also send information that you have about your complaint to **[BH-MCO Name]**:

[BH-MCO Address]

If you think your issue is really a grievance and should not be treated as a complaint, you may call or write to the Pennsylvania Department of Health:

Pennsylvania Department of Health
Bureau of Managed Care
Room 912, Health & Welfare Building
625 Forster Street
Harrisburg, PA 17120-0701
Telephone: 1-888-466-2787; Fax: 1-717-705-0947
AT&T Relay: 1-800-654-5984 (for persons with hearing impairments)

You and your representative may appear at the complaint review in person, by phone or by videoconference, if available, by calling us at **[BH-MCO Phone #]**. You may also bring a family member, friend, lawyer or other person to help you. If you decide that you do not want to attend, that will not affect the decision of the committee.

To ask for an early decision

If your doctor or psychologist believes that waiting **[30, unless the BH-MCO will be using a shorter time frame to decide first level complaints]** days to get a decision could harm your health, you may ask that your complaint be decided more quickly. To do this:

- Call **[BH-MCO Name]** at **[#]**;
- Your doctor or psychologist must fax a letter to **[BH-MCO fax #]** explaining why taking **[30, unless the BH-MCO will be using a shorter time frame to decide first level complaints]** days to decide your complaint could harm your health.

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

The Fair Hearing Process

At any point before **[BH-MCO Name]** makes its decision, you may ask for a fair hearing from the Department of Human Services. Your request for a fair hearing must be in writing and must be postmarked **within 30 days from the date on this letter**. 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;
- The reason(s) you are asking for a fair hearing, or a copy of this letter;
- A copy of the original denial notice, if available. **[BH-MCO: Include this last item only for complaints challenging a denial because service is not a covered benefit or because the service was provided without authorization by a non-MA provider.]**

Your request for a fair hearing must be sent to the following address:

Department of Human Services
Office of Mental Health Substance Abuse Services
Division of Quality Management
Commonwealth Towers, 12th Floor
P.O. Box 2675
Harrisburg, PA 17101

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 psychologist believes that the usual time frame for deciding 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 1-877-356-5355, or fax your request to 1-717-772-7827;
- Your doctor or psychologist must fax a letter to 1-717-772-7827 explaining why taking the usual amount of time to decide your request for a fair hearing could harm your health. If your doctor or psychologist does not send a letter, your doctor or psychologist 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 3 business days from when it receives your request.

To get help with your complaint or request for fair hearing

- If you need help with your complaint, call us at **[BH-MCO Phone #]** and **[BH-MCO Name]** will assign someone who has not been involved in the complaint issue to help you.
- If you have any other questions, or need help filing a request for a fair hearing, you may call us at **[BH-MCO Phone #]**, the legal aid office at 1-800-322-7572 (www.palegalservices.org), or the Pennsylvania Health Law Project at 1-800-274-3258 (www.phlp.org).
- If you ask, **[BH-MCO Name]** will provide you with a list of advocacy organizations that may be able to assist you.

Sincerely,

[BH-MCO Name]

cc: **[Member Representative, if designated]**

[BH-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 letter is about the complaint you made with [BH-MCO Name]. It is available in other languages and formats by calling [BH-MCO Name] at [#].

ATTACHMENT 3a

First Level Complaint Decision Notice

MCO, Use this template for all complaints EXCEPT for those involving the following:

1. **A denial because the requested service is not a covered benefit.**
2. **Failure of the MCO to meet the required time frames for providing a service, which includes the BH-MCO's failure to deliver all services as authorized.**
3. **Failure of the MCO to decide a complaint or a grievance within the specified time frames.**
4. **A denial of payment after a service has been delivered because the service(s) was provided without authorization by a provider not enrolled in the Pennsylvania Medical Assistance Program.**
5. **A denial of payment after a service has been delivered because the service is not a covered benefit.**

[Date the notice is mailed]
[Member or Parent/Guardian Name]
[Address]
[County]

RE: **[Member's name, DOB, and Member or Complaint Identifier]**

Subject: Decision About Your Complaint

Dear **[Member or Parent/Guardian Name]**:

[BH-MCO Name] has reviewed your complaint received on **[date]**.

Based on a review of all information provided, the first level complaint review committee has decided on **[include the date the decision was made]** that:

- **[List each complaint issue separately in its own bullet, including either: "the available information supported your complaint" or "the available information did not support your complaint"]**

The reasons for this decision are:

[Explain in detail every reason for the decision on each complaint issue; in addition to explanation for decision, include specific references to approved criteria, rules or protocols on which decision is based; if unable

to make a decision because of insufficient information, identify all additional information needed to render decision].
IF YOU DO NOT AGREE WITH THIS DECISION, YOU MAY DO ONE OR BOTH OF THE FOLLOWING:

1) Request Guidelines

You may ask for a copy of the rules or other guidelines on which the decision was based by sending a written request to:

[BH-MCO Address]

2) File a Second Level Complaint

You may file a second level complaint with **[BH-MCO Name] within 45 calendar days from the date you get this notice**. A decision will be made on your second level complaint no later than **[30, unless the BH-MCO will be using a shorter time frame to decide second level complaints]** days from when we receive it.

To file a second level complaint:

- Call **[BH-MCO Name]** at **[#]; or**
- Send your complaint to **[BH-MCO Name]** at the following address:

[BH-MCO Address for filing complaint]

To get help with a complaint

- If you need help filing a second level complaint, call us at **[BH-MCO Phone #]** and **[BH-MCO Name]** will assign someone who has not been involved in the complaint issue to help you.
- If you have any other questions, you may call us at **[BH-MCO Phone #]**, the legal aid office at 1-800-322-7572 (www.palegalservices.org), or the Pennsylvania Health Law Project at 1-800-274-3258 (www.phlp.org).
- If you ask, [BH-MCO Name] will provide you with a list of advocacy organizations that may be able to assist you.

Sincerely,

[BH-MCO Name]

cc: **[Member Representative, if designated]**

[BH-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 about the complaint you filed with [BH-MCO Name]. It is available in other languages and formats by calling [BH-MCO Name] at [#].

ATTACHMENT 3b

First Level Complaint Decision Notice

MCO, Use this template ONLY for complaints involving the following:

1. **A denial because the requested service is not a covered benefit.**
2. **Failure of the MCO to meet the required time frames for providing a service, which includes the BH-MCO's failure to deliver all services as authorized.**
3. **Failure of the MCO to decide a complaint or a grievance within the specified time frames.**
4. **A denial of payment after a service has been delivered because the service(s) was provided without authorization by a provider not enrolled in the Pennsylvania Medical Assistance Program.**
5. **A denial of payment after a service has been delivered because the service is not a covered benefit.**

[Date the notice is mailed]
[Member or Parent/Guardian Name]
[Address]
[County]

RE: **[Member's name, DOB, and Member or Complaint Identifier]**

Subject: Decision About Your Complaint

Dear **[Member or Parent/Guardian Name]**:

[BH-MCO Name] has reviewed your complaint received on **[date]**.

Based on a review of all information provided, the first level complaint review committee has decided on **[include the date the decision was made]** that:

- **[List each complaint issue separately in its own bullet, including either: "the available information supported your complaint" or "the available information did not support your complaint"]**

The reasons for this decision are:

[Explain in detail every reason for the decision on each complaint issue; in addition to explanation for decision, include specific references to approved criteria, rules or protocols on which decision is based; if unable

to make a decision because of insufficient information, identify all additional information needed to render decision].

[BH-MCO: Include the following paragraph only if the complaint challenges a denial because the service is not a covered benefit.]

How to file to continue getting services

If you have been receiving the services that are being reduced, changed, or denied and you file a second level complaint, or request for a fair hearing (see instructions below) that is either received by the BH-MCO or the Department of Human Services or postmarked **within 1 calendar day from the date of the notice that inpatient services are being reduced, changed, or denied or within 10 calendar days from the date on the notice that any other services are being reduced, changed, or denied,** the services 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 Guidelines

You may ask for a copy of the rules or other guidelines on which the decision was based by sending a written request to:

[BH-MCO Address]

2) File a Second Level Complaint

You may file a second level complaint with **[BH-MCO Name] within 45 calendar days from the date you get this notice**. A decision will be made on your second level complaint no later than **[30, unless the BH-MCO will be using a shorter time frame to decide second level complaints]** days from when we receive it.

To file a second level complaint:

- Call **[BH-MCO Name]** at **[#]**; **or**
- Send or hand-deliver your complaint to **[BH-MCO Name]** at the following address:

[BH-MCO Address for filing complaint]

To ask for an early decision

If your doctor or psychologist believes that waiting **[30, unless the BH-MCO will be using a shorter time frame to decide second level complaints]** days to get a decision could harm your health, you may ask that your complaint be decided more quickly. To do this:

- Call **[BH-MCO Name]** at **[#]**;
- Your doctor or psychologist must fax a letter to **[BH-MCO fax #]** explaining why taking **[30 unless the BH-MCO will be using a shorter time frame to decide second level complaints]** days to decide your complaint could harm your health.

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

3) Request a Fair Hearing

You may ask for a fair hearing from the Department of Human Services. 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;
- The reason(s) you are asking for a fair hearing, or a copy of this notice;
- A copy of the original denial notice, if available. **[BH-MCO: Include this last item only for complaints challenging a denial because service is not a covered benefit or because the service was provided without authorization by a non-MA provider.]**

Your request for a fair hearing must be sent to the following address:

Department of Human Services
Office of Mental Health Substance Abuse Services
Division of Quality Management
Commonwealth Towers, 12th Floor
P.O. Box 2675
Harrisburg, PA 17101

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 psychologist believes that the usual time frame for deciding 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 1-877-356-5355, or fax your request to 1-717-772-7827;
- Your doctor or psychologist must fax a letter to 1-717-772-7827 explaining why taking the usual amount of time to decide your request for a fair hearing could harm your health. If your doctor or psychologist does not send a letter, your doctor or psychologist 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 3 business days from when it receives your request.

To get help with a complaint or request for fair hearing

- If you need help filing a second level complaint, call us at **[BH-MCO Phone #]** and **[BH-MCO Name]** will assign someone who has not been involved in the complaint issue to help you.
- If you have any other questions, or need help filing a request for a fair hearing, you may call us at **[BH-MCO Phone #]**, the legal aid office at 1-800-322-7572 (www.palegalservices.org), or the Pennsylvania Health Law Project at 1-800-274-3258 (www.phlp.org).
- If you ask, **[BH-MCO Name]** will provide you with a list of advocacy organizations that may be able to assist you.

Sincerely,

[BH-MCO Name]

cc: **[Member Representative, if designated]**
[Provider]

[BH-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 about the complaint you filed with [BH-MCO Name]. It is available in other languages and formats by calling [BH-MCO Name] at [#].

ATTACHMENT 4

Second Level Complaint Acknowledgment Letter

[DATE the letter is mailed]
[Member or Parent/Guardian Name]
[Address]
[County]

RE: **[Member's name, DOB, and Member or Complaint Identifier]**

Subject: Your Second Level Complaint

Dear **[Member or Parent/Guardian Name]**:

[BH-MCO Name] received your second level complaint about:

- **[list each complaint issue].**

The complaint was received on **[date of receipt]**.

The Second Level Complaint Process

A committee of three or more people, including at least one person who is a **[BH-MCO Name]** member or the parent or guardian of a **[BH-MCO Name]** member, will make a decision about your complaint by **[date that is no more than 30 days from receipt of the complaint]**. This is called the "complaint review." No one on the committee will have been involved in the complaint issue. A letter will be mailed to you within five business days after the decision is made, telling you each reason for the decision.

At any time during the complaint process, you can have someone you know represent you or act on your behalf. This person will be "your representative." If you decide to have someone represent you or act for you, tell **[BH-MCO Name]**, in writing, the name of that person and how we can reach him or her.

You or your representative may ask **[BH-MCO Name]** to see any information relevant to your complaint. You may also send information that you have about your complaint to **[BH-MCO Name]**:

[BH-MCO Address]

You and your representative may appear at the complaint review in person, by phone or by videoconference, if available, by calling us at **[BH-MCO Phone #].**You may also bring a family member, friend, lawyer or other person to help you. We will send you another letter at least 15 days before the date of the complaint review, telling you the place, date and time of the review. If you decide that you do not want to attend, that will not affect the decision of the committee.

To get help with your complaint

- If you need help with your complaint, call us at **[BH-MCO Phone #]** and **[BH-MCO Name]** will assign someone who has not been involved in the complaint issue to help you.
- If you have any other questions, you may call us at **[BH-MCO Phone #]**, the legal aid office at 1-800-322-7572 (www.palegalservices.org), or the Pennsylvania Health Law Project at 1-800-274-3258 (www.phlp.org).
- If you ask, [BH-MCO Name] will provide you with a list of advocacy organizations that may be able to assist you.

Sincerely,

[BH-MCO Name]

cc: **[Member Representative, if designated]**

[BH-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 letter is about the complaint you filed with [BH-MCO Name]. It is available in other languages and formats by calling [BH-MCO Name] at [#].

ATTACHMENT 5a

Second Level Complaint Decision Notice

MCO, Use this template for all complaints EXCEPT for those involving the following:

1. **A denial because the requested service is not a covered benefit.**
2. **Failure of the MCO to meet the required time frames for providing a service, which includes the BH-MCO's failure to deliver all services as authorized.**
3. **Failure of the MCO to decide a complaint or a grievance within the specified time frames.**
4. **A denial of payment after a service has been delivered because the service(s) was provided without authorization by a provider not enrolled in the Pennsylvania Medical Assistance Program.**
5. **A denial of payment after a service has been delivered because the service is not a covered benefit.**

[Date the notice is mailed]
[Member or Parent/Guardian Name]
[Address]
[County]

RE: **[Member's name, DOB, and Member or Complaint Identifier]**

Subject: Decision About Your Second Level Complaint

Dear **[Member or Parent/Guardian Name]**:

[BH-MCO Name] has reviewed your second level complaint received on **[date]**.

Based on a review of all information provided, the second level complaint review committee has decided on **[Include the date the decision was made]** that:

- **[List each complaint issue separately in its own bullet, including either: "the available information supported your complaint" or "the available information did not support your complaint"]**

The reasons for this decision are:

[Explain in detail every reason for the decision on each complaint issue; in addition to explanation for decision, include specific references to approved criteria, rules or protocols on which decision is based; if unable

to make a decision because of insufficient information, identify all additional information needed to render decision].

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

1) Request Guidelines

You may ask for a copy of the rules or other guidelines on which the decision was based by sending a written request to:

[BH-MCO Address]

2) Request an External Review

You may ask for an "external review" of the second level complaint decision from the Pennsylvania Department of Health or the Pennsylvania Insurance Department **within 15 days from the date you get this notice**.

Send your request to one of the following addresses:

Pennsylvania Department of Health
Bureau of Managed Care
Room 912, Health & Welfare Building
625 Forster Street
Harrisburg, PA 17120-0701
Telephone: 1-888-466-2787
Fax: 1-717-705-0947
AT&T Relay: 1-800-654-5984 (for persons with hearing impairments)

Pennsylvania Insurance Department
Bureau of Customer Service
1321 Strawberry Square
Harrisburg, PA 17120
Telephone: 1-877-881-6388

Your request for external review by either Department must include the following information:

- Your (the member's) name, address, and daytime telephone number;
- Your (the member's) **[BH-MCO Name]** identification number;
- **[BH-MCO Name]**'s name;
- A brief description of the issue;
- A copy of this notice.

If you send your request for external review to the wrong Department, that Department will send it to the other Department.

To get help with a request for external review

- If you need help filing a request for an external review, call us at **[BH-MCO Phone #]** and **[BH-MCO Name]** will assign someone who has not been involved in the complaint issue to help you.
- If you have any other questions, you may call us at **[BH-MCO Phone #]**, the legal aid office at 1-800-322-7572 (www.palegalservices.org), or the Pennsylvania Health Law Project at 1-800-274-3258 (www.phlp.org).
- If you ask, [BH-MCO Name] will provide you with a list of advocacy organizations that may be able to assist you.

Sincerely,

[BH-MCO Name]

cc: **[Member Representative, if designated]**

[BH-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 about the complaint you filed with [BH-MCO Name]. It is available in other languages and formats by calling [BH-MCO Name] at [#].

ATTACHMENT 5b

Second Level Complaint Decision Notice

MCO, Use this template ONLY for complaints involving the following:

1. **A denial because the requested service is not a covered benefit.**
2. **Failure of the MCO to meet the required time frames for providing a service, which includes the BH-MCO's failure to deliver all services as authorized;**
3. **Failure of the MCO to decide a complaint or a grievance within the specified time frames.**
4. **A denial of payment after a service has been delivered because the service(s) was provided without authorization by a provider not enrolled in the Pennsylvania Medical Assistance Program.**
5. **A denial of payment after a service has been delivered because the service is not a covered benefit.**

[Date the notice is mailed]
[Member or Parent/Guardian Name]
[Address]
[County]

RE: **[Member's name, DOB, and Member or Complaint Identifier]**

Subject: Decision About Your Second Level Complaint

Dear **[Member or Parent/Guardian Name]**:

[BH-MCO Name] has reviewed your second level complaint received on **[date]**.

Based on a review of all information provided, the second level complaint review committee has decided on **[Include the date the decision was made]** that:

- **[List each complaint issue separately in its own bullet, including either: "the available information supported your complaint" or "the available information did not support your complaint"]**

The reasons for this decision are:

[Explain in detail every reason for the decision on each complaint issue; in addition to explanation for decision, include specific references to approved criteria, rules or protocols on which decision is based; if unable to make a decision because of insufficient information, identify all additional information needed to render decision].

BH-MCO: Include the following paragraph only if the complaint challenges a denial because the service is not a covered benefit

How to file to continue getting services

If you have been receiving the services that are being reduced, changed, or denied and you file a request for an external review or request for a fair hearing (see instructions below) that is either received by the BH-MCO or the Department of Human Services or postmarked **within 1 calendar day from the date of the notice that inpatient services are being reduced, changed, or denied or within 10 calendar days from the date on the notice that any other services are being reduced, changed, or denied**, the services 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 Guidelines

You may ask for a copy of the rules or other guidelines on which the decision was based by sending a written request to:

[BH-MCO Address]

2) Request an External Review

You may ask for an "external review" of the second level complaint decision from the Pennsylvania Department of Health or the Pennsylvania Insurance Department **within 15 days from the date you get this notice**.

Send your request to one of the following addresses:

Pennsylvania Department of Health
Bureau of Managed Care
Room 912, Health & Welfare Building
625 Forster Street
Harrisburg, PA 17120-0701
Telephone: 1-888-466-2787
Fax: 1-717-705-0947
AT&T Relay: 1-800-654-5984 (for persons with hearing impairments)

Pennsylvania Insurance Department
Bureau of Customer Service
1321 Strawberry Square
Harrisburg, PA 17120
Telephone: 1-877-881-6388

Your request for external review by either Department must include the following information:

- Your (the member's) name, address, and daytime telephone number;
- Your (the member's) **[BH-MCO Name]** identification number;
- **[BH-MCO Name]**'s name;
- A brief description of the issue;
- A copy of this notice.

If you send your request for external review to the wrong Department, that Department will send it to the other Department.

3) Request a Fair Hearing

You may ask for a fair hearing from the Department of Human Services. 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;
- The reason(s) you are asking for a fair hearing, or a copy of this notice;
- A copy of the original denial notice, if available. **[BH-MCO: Include this last item only for complaints challenging a denial because service is**

not a covered benefit or because the service was provided without authorization by a non-MA provider.]

Your request for a fair hearing must be sent to the following address:

Department of Human Services
Office of Mental Health Substance Abuse Services
Division of Quality Management
Commonwealth Towers, 12th Floor
P.O. Box 2675
Harrisburg, PA 17101

The Department will issue a decision within 90 days from when it receives your request.

To ask for an early decision

If your doctor or psychologist believes that the usual time frame for deciding 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 1-877-356-5355, or fax your request to 1-717-772-7827;
- Your doctor or psychologist must fax a letter to 1-717-772-7827 explaining why taking the usual amount of time to decide your request for a fair hearing could harm your health. If your doctor or psychologist does not send a letter, your doctor or psychologist 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 3 business days from when it receives your request.

To get help with a request for external review or fair hearing

- If you need help filing a request for an external review, call us at **[BH-MCO Phone #]** and **[BH-MCO Name]** will assign someone who has not been involved in the complaint issue to help you.
- If you have any other questions, or need help filing a request for a fair hearing, you may call us at **[BH-MCO Phone #]**, the legal aid office at 1-800-322-7572 (www.palegalservices.org), or the Pennsylvania Health Law Project at 1-800-274-3258 (www.phlp.org).
- If you ask, **[BH-MCO Name]** will provide you with a list of advocacy organizations that may be able to assist you.

Sincerely,

[BH-MCO Name]

cc: **[Member Representative, if designated]**
[Provider]

[BH-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 about the complaint you filed with [BH-MCO Name]. It is available in other languages and formats by calling [BH-MCO Name] at [#].

ATTACHMENT 5c

Notice of Failure to Receive Provider Certification for an Expedited Complaint

[Date the notice is mailed]
[Member or Parent/Guardian Name]
[Address]
[County]

RE: **[Member's name, DOB, and Member or Complaint Identifier]**

Subject: Request for Expedited Complaint

Dear **[Member or Parent/Guardian Name]**:

[BH-MCO Name] received your complaint about **[identify subject of complaint]**, on **[date]** and your request to have the complaint decided more quickly than the usual **[30, unless the BH-MCO will be using a shorter time frame to decide first level complaints]**-day time frame. As we told you when you filed your complaint, in order for your complaint to be decided more quickly, your **[doctor][psychologist]** needed to send us a written statement that taking the usual amount of time to decide the complaint could harm your health. **[BH-MCO Name]** also asked your **[doctor][psychologist]** for this statement.

We have not received your **[doctor's][psychologist's]** statement, so your complaint will be decided within the usual time frame of **[30, unless the BH-MCO will be using a shorter time frame to decide first level complaints]** days from when we first got your complaint.

The First Level Complaint Process

A committee of one or more **[BH-MCO Name]** staff members who have not been involved in the issue you filed your complaint about will make a decision about your complaint by **[date that is no more than 30 days from receipt of the complaint]**. This is called the "complaint review." A letter will be mailed to you within five business days after the decision is made, telling you each reason for the decision.

At any time during the complaint process, you can have someone you know represent you or act on your behalf. This person will be "your representative." If you decide to have someone represent you or act for you, tell **[BH-MCO Name]**, in writing, the name of that person and how we can reach him or her.

You or your representative may ask **[BH-MCO Name]** to see all information relevant to your complaint. You may also send information that you have about your complaint to **[BH-MCO Name]**:

[BH-MCO Address]

[BH-MCO: Include the following paragraphs on the complaint review, Fair Hearings, and Expedited Fair Hearings only if the complaint is about one of the following: Failure to provide services in a timely manner; failure to decide a complaint or grievance within 30 days; denial of service as not a covered benefit (whether prior authorization or payment denial); or denial because the service was provided without authorization by a non-MA provider.]

You and your representative may appear at the complaint review in person, by phone or by videoconference, if available, by calling us at **[BH-MCO Phone #]**. You may also bring a family member, friend, lawyer or other person to help you. If you decide that you do not want to attend, that will not affect the decision of the committee.

The Fair Hearing Process

You may also ask for a fair hearing from the Department of Human Services. 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;
- The reason(s) you are asking for a fair hearing, or a copy of this notice;
- A copy of the original denial notice, if available **[BH-MCO: Include this last item for complaints challenging a denial because service is not a covered benefit or because the service was provided without authorization by a non-MA provider.]**

Your request for a fair hearing must be sent to the following address:

Department of Human Services
Office of Mental Health Substance Abuse Services
Division of Quality Management
Commonwealth Towers, 12th Floor
P.O. Box 2675
Harrisburg, PA 17101

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 psychologist believes that the usual time frame for deciding 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 1-877-356-5355, or fax your request to 1-717-772-7827;
- Your doctor or psychologist must fax a letter to 1-717-772-7827 explaining why taking the usual amount of time to decide your request for a fair hearing could harm your health. If your doctor or psychologist does not send a letter, your doctor or psychologist 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 3 business days from when it receives your request.

To get help with your complaint or request for fair hearing

- If you need help with your complaint, call us at **[BH-MCO Phone #]**, and **[BH-MCO Name]** will assign someone who has not been involved in the complaint issue to help you.
- If you have any other questions, or need help filing a request for a fair hearing, you may call us at **[BH-MCO Phone #],** the legal aid office at 1-800-322-7572 (www.palegalservices.org), or the Pennsylvania Health Law Project at 1-800-274-3258 (www.phlp.org)**.**
- If you ask, [BH-MCO Name] will provide you with a list of advocacy organizations that may be able to assist you.

Sincerely,

[BH-MCO Name]

cc: **[Member Representative, if designated]**
[Provider]

[BH-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 about the complaint you filed with [BH-MCO Name]. It is available in other languages and formats by calling [BH-MCO Name] at [#].

ATTACHMENT 6

Expedited Complaint Decision Notice

[Date Notice Mailed (no more than 2 days after the date of the decision)]

Date notice is mailed]
[Member or Parent/Guardian Name]
[Address]
[County]

RE: **[Member's name, DOB, and Member or Complaint Identifier]**

Subject: "Expedited" Decision About Your Complaint

Dear **[Member Name]**:

[BH-MCO Name] has reviewed your complaint about **[issue]**, received on **[date]**.

Based on a review of all information provided, the review committee has decided on **[Include the date the decision was made]** that:

- **[List each complaint issue separately in its own bullet, including either: "the available information supported your complaint" or "the available information did not support your complaint"]**

The reasons for this decision are:

[Explain in detail every reason for the decision on each complaint issue; in addition to explanation for decision, include specific references to approved criteria, rules or protocols on which decision is based; if unable to make a decision because of insufficient information, identify all additional information needed to render decision].

[BH-MCO: Include the following paragraph only if the complaint challenges a denial because the service is not a covered benefit.]

How to file to continue getting services

If you have been receiving the services that are being reduced, changed, or denied and you file a second level complaint or request for a fair hearing (see instructions below) that is either received by the BH-MCO or the Department of Human Services or postmarked **within 1 calendar day from the date of the notice that inpatient services are being reduced, changed, or denied or within 10 calendar days from the date on the notice that any other services are being reduced, changed, or denied** , the services 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 Guidelines

You may ask for a copy of the rules or other guidelines on which the decision was based by sending a written request to:

[BH-MCO Address]

2) Request an Expedited External Review

You may ask for an "expedited external review" of the complaint decision from the Pennsylvania Department of Health. You may ask for the external review **within two business days from the date you get this notice.** A decision will be issued within five business days from when we receive your request.

To file an expedited external review:

- Call **[BH-MCO Name]** at **[BH-MCO Phone #]**; **or**
- Fax **[BH-MCO Name]** at **[BH-MCO Fax #]; or**
- Send your request to **[BH-MCO Name]** at the following address:

[BH-MCO Address for requesting external review]

3) Request a Fair Hearing

To ask for an early decision

You may ask for a fair hearing from the Department of Human Services. If your doctor or psychologist still believes that the usual time frame for

deciding a fair hearing (between 60 and 90 days) could harm your health, you may ask that the fair hearing take place more quickly. To do this:

- Call the Department at 1-877-356-5355, or fax your request to 1-717-772-7827;
- Your doctor or psychologist must fax a letter to 1-717-772-7827 explaining why taking the usual amount of time to decide your request for a fair hearing could harm your health. If your doctor or psychologist does not send a letter, your doctor or psychologist 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 3 business days from when it receives your request.

Even if you no longer need an early decision, 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;
- The reason(s) you are asking for a fair hearing, or a copy of this notice;
- A copy of the original denial notice, if available. **[BH-MCO: Include this last item only for complaints challenging a denial because the service is not a covered benefit.]**

Your request for a fair hearing must be sent to the following address:

Department of Human Services
Office of Mental Health Substance Abuse Services
Division of Quality Management
Commonwealth Towers, 12th Floor
P.O. Box 2675
Harrisburg, PA 17101

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 get help with a request for external review or fair hearing

- If you need help filing a request for an external review, call us at **[BH-MCO Phone #]** and **[BH-MCO Name]** will assign someone who has not been involved in the complaint issue to help you.
- If you have any other questions, or need help filing a request for a fair hearing, you may call us at **[BH-MCO Phone #]**, the legal aid office at 1-800-322-7572 (www.palegalservices.org), or the Pennsylvania Health Law Project at 1-800-274-3258 (www.phlp.org).
- If you ask, **[BH-MCO Name]** will provide you with a list of advocacy organizations that may be able to assist you.

Sincerely,

[BH-MCO Name]

cc: **[Member Representative, if designated]**
[Provider]

[BH-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 about the complaint you filed with [BH-MCO Name]. It is available in other languages and formats by calling [BH-MCO Name] at [#].

ATTACHMENT 7

First Level Grievance Acknowledgment Letter

[Date the letter is mailed]
[Member or Parent/Guardian Name]
[Address]
[County]

RE: **[Member's name, DOB, and Member or Grievance Identifier]**

Subject: Your Grievance

Dear **[Member or Parent/Guardian Name]**:

[BH-MCO Name] received your grievance about:

The denial of the following services: **[list services denied].**

The grievance was received on **[date of receipt]**.

The First Level Grievance Process

A committee of one or more **[BH-MCO Name]** staff members that includes a licensed doctor or licensed psychologist, who have not been involved in the issue you filed your grievance about, will review your grievance. This is called the "grievance review." A decision will be made by **[date that is no more than 30 days from receipt of the grievance].** A letter will be mailed to you within five business days after the decision is made, telling you each reason for the decision.

At any time during the grievance process, you can have someone you know represent you or act on your behalf. This person will be "your representative." If you decide to have someone represent you or act for you, tell **[BH-MCO Name]**, in writing, the name of that person and how we can reach him or her.

You or your representative may ask **[BH-MCO Name]** to see all information relevant to your grievance. You may also send information that you have about your grievance to **[BH-MCO Name]**:

[BH-MCO Address]

You and your representative may appear at the grievance review in person, by phone or by videoconference, if available, by calling us at **[BH-MCO Phone #]**. You may also bring a family member, friend, lawyer or other person to help you. If you decide that you do not want to attend, that will not affect the decision of the committee.

If you think your issue is really a complaint and should not be treated as a grievance, you may call or write to the Pennsylvania Department of Health:

Pennsylvania Department of Health
Bureau of Managed Care
Room 912, Health & Welfare Building
625 Forster Street
Harrisburg, PA 17120-0701
Telephone: 1-888-466-2787; Fax: 1-717-705-0947
AT&T Relay: 1-800-654-5984 (for persons with hearing impairments)

If you need more information on what a complaint is, you can read your member handbook or call us at **[BH-MCO Phone #]**.

To get help with your grievance

- If you need help with your grievance, call us at **[BH-MCO Phone #]** and **[BH-MCO Name]** will assign someone who has not been involved in the grievance issue to help you.
- If you have any other questions, you may call us at **[BH-MCO Phone #]**, the legal aid office at 1-800-322-7572 (www.palegalservices.org), or the Pennsylvania Health Law Project at 1-800-274-3258 (www.phlp.org).
- If you ask, **[BH-MCO Name]** will provide you with a list of advocacy organizations that may be able to assist you.

Sincerely,

[BH-MCO Name]

cc: **[Member Representative, if designated]**
[Provider]

[BH-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 letter is about the grievance you filed with [BH-MCO Name]. It is available in other languages and formats by calling [BH-MCO Name] at [#].

ATTACHMENT 8a

First Level Grievance Decision Notice
[Use for grievances that are overturned]

[Date the notice is mailed]
[Member or Parent/Guardian Name]
[Address]
[County]

RE: **[Member's name, DOB, and Member or Grievance Identifier]**

Subject: Decision About Your Grievance

Dear **[Member or Parent/Guardian Name]**:

On **[include date of the first level grievance review] [BH-MCO Name]** has reviewed your grievance about the denial of services.

Based on a review of all information provided, the first level grievance review committee has decided that the decision to deny services is overturned.
The following services were requested on **[include date of original requested services]**:

- **[list all services requested]**
- **[include each individual service requested in its own bullet]**
- **[include specifics of the request, including hours per week, service type, and dates requested]**

The following services were authorized:

- **[list all services approved]**
- **[designate if a service was approved other than requested]**
- **[include each individual service approved in its own bullet]**
- **[include specifics of the services approved, including hours per week, service type, and dates requested]**
- **[if no services were approved do not include this category]**

The following services were denied:

- **[list all services denied]**
- **[include each individual service denied in its own bullet]**
- **[include specifics of the services denied, including hours per week, service type, and dates requested]**

As a result of the decision of the first level grievance review committee the following services have been authorized effective **[include date of the decision]** until **[include date authorized services will end]**:

- **[list all services approved]**
- **[list must be the same as list of services originally requested]**

The reasons for this decision are:

[Explain in detail every reason for each decision; 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].

Sincerely,

[BH-MCO Name]

cc: **[Member Representative, if designated]**
[Provider]

[BH-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 about the grievance you filed with [BH-MCO Name]. It is available in other languages and formats by calling [BH-MCO Name] at [#].

ATTACHMENT 8b

First Level Grievance Decision Notice
[Use for grievances that are partially overturned]

[Date the notice is mailed]
[Member or Parent/Guardian Name]
[Address]
[County]

RE: **[Member's name, DOB, and Member or Grievance Identifier]**

Subject: Decision About Your Grievance

Dear **[Member or Parent/Guardian Name]**:

On **[include date of the first level grievance review] [BH-MCO Name]** has reviewed your grievance about the denial of services.

Based on a review of all information provided, the first level grievance review committee has decided that the decision to deny services is partially overturned.

The following services were requested on **[include date of original requested services]**:

- **[list all services requested]**
- **[include each individual service requested in its own bullet]**
- **[include specifics of the request, including hours per week, service type, and dates requested]**

The following services were authorized:

- **[list all services approved]**
- **[designate if a service was approved other than requested]**
- **[include each individual service approved in its own bullet]**
- **[include specifics of the services approved, including hours per week, service type, and dates requested]**
- **[if no services were approved do not include this category]**

The following services were denied:

- **[list all services denied]**
- **[include each individual service denied in its own bullet]**
- **[include specifics of the services denied, including hours per week, service type, and dates requested]**

As a result the decision of the first level grievance review committee the following services have been authorized effective **[include date of the decision]** until **[include date authorized services will end]**:

- **[list all services approved]**
- **[designate if a service was approved other than requested]**
- **[include each individual service approved in its own bullet]**
- **[include specifics of the services approved, including hours per week, service type, and dates requested]**

As a result of the decision of the first level grievance review committee the following services have been denied:

- **[list all services denied]**
- **[include each individual service denied in its own bullet]**
- **[include specifics of the service denied, including hours per week, service type, and dates requested]**

The reasons for this decision are:

[Explain in detail every reason for each decision; 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].

How to file to continue getting services

If you have been receiving the services that are being reduced, changed, or denied and you file a second level grievance or request for a fair hearing (see instructions below) that is either received by the BH-MCO or the Department of Human Services or postmarked **within 1 calendar day from the date of the notice that inpatient services are being reduced, changed, or denied or within 10 calendar days from the date on the notice that any other services are being reduced, changed, or denied**, the services 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 ask for a copy of the medical necessity criteria or other rules on which the decision was based by sending a written request to:

[BH-MCO Address]

2) <u>File a Second Level Grievance</u>

You may file a second level grievance with **[BH-MCO Name]** **<u>within 45 days from the date you get this notice</u>**. A decision will be made on your second level grievance no later than **[30, unless the BH-MCO will be using a shorter time frame to decide second level grievances]** days from when we receive it.

To file a second level grievance:

- Call **[BH-MCO Name]** at **[#]**; **or**
- Send or hand-deliver your grievance to **[BH-MCO Name]** at the following address:

[BH-MCO Address for filing grievance]

<u>To ask for an early decision</u>

If your doctor or psychologist believes that waiting **[30, unless the BH-MCO will be using a shorter time frame to decide second level grievances]** days to get a decision could harm your health, you may ask that your grievance be decided more quickly. To do this:

- Call **[BH-MCO Name]** at **[#]**;
- Your doctor or psychologist must fax a letter to **[BH-MCO fax #]** explaining why taking **[30 unless the BH-MCO will be using a shorter time frame to decide second level grievances]** days to decide your grievance could harm your health.

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

3) <u>Request a Fair Hearing</u>

You may ask for a fair hearing from the Department of Human Services. Your request for a fair hearing must be in writing and must be postmarked **<u>within 30 days from the date on this notice</u>**. 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;
- The reason(s) you are asking for a fair hearing, or a copy of this notice;
- A copy of the original denial notice, if available.

Your request for a fair hearing must be sent to the following address:

Department of Human Services
Office of Mental Health Substance Abuse Services
Division of Quality Management
Commonwealth Towers, 12th Floor
P.O. Box 2675
Harrisburg, PA 17101

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 psychologist believes that the usual time frame for deciding 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 1-877-356-5355, or fax your request to 1-717-772-7827;
- Your doctor or psychologist must fax a letter to 1-717-772-7827 explaining why taking the usual amount of time to decide your request for a fair hearing could harm your health. If your doctor or psychologist does not send a letter, your doctor or psychologist 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.

To get help with a grievance or request for fair hearing

- If you need help filing a second level grievance, call us at **[BH-MCO Phone #]** and **[BH-MCO Name]** will assign someone who has not been involved in the grievance issue to help you.
- If you have any other questions, or need help filing a request for a fair hearing, you may call us at **[BH-MCO Phone #]**, the legal aid office at 1-

800-322-7572 (www.palegalservices.org), or the Pennsylvania Health Law Project at 1-800-274-3258 (www.phlp.org).

- If you ask, **[BH-MCO Name]** will provide you with a list of advocacy organizations that may be able to assist you.

[BH-MCO Name]

cc: **[Member Representative, if designated]**
[Provider]

[BH-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 about the grievance you filed with [BH-MCO Name]. It is available in other languages and formats by calling [BH-MCO Name] at [#].

ATTACHMENT 8c

First Level Grievance Decision Notice
[Use for grievances that are upheld]

[Date the notice is mailed]
[Member or Parent/Guardian Name]
[Address]
[County]

RE: **[Member's name, DOB, and Member or Grievance Identifier]**

Subject: Decision About Your Grievance

Dear **[Member or Parent/Guardian Name]**:

On **[include date of the first level grievance review] [BH-MCO Name]** reviewed your grievance about the denial of services.

Based on a review of all information provided, the first level grievance review committee has decided that the decision to deny services is upheld.

The following services were requested on **[include date of original requested services]**:

- **[list all services requested]**
- **[include each individual service requested in its own bullet]**
- **[include specifics of the request, including hours per week, service type, and dates requested]**

The following services were authorized:

- **[list all services approved]**
- **[designate if a service was approved other than requested]**
- **[include each individual service approved in its own bullet]**
- **[include specifics of the services approved, including hours per week, service type, and dates requested]**
- **[if no services were approved do not include this category]**

The following services were denied:

- **[list all services denied]**
- **[include each individual service denied in its own bullet]**
- **[include specifics of the services denied, including hours per week, service type, and dates requested]**

As a result of the decision of the first level grievance review committee there is no change in the services authorized for you. If any services have been authorized, they are authorized until **[include date authorized services will end]**:

The reasons for this decision are:

[Explain in detail every reason for each decision; 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].

How to file to continue getting services

If you have been receiving the services that are being reduced, changed, or denied and you file a second level grievance or request for a fair hearing (see instructions below) that is either received by the BH-MCO or the Department of Human Services or postmarked **within 1 calendar day from the date of the notice that inpatient services are being reduced, changed, or denied or within 10 calendar days from the date on the notice that any other services are being reduced, changed, or denied**, the services 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 ask for a copy of the medical necessity criteria or other rules on which the decision was based by sending a written request to:

[BH-MCO Address]

2) File a Second Level Grievance

You may file a second level grievance with **[BH-MCO Name]** **within 45 days from the date you get this notice**. A decision will be made on your second level grievance no later than **[30, unless the BH-MCO will be using a shorter time frame to decide second level grievances]** days from when we receive it.

To file a second level grievance:

- Call **[BH-MCO Name]** at **[#]**; **or**
- Send or hand-deliver your grievance to **[BH-MCO Name]** at the following address:

[BH-MCO Address for filing grievance]

To ask for an early decision

If your doctor or psychologist believes that waiting **[30, unless the BH-MCO will be using a shorter time frame to decide second level grievances]** days to get a decision could harm your health, you may ask that your grievance be decided more quickly. To do this:

- Call **[BH-MCO Name]** at **[#]**;
- Your doctor or psychologist must fax a letter to **[BH-MCO fax #]** explaining why taking **[30 unless the BH-MCO will be using a shorter time frame to decide second level grievances]** days to decide your grievance could harm your health.

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

3) Request a Fair Hearing

You may ask for a fair hearing from the Department of Human Services. 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;
- The reason(s) you are asking for a fair hearing, or a copy of this notice;
- A copy of the original denial notice, if available.

Your request for a fair hearing must be sent to the following address:

Department of Human Services
Office of Mental Health Substance Abuse Services
Division of Quality Management
Commonwealth Towers, 12th Floor
P.O. Box 2675
Harrisburg, PA 17101

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 psychologist believes that the usual time frame for deciding 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 1-877-356-5355, or fax your request to 1-717-772-7827;
- Your doctor or psychologist must fax a letter to 1-717-772-7827 explaining why taking the usual amount of time to decide your request for a fair hearing could harm your health. If your doctor or psychologist does not send a letter, your doctor or psychologist 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.

To get help with a grievance or request for fair hearing

- If you need help filing a second level grievance, call us at **[BH-MCO Phone #]** and **[BH-MCO Name]** will assign someone who has not been involved in the grievance issue to help you.
- If you have any other questions, or need help filing a request for a fair hearing, you may call us at **[BH-MCO Phone #]**, the legal aid office at 1-800-322-7572 (www.palegalservices.org), or the Pennsylvania Health Law Project at 1-800-274-3258 (www.phlp.org).
- If you ask, [BH-MCO Name] will provide you with a list of advocacy organizations that may be able to assist you.

[BH-MCO Name]

cc: **[Member Representative, if designated]**
[Provider]

[BH-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 about the grievance you filed with [BH-MCO Name]. It is available in other languages and formats by calling [BH-MCO Name] at [#].

ATTACHMENT 9

Second Level Grievance Acknowledgment Letter

[Date the letter is mailed]
[Member or Parent/Guardian Name]
[Address]
[County]

RE: **[Member's name, DOB, and Member or Grievance Identifier]**

Subject: Your Second Level Grievance

Dear **[Member or Parent/Guardian Name]**:

[BH-MCO Name] received your second level grievance about:

The denial of the following services: **[list services denied].**

The grievance was received on **[date of receipt]**.

The Second Level Grievance Process

A committee of three or more people, which includes a licensed doctor or licensed psychologist, and at least one **[BH-MCO Name]** member or the parent or guardian of a **[BH-MCO Name]** member, will review your grievance. This is called the "grievance review." No one on the committee will have been involved in the grievance issue. A decision will be made by **[date that is no more than 30 days from receipt of the grievance]**. A letter will be mailed to you within five business days after the decision is made, telling you each reason for the decision.

At any time during the grievance process, you can have someone you know represent you or act on your behalf. This will be "your representative." If you decide to have someone represent you or act for you, tell **[BH-MCO Name]**, in writing, the name of that person and how we can reach him or her.

You or your representative may ask **[BH-MCO Name]** to see any information relevant to your grievance. You may also send information that you have about your grievance to **[BH-MCO Name]**:

[BH-MCO Address]

You and your representative may appear at the grievance review in person, by phone or by videoconference, if available, by calling us at **[BH-MCO Phone #]**. You may also bring a family member, friend, lawyer or other person to help you. We will send you another letter at least 15 days before the date of the grievance review, telling you the place, date

and time of the review. If you decide that you do not want to attend, that will not affect the decision of the committee.

To get help with your grievance

- If you need help with your grievance, call us at **[BH-MCO Phone #]** and **[BH-MCO Name]** will assign someone who has not been involved in the grievance issue to help you.
- If you have any other questions, you may call us at **[BH-MCO Phone #],** the legal aid office at 1-800-322-7572 (www.palegalservices.org), or the Pennsylvania Health Law Project at 1-800-274-3258 (www.phlp.org).
- If you ask, [BH-MCO Name] will provide you with a list of advocacy organizations that may be able to assist you.

Sincerely,

[BH-MCO Name]

cc: **[Member Representative, if designated]**
[Provider]

[BH-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 letter is about the grievance you filed with [BH-MCO Name]. It is available in other languages and formats by calling [BH-MCO Name] at [#].

ATTACHMENT 10a

Second Level Grievance Decision Notice
[Use for grievances that are overturned]

[Date the notice is mailed]
[Member or Parent/Guardian Name]
[Address]
[County]

RE: **[Member's name, DOB, and Member or Grievance Identifier]**

Subject: Decision About Your Second Level Grievance

Dear **[Member or Parent/Guardian Name]**:

On **[include date of the second level grievance review] [BH-MCO Name]** has reviewed your second level grievance about the denial of services.

Based on a review of all information provided, the second level grievance review committee has decided that the decision of the first level grievance review committee is overturned.
The following services were requested on **[Include date of original requested services]**:

- **[list all services requested]**
- **[include each individual service requested in its own bullet]**
- **[include specifics of the request, including hours per week, service type, and dates requested]**

The decision of the first level grievance review committee resulted in the following services being authorized:

- **[list all services approved]**
- **[designate if a service was approved other than requested]**
- **[include each individual service approved in its own bullet]**
- **[include specifics of the service approved, including hours per week, service type, and dates requested]**
- **[if no services were approved do not include this category]**

The decision of the first level grievance review committee resulted in the following services being denied:

- **[list all services denied]**
- **[include each individual service denied in its own bullet]**

- **[include specifics of the service denied, including hours per week, service type, and dates requested]**

As a result of the decision of the second level grievance review committee the following services have been authorized effective **[include date of the decision]** until **[include date authorized services will end]**:

- **[list all services approved]**
- **[list must be the same as the list of services originally requested]**

The reasons for this decision are:

[Explain in detail every reason for each decision; 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].

Sincerely,

[BH-MCO Name]

cc: **[Member Representative, if designated]**
[Provider]

[BH-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 about the grievance you filed with [BH-MCO Name]. It is available in other languages and formats by calling [BH-MCO Name] at [#].

ATTACHMENT 10b

Second Level Grievance Decision Notice
[Use for grievances that are partially overturned]

[Date the notice is mailed]
[Member or Parent/Guardian Name]
[Address]
[County]

RE: **[Member's name, DOB, and Member or Grievance Identifier]**

Subject: Decision About Your Second Level Grievance

Dear **[Member or Parent/Guardian Name]**:

On **[include date of the second level grievance review] [BH-MCO Name]** has reviewed your second level grievance about the denial of services.

Based on a review of all information provided, the second level grievance review committee has decided that the decision of the first level grievance review committee is partially overturned.

The following services were requested on **[include date of original requested services]**:

- **[list all services requested]**
- **[include each individual service requested in its own bullet]**
- **[include specifics of the request, including hours per week, service type, and dates requested]**

The decision of the first level grievance review **committee** resulted in the following services being authorized:

- **[list all services approved]**
- **[designate if a service was approved other than requested]**
- **[include each individual service approved in its own bullet]**
- **[include specifics of the service approved, including hours per week, service type, and dates requested]**
- **[if no services were approved do not include this category]**

The decision of the first level grievance review committee resulted in the following services being denied:

- **[list all services denied]**

- **[include each individual service denied in its own bullet]**
- **[include specifics of the service denied, including hours per week, service type, and dates requested]**

As a result of the decision of the second level grievance review committee the following services have been authorized effective **[include date of the decision]** until **[include date authorized services will end]**:

- **[list all approved services]**
- **[designate if a service was approved other than requested]**
- **[include each individual service approved in its own bullet]**
- **[include specifics of the services approved, including hours per week, service type, and dates requested]**

As a result of the decision of the second level grievance review committee the following services have been denied:

- **[list all services denied]**
- **[include each individual service denied in its own bullet]**
- **[include specifics of the service denied, including hours per week, service type, and dates requested]**

The reasons for this decision are:

[Explain in detail every reason for each decision; 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].

How to file to continue getting services

If you have been receiving the services that are being reduced, changed, or denied and you file a request for an external review or request for a fair hearing (see instructions below) that is either received by the BH-MCO or the Department of Human Services or postmarked **within 1 calendar day from the date of the notice that inpatient services are being reduced, changed, or denied or within 10 calendar days from the date on the notice that any other services are being reduced, changed, or denied**, the services 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 ask for a copy of the medical necessity criteria or other rules on which the decision was based by sending a written request to:

[BH-MCO Address]

2) Request an External Review

You may ask for an "external review" of the second level grievance decision **within 15 days from the date on this notice**. An external review is a review by a licensed doctor who does not work for **[BH-MCO Name]**.

Your request for an external review must be sent to the following address:

[BH-MCO Address for requesting external review]

A decision will be issued within 60 days from when we receive your request.

3) Request a Fair Hearing

You may ask for a fair hearing from the Department of Human Services. 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;
- The reason(s) you are asking for a fair hearing, or a copy of this notice;
- A copy of the original denial notice, if available.

Your request for a fair hearing must be sent to the following address:

Department of Human Services
Office of Mental Health Substance Abuse Services
Division of Quality Management
Commonwealth Towers, 12th Floor
P.O. Box 2675
Harrisburg, PA 17101

The Department will issue a decision within 90 days from when it receives your request.

To ask for an early decision

If your doctor or psychologist believes that the usual time frame for deciding 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 1-877-356-5355, or fax your request to 1-717-772-7827;
- Your doctor or psychologist must fax a letter to 1-717-772-7827 explaining why taking the usual amount of time to decide your request for a fair hearing could harm your health. If your doctor or psychologist does not send a letter, your doctor or psychologist 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 3 business days from when it receives your request.

To get help with a request for external review or fair hearing

- If you need help filing a request for an external review, call us at **[BH-MCO Phone #]** and **[BH-MCO Name]** will assign someone who has not been involved in the grievance issue to help you.
- If you have any other questions, or need help filing a request for a fair hearing, you may call us at **[BH-MCO Phone #]**, the legal aid office at 1-800-322-7572 (www.palegalservices.org), or the Pennsylvania Health Law Project at 1-800-274-3258 (www.phlp.org).
- If you ask, [BH-MCO Name] will provide you with a list of advocacy organizations that may be able to assist you.

Sincerely,

[BH-MCO Name]

cc: **[Member Representative, if designated]**
[Provider]

[BH-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 about the grievance you filed with [BH-MCO Name]. It is available in other languages and formats by calling [BH-MCO Name] at [#].

ATTACHMENT 10c

Second Level Grievance Decision Notice
[Use for grievances that are upheld]

[Date the notice is mailed]
[Member or Parent/Guardian Name]
[Address]
[County]

RE: **[Member's name, DOB, and Member or Grievance Identifier]**

Subject: Decision About Your Second Level Grievance

Dear **[Member or Parent/Guardian Name]**:

On **[include date of the second level grievance review] [BH-MCO Name]** has reviewed your second level grievance about the denial of services.

Based on a review of all information provided, the second level grievance review committee has decided that the decision of the first level grievance review committee is upheld.

The following services were requested on **[include date of original requested services]**:

- **[list all services requested]**
- **[include each individual service requested in its own bullet]**
- **[include specifics of the request, including hours per week, service type, and dates requested]**

The decision of the first level grievance review committee resulted in the following services being authorized:

- **[list all services approved]**
- **[designate if a service that approved other than requested]**
- **[include each individual service approved in its own bullet]**
- **[include specifics of the service approved, including hours per week, service type, and dates requested]**
- **[if no services were approved do not include this category]**

The decision of the first level grievance review committee resulted in the following services being denied:

- **[list all services denied]**
- **[include each individual service denied in its own bullet]**
- **[include specifics of the service denied, including hours per week, service type, and dates requested]**

As a result of the decision of the second level grievance review committee there is no change in the services authorized for you. If any services have been authorized, they are authorized until **[include date authorized services will end]**:

The reasons for this decision are:

[Explain in detail every reason for each service; 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].

How to file to continue getting services

If you have been receiving the services that are being reduced, changed, or denied and you file a request for an external review or request for a fair hearing (see instructions below) that is either received by the BH-MCO or the Department of Human Services or postmarked **within 1 calendar day from the date of the notice that inpatient services are being reduced, changed, or denied or within 10 calendar days from the date on the notice that any other services are being reduced, changed, or denied**, the services 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 ask for a copy of the medical necessity criteria or other rules on which the decision was based by sending a written request to:

[BH-MCO Address]

2) Request an External Review

You may ask for an "external review" of the second level grievance decision **within 15 days from the date on this notice**. An external review is a review by a licensed doctor who does not work for **[BH-MCO Name]**.

Your request for an external review must be sent to the following address:

[BH-MCO Address for requesting external review]

A decision will be issued within 60 days from when we receive your request.

3) Request a Fair Hearing

You may ask for a fair hearing from the Department of Human Services. 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;
- The reason(s) you are asking for a fair hearing, or a copy of this notice;
- A copy of the original denial notice, if available.

Your request for a fair hearing must be sent to the following address:

Department of Human Services
Office of Mental Health Substance Abuse Services
Division of Quality Management
Commonwealth Towers, 12th Floor
P.O. Box 2675
Harrisburg, PA 17101

The Department will issue a decision within 90 days from when it receives your request.

To ask for an early decision

If your doctor or psychologist believes that the usual time frame for deciding 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 1-877-356-5355, or fax your request to 1-717-772-7827;
- Your doctor or psychologist must fax a letter to 1-717-772-7827 explaining why taking the usual amount of time to decide your request for a fair hearing could harm your health. If your doctor or psychologist does not send a letter, your doctor or psychologist 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 3 business days from when it receives your request.

To get help with a request for external review or fair hearing

- If you need help filing a request for an external review, call us at **[BH-MCO Phone #]** and **[BH-MCO Name]** will assign someone who has not been involved in the grievance issue to help you.
- If you have any other questions, or need help filing a request for a fair hearing, you may call us at **[BH-MCO Phone #]**, the legal aid office at 1-800-322-7572 (www.palegalservices.org), or the Pennsylvania Health Law Project at 1-800-274-3258 (www.phlp.org).
- If you ask, [BH-MCO Name] will provide you with a list of advocacy organizations that may be able to assist you.

Sincerely,

[BH-MCO Name]

cc: **[Member Representative, if designated]**
[Provider]

[BH-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 about the grievance you filed with [BH-MCO Name]. It is available in other languages and formats by calling [BH-MCO Name] at [#].

ATTACHMENT 10d

Notice of Failure to Receive Provider Certification for an Expedited Grievance

[Date the notice is mailed]
[Member or Parent/Guardian Name]
[Address]
[County]

RE: **[Member's name, DOB, and Member or Grievance Identifier]**

Subject: Request for Expedited Grievance

Dear **[Member or Parent/Guardian Name]**:

[BH-MCO Name] received your grievance about **[identify subject of grievance]**, on **[date]** and your request to have the grievance decided more quickly than the usual **[30, unless the BH-MCO will be using a shorter time frame to decide first level grievances]**-day time frame. As we told you when you filed your grievance, in order for your grievance to be decided more quickly, your **[doctor][psychologist]** needed to send us a written statement that taking the usual amount of time to decide the grievance could harm your health. **[BH-MCO Name]** also asked your **[doctor][psychologist]** for this statement.

We have not received your **[doctor's][psychologist's]** statement, so your grievance will be decided within the usual time frame of **[30, unless the BH-MCO will be using a shorter time frame to decide first level grievances]** days from when we first got your grievance.

The First Level Grievance Process

A committee of one or more **[BH-MCO Name]** staff members that includes a licensed doctor or licensed psychologist, who have not been involved in the issue you filed your grievance about, will review your grievance. This is called the "grievance review." A decision will be made by **[date that is no more than 30**

days from receipt of the grievance]. A letter will be mailed to you within five business days after the decision is made, telling you each reason for the decision.

At any time during the grievance process, you can have someone you know represent you or act on your behalf. This person will be "your representative." If you decide to have someone represent you or act for you, tell **[BH-MCO Name]**, in writing, the name of that person and how we can reach him or her.

You or your representative may ask **[BH-MCO Name]** to see any information relevant to your grievance. You may also send information that you have about your grievance to **[BH-MCO Name]**:

[BH-MCO Address]

You and your representative may appear at the grievance review in person, by phone or by videoconference, if available, by calling us at **[BH-MCO Phone #]**. You may also bring a family member, friend, lawyer or other person to help you. If you decide that you do not want to attend, that will not affect the decision of the committee.

The Fair Hearing Process

You may also ask for a fair hearing from the Department of Human Services. 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;
- The reason(s) you are asking for a fair hearing, or a copy of this notice;
- A copy of the original denial notice, if available.

Your request for a fair hearing must be sent to the following address:

Department of Human Services
Office of Mental Health Substance Abuse Services
Division of Quality Management
Commonwealth Towers, 12th Floor
P.O. Box 2675
Harrisburg, PA 17101

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 psychologist believes that the usual time frame for deciding 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 1-877-356-5355**,** or fax your request to 1-717-772-7827;
- Your doctor or psychologist must fax a letter to 1-717-772-7827 explaining why taking the usual amount of time to decide your request for a fair hearing could harm your health. If your doctor or psychologist does not send a letter, your doctor or psychologist 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 3 business days from when it receives your request.

To get help with your grievance or request for fair hearing

- If you need help with your grievance, call us at **[BH-MCO Phone #]** and **[BH-MCO Name]** will assign someone who has not been involved in the grievance issue to help you.
- If you have any other questions, or need help filing a request for a fair hearing, you may call us at **[BH-MCO Phone #]**, the legal aid office at 1-800-322-7572 (www.palegalservices.org), or the Pennsylvania Health Law Project at 1-800-274-3258 (www.phlp.org).
- If you ask, [BH-MCO Name] will provide you with a list of advocacy organizations that may be able to assist you.

Sincerely,

[BH-MCO Name]

cc: **[Member Representative, if designated]**
[Provider]

[BH-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 about the grievance you filed with [BH-MCO Name]. It is available in other languages and formats by calling [BH-MCO Name] at [#].

ATTACHMENT 11

Expedited Grievance Decision Notice

Date notice is mailed]
[Member or Parent/Guardian Name]
[Address]
[County]

RE: **[Member's name, DOB, and Member or Grievance Identifier]**

Subject: Expedited Decision About Your Grievance

Dear **[Member or Parent/Guardian Name]**:

[BH-MCO Name] has reviewed your grievance about **[issue]**, received on **[date]**.

Based on a review of all information provided, the review committee has decided that **[state decision in detail]**.

The reasons for this decision are:

[Explain in detail every reason for decision; 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].

How to file to continue getting services

If you have been receiving the services that are being reduced, changed, or denied and you file a request for an external review or request for a fair hearing (see instructions below) that is either received by the BH-MCO or the Department of Human Services or postmarked **within 1 calendar day from the date of the notice that inpatient services are being reduced, changed, or denied or within 10 calendar days from the date on the notice that any other services are being reduced, changed, or denied**, the services 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 ask for a copy of the medical necessity criteria or other rules on which the decision was based by sending a written request to:

[BH-MCO Address]

2) Request an Expedited External Review

You may ask for an "expedited" external review of the grievance decision. An external review is a review by a licensed doctor who does not work for **[BH-MCO Name]**. You must ask for the "external review" **within two business days from the date you get this notice**. A decision will be issued within five business days from when we receive your request.

To ask for an external review:

- Call **[BH-MCO Name]** at **[BH-MCO Phone #]**; **or**
- Fax **[BH-MCO Name]** at **[BH-MCO Fax #]**; **or**
- Send your request to **[BH-MCO Name]** at the following address:

[BH-MCO Address for requesting external review]

3) Request a Fair Hearing

To ask for an early decision

You may ask for a fair hearing from the Department of Human Services. If your doctor or psychologist still believes that the usual time frame for deciding a fair hearing (between 60 and 90 days) could harm your health, you may ask that the fair hearing take place more quickly. To do this:

- Call the Department at 1-877-356-5355**,** or fax your request to 1-717-772-7827;
- Your doctor or psychologist must fax a letter to 1-717-772-7827 explaining why taking the usual amount of time to decide your request for a fair hearing could harm your health. If your doctor or psychologist does not send a letter, your doctor or psychologist 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. Even if you no longer need an early decision, you may ask for a fair hearing from the Department of Human Services. The 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;
- The reason(s) you are asking for a fair hearing, or a copy of this notice;
- A copy of the original denial notice, if available.

Your request for a fair hearing must be sent to the following address:

Department of Human Services
Office of Mental Health Substance Abuse Services
Division of Quality Management
Commonwealth Towers, 12th Floor
P.O. Box 2675
Harrisburg, PA 17101

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 get help with a request for external review or fair hearing

- If you need help filing a request for an external review, call us at **[BH-MCO Phone #]** and **[BH-MCO Name]** will assign someone who has not been involved in the grievance issue to help you.
- If you have any other questions, or need help filing a request for a fair hearing, you may call us at **[BH-MCO Phone #]**, the legal aid office at 1-800-322-7572 (www.palegalservices.org), or the Pennsylvania Health Law Project at 1-800-274-3258 (www.phlp.org).
- If you ask, [BH-MCO Name] will provide you with a list of advocacy organizations that may be able to assist you.

Sincerely,

[BH-MCO Name]

cc: **[Member Representative, if designated]**

[Provider]

[BH-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 about the grievance you filed with [BH-MCO Name]. It is available in other languages and formats by calling [BH-MCO Name] at [#]

COMMONWEALTH OF PENNSYLVANIA

DEPARTMENT OF HUMAN SERVICES

OFFICE OF MENTAL HEALTH AND SUBSTANCE ABUSE SERVICES

Indicators of the Application of CASSP Principles

For County Mental Health Programs

Instructions: The Local CASSP Advisory Committee should receive a copy of the Indicators of the Application of the CASSP Principles Checklist from the County Administrator for completion. In the event that there is no functioning local CASSP Advisory Committee, a committee composed of equal representation of family members, consumers, and professionals should be convened for this purpose. The CASSP Advisory Committee shall then forward the completed document to the MH/MR Administrator's Office for inclusion in the County Plan for submission to OMHSAS.

Please complete the following checklist by denoting the presence of CASSP indicators in the county programs.

1. The first set of indicators address the county programs on a whole.
   Please indicate a "yes" or "no" response.

2. The second set is applicable to individual agencies. (They can also be found in the HealthChoices Southwest RFP, Appendix I). Please indicate the responses, "All", "Most", "Some", and "Few", that best describe the presence of the agency indicators in the county programs.

3. In addition to checking a response, please provide: a) any necessary explanation in the margins, especially for "no responses, b) any additional county program indicators that were not included in the checklist, and c) a one paragraph narrative summarizing how the principle will be strengthened in plan year 2001-2002.

I. Child-centered

The Principle:

Services are planned to meet the individual needs of the child, rather than to fit the child into an existing service. Services consider the child's family and community contexts, are developmentally appropriate and child-specific, and also build on the strengths of the child and family to meet the mental health, social and physical needs of the child.

The Indicators for County Mental Health Program:

YES	NO	
[ ]	[ ]	Office staff are courteous, respectful, and willing to assist parents either in person or on the telephone.
[ ]	[ ]	CASSP Coordinator position is filled.
[ ]	[ ]	CASSP Coordinator has a Master's Degree or a minimum of 5 years experience with children's services.
[ ]	[ ]	CASSP Coordinator is a discrete position located in an administrative office, has administrative responsibility for children's services and provides no direct services.
[ ]	[ ]	Credentialing criteria for staff overseeing children's programs reflect personnel qualifications indicative of expertise in child and adolescent growth and development and therapeutic interventions, and experience in child-serving systems.
[ ]	[ ]	Orientation to CASSP values has become an integrated component for new staff in administrative, supervisory, and direct service positions.
[ ]	[ ]	A service plan format for CASSP meetings with a reading level understandable to a child or adolescent is used and is signed by the child or adolescent.
[ ]	[ ]	Adolescents are included in CASSP meetings.
[ ]	[ ]	The county has a Consumer Satisfaction Team and/or Family Satisfaction Team and an adolescent satisfaction survey is included in consumer/family satisfaction protocols.
[ ]	[ ]	When conducting program evaluations, data elements collected include child and adolescent factors identified in the performance outcome measures (POMS).
[ ]	[ ]	CASSP Coordinator is provided with opportunity for training in child/adolescent issues.

Other county level indicators:

[ ]	[ ]	**County staff are familiar with and utilize special communication tools such as qualified interpreters, TTY, large print, Braille, readers, etc. in assisting children and adolescents with special needs from initial intake, through assessment planning, intervention and after care services, and the communication tool of the child/adolescent's choice is utilized.**

All	Most	Some	Few		All	Most	Some	Few	
[ ]	[ ]	[ ]	[ ]	county funded agencies demonstrate	[ ]	[ ]	[ ]	[ ]	of the following:

The Indicators for Agencies:

- Toys, children's literature, furniture for small children, and adolescent literature are available in the waiting rooms and offices.
- Credentialing criteria reflect personnel qualifications indicative of expertise in child and adolescent growth and development and therapeutic interventions, and experience in child-serving systems.
- Assessments include the use of tools that are age- and/or developmentally-appropriate.
- The strengths, interests and resources of the child are identified in assessments, treatment plans and progress notes.
- An individualized treatment plan format with a reading level understandable to a child or adolescent is used and is signed by the child or adolescent.
- An adolescent satisfaction survey is included in consumer satisfaction protocols.
- Adolescents are included in interagency team meetings.
- Data elements collected include child and adolescent factors identified in the performance outcome measures (POMS).
- Financial support is given to the training of staff in child and adolescent clinical specialty areas.

Narrative summarizing how the "child-centered" principle will be strengthened in plan year 2001-2002:

II. Family-focused

The Principle: *Services recognize that the family is the primary support system for the child. The family participates as full partner in all stages of the decision-making and treatment planning process, including implementation, monitoring and evaluation. A family may include biological, adoptive and foster parents, siblings, grandparents and other relatives, and other adults who are committed to the child. The development of mental health policy at state and local levels includes family representation.*

The Indicators for County Mental Health Programs:

YES	NO	
[ ]	[ ]	Information for families, including local family support/advocacy organizations, is available in the office; for example, the PIN newsletter, *Sharing*, Right to Education, etc.
[ ]	[ ]	Parents/guardians participate as team members in CASSP meetings, or records include documentation of efforts to include them.
[ ]	[ ]	Parents/guardians sign the CASSP service plan after they have been fully involved in the development of it.
[ ]	[ ]	Personnel work to ensure that office hours and CASSP meetings are available in the evenings and on weekends and at times convenient for the family.

[ ] **[ ]** The county has a Family Satisfaction Team and the satisfaction protocols include items specific for families of children and adolescents, such as whether parents perceive themselves to be respected as the primary caretakers for their children, are treated as resources, and are included in decision-making about their child.

[ ] **[ ]** A CASSP Advisory/Management Committee meets at least quarterly and includes families of children and/or adolescents.

[ ] **[ ]** A parent/professional co-chair model for the Advisory/Steering Committee has been adopted.

[ ] **[ ]** Families are included on the county MH Committee.

[ ] **[ ]** Parents have input into county plans.

[ ] **[ ]** Parent-led support group(s) meet regularly.

[ ] **[ ]** Parent leaders routinely participate on child-serving system planning meetings.

[ ] **[ ]** Parents provide training to professionals on the parent's perspective as a routine segment of orientation and agency training events.

[ ] **[ ]** Parents are invited to attend provider and administrative training on children's issues.

[ ] **[ ]** Parents are supported in becoming leaders through scholarships to attend state and national conferences.

[ ] **[ ]** When parents act as trainers for professionals, they are paid the same honorarium as professional trainers.

[ ] **[ ]** The county funds a family advocate position.

[ ] **[ ]** Proposals submitted to state offices for new service initiatives include support letters from parents.

[ ] **[ ]** Parent leaders or groups agree that the local CASSP project has addressed their concerns.

[ ] **[ ]** Parents are included in program reviews

[ ] **[ ]** The county reimburses families for transportation and child-care cots related to participation in county CASSP activities.

Other county level indicators:

[ ] [ ] County staff are familiar with and will provide for and utilize special communication tools such as qualified interpreters, TTY, large print, Braille, readers, etc. in involving families/caregivers with special needs to participate in all phases of planning and treatment for their special needs family member. The communication tool of family's/caregiver's choice is utilized.

All	Most	Some	Few		All	Most	Some	Few	
[ ]	[ ]	[ ]	[ ]	county funded agencies demonstrate	[ ]	[ ]	[ ]	[ ]	of the following:

The Indicators for Agencies:

- Information for families, including local family support/advocacy organizations, is in the waiting room; for example, the PIN newsletter, *Sharing*; CHADD; Right to Education, etc.
- Parents/guardians participate as team members on treatment teams or any interagency meetings, or records include documentation of efforts to include them.
- Parents/guardians sign the treatment plan after they have been fully involved in the development of it.
- Personnel work to ensure that appointments are available in the evenings and on weekends and at times convenient for the family.
- An agency handbook, which includes a grievance and appeals procedure, is written in clear and understandable language.
- Personnel ensure that families get copies of the agency handbook and understand who to call for help with questions.
- Consumer satisfaction protocols include items specific for families of children and adolescents.
- Families of children and/or adolescents are involved on the agency/management board or a family/community advisory committee to the agency.
- The agency handbook indicates that child and adolescent specialists can be requested by the family to provide treatment services for their child.
- The agency handbook contains information for families regarding the availability of training and education to assist them in supporting their child through the treatment process.

Narrative summarizing how the "family-focused" principle will be strengthened in plan year 2001-2002:

III. **Community-based**

The Principle: *Whenever possible, services are delivered in the child's home community, drawing on formal and informal resources to promote the child's successful participation in the community. Community resources include not only mental health professionals and provider agencies, but also social, religious and cultural organizations and other natural community support networks.*

The Indicators for County Mental Health Programs:

YES	NO	
[ ]	[ ]	County office maintains a list of resources within the zip code or within 10 miles.
[ ]	[ ]	Local resource pamphlets - such as (but not limited to) the local library, the YMCA or YWCA, Boys and Girls Clubs - are available in the office.
[ ]	[ ]	Natural and community resources are used in the CASSP service plan, such as family, neighbors, school, work, leisure and church activities.
[ ]	[ ]	Orientation to and support for public transportation are available to families.
[ ]	[ ]	The data system tracks the use of local/community resources.
[ ]	[ ]	The county funds outreach programs.
[ ]	[ ]	The staff training schedule includes topics on community resources and understanding the community in which the staff works.
[ ]	[ ]	The county has identified gaps in the service system and has developed a plan to address them.
[ ]	[ ]	The county maintains records of community involvement and participation in activities including public meetings, hearings, and discussions.

Other county level indicators:

All	Most	Some	Few		All	Most	Some	Few	
[ ]	[ ]	[ ]	[ ]	county funded agencies demonstrate	[ ]	[ ]	[ ]	[ ]	of the following:

The Indicators for Agencies:

- Resources within the zip code or within 10 miles are used.
- Local resource pamphlets - such as (but not limited to) the local library, the YMCA or YWCA, Boys and Girls Clubs - are available in service management offices.
- Natural resources are used in each treatment plan, such as family, neighbors, school, work, leisure and church activities.
- Orientation to and support for public transportation are available to families.
- The data system tracks the use of local/community resources.
- There is a policy/procedure to reach out to families and their children when needed.
- The staff training schedule includes topics on community resources and understanding the community in which the staff works.
- If community-based resources are not available for a family, there is an administrative/financial plan to address the service gap.
- Records of community involvement and participation are maintained.

Narrative summarizing how the "community-based" principle will be implemented in plan year 2001-2002:

IV. **Multi-system**

The Principle: *Services are planned in collaboration with all the child-serving systems involved in the child's life. Representatives from all these systems and the family collaborate to define the goals for the child, develop a service plan, develop the necessary resources to implement the plan, provide appropriate support to the child and family, and evaluate progress.*

The Indicators for County Mental Health Programs:

YES	NO	
[ ]	[ ]	A CASSP Advisory/Management Committee meets at least quarterly and includes representatives of each of the child-serving systems.
[ ]	[ ]	Directors of MH/MR, Drug & Alcohol, Children and Youth, Special Education, Juvenile Probation, meet at least quarterly to discuss children's issues.
[ ]	[ ]	The CASSP Coordinator is responsible for assuring coordination among MH providers and child-serving systems in the county.
[ ]	[ ]	Intersystem children's needs assessment occurs on an annual basis with input from all CASSP participants.
[ ]	[ ]	Intersystem professionals have input into county plans.
[ ]	[ ]	CASSP projects provide input for annual plans which address local children's service gaps and priorities for agencies including Children and Youth, Education/Special Education, Drug & Alcohol, Juvenile Probation, Mental Health, and Mental Retardation.
[ ]	[ ]	Cross-system training occurs routinely, and/or agencies routinely invite other system staff to scheduled training.
[ ]	[ ]	An intersystem conflict resolution process is established and reviewed/revised as needed.
[ ]	[ ]	An intersystem release of information procedure is established and integrated into staff orientations.
[ ]	[ ]	An intersystem forum to develop/review treatment/service plans for children needing multi system support meets regularly with all major child-serving systems participating.
[ ]	[ ]	Child-serving system directors have formal or informal input into the CASSP Coordinator's performance evaluation.
[ ]	[ ]	Fiscal procedures to implement shared funding of children's services are developed.
[ ]	[ ]	The local ideal system of care for children has been described.

[ ] **[ ]** Proposals for new children's services to state offices routinely include support letters from each of the child-serving systems.

[ ] **[ ]** Procedures to coordinate discharge planning for children and adolescents returning from community inpatient units, residential treatment centers, mental retardation centers, youth development centers and forestry camps and/or other out-of-county group care settings are established with mechanisms to ensure continuity for the child, aftercare, and establishment of "lead" or joint case management.

[ ] **[ ]** A local Student Assistance Program coordinating mechanism is in place.

[ ] **[ ]** Each of the major child-serving systems agrees that the local CASSP project has addressed intersystem issues which affect their own target populations.

[ ] **[ ]** Shared funding of children's services based on an individualized service plan occurs routinely for children/adolescents requiring multi-system support.

[ ] **[ ]** Early Intervention issues and coordination have been addressed by the system directors.

Other county level indicators:

All	Most	Some	Few		All	Most	Some	Few	
[ ]	**[ ]**	**[ ]**	**[ ]**	county funded agencies demonstrate	**[ ]**	**[ ]**	**[ ]**	**[ ]**	of the following:

The Indicators for Agencies:

- Families and, if they choose, an advocate/support person participate in the interagency meeting as members of the team.
- Interagency team meetings are held in a convenient and comfortable room with access to blackboard/newsprint, etc.
- At a minimum, mental health and education personnel are involved in interagency team meetings for children and adolescents who are of school age.
- Child-serving systems and other persons/informal support systems involved with the child are included in the treatment process as documented in telephone calls, conferences and interagency meetings.
- Letters of agreement with each child-serving system are current (for each fiscal year) and include a conflict resolution protocol.
- Procedures are written for convening the interagency team, including when meetings are called, who calls them and who leads them.
- Each child's service plan reflects the contribution of each involved service system.
- The data system reports cross-system outcome measures.
- Individual practitioners/agency/MCO staff are knowledgeable and participate in the county child-serving system's collaborative structure.
- Progress notes reflect a summary of interagency team meetings and attendees, and are distributed to the team.

Narrative summarizing how the "multi-system" principle will be strengthened in plan year 2001-2002:

V. Culturally competent

The Principle: *Culture determines our world view and provides a general design for living and patterns for interpreting reality that are reflected in our behavior. Therefore, services that are culturally competent are provided by individuals who have the skills to recognize and respect the behavior, ideas, attitudes, values, beliefs, custom, language, rituals, ceremonies and practices characteristic of a particular group of people.*

Note: Pennsylvania's cultural competence initiative has focused specifically on African Americans, Latinos, Asian Americans and Native Americans who have historically not received culturally appropriate services.

The Indicators for County Mental Health Programs:

YES NO

[ ] **[ ]** A CASSP Advisory/Management Committee meets at least quarterly and includes persons representing the cultural diversity of the county.

[ ] **[ ]** The county office has resources and materials that reflect the cultural diversity of the county.

[ ] **[ ]** Persons of various cultural backgrounds representative of the county have input into county plans.

[ ] **[ ]** Cross-system training includes a component on cultural competence for administrators, supervisors, and direct service staff.

[ ] **[ ]** Orientation procedures to county staff include cultural competence values and issues.

[ ] **[ ]** Persons of color, ethnic and religious groups are provided the opportunity to comment on the cultural appropriateness of the service they or their child received.

[ ] **[ ]** Assessment of the cultural diversity and competencies of local staff and clients has promoted the development of strategies to move toward a culturally competent system of care.

[ ] **[ ]** Local CASSP network mailing list includes ministers, churches, cultural centers, and community leaders who represent/service African, Latino, Asian, or Native American cultures.

[ ] **[ ]** County administrative and direct care staff represent the cultural diversity of the county.

[ ] **[ ]** Consumer and family satisfaction protocols include questions tailored to ethnic communities.

Other county level indicators:

[ ] [ ] County staff are trained in Deaf Culture and other cultures, communication skills and the distinction related to language, syntax, and expression of feelings in the culture.

[ ] [ ] County staff are trained in the protocol and use of interpreters.

All	Most	Some	Few		All	Most	Some	Few	
[ ]	[ ]	[ ]	[ ]	county funded agencies demonstrate	[ ]	[ ]	[ ]	[ ]	of the following:

The Indicators for Agencies:

- Staff resources, consisting of literature (books, magazines and brochures), video and/or audio tapes, reflect the cultural diversity of the people served by the agency.
- Waiting rooms and offices have literature reflecting the ethnic groups in the community.
- The schedule of regular staff training includes cultural competence development, and related topics.
- Introductory cultural competency trainings for staff incorporate the following elements:
  - overview of cultural competence including specifics on local cultural diversity
    - the principles of cultural competency development
    - conducting psychiatric and psychological assessments applicable to the individual's cultural context
    - treatment planning appropriate to the individual, family, and cultural context
    - integrating community supports and resources
    - considering and using non-traditional methods and services
    - direct service provision and effectively engaging minorities in treatment
    - more advanced trainings involve issues and related topics
- Service delivery reflects:
    - psychiatric assessments which incorporate an appreciation of the child's or adolescent's culture and level of acculturation
    - treatment plans/consultations which involve or reflect the family's cultural perspective
    - up to date information on medications through current literature/studies on psychotropic medications and how they relate to minority populations
    - recognition of the importance of religion, religious expression and religious institutions
    - services available from clinical staff who speak the language understood by children and families or who use interpreters
    - interagency meetings which welcome extended family members
    - recognition of culturally relevant holidays and traditions
    - tracking of completion rates for appointments by ethnicity, age, and gender
- Administrative and treatment staff represent the cultural diversity of the community the agency serves.
- Minority members participate at the policy-making and administrative/monitoring levels.
- Advisory boards include minority membership.
- Consumer satisfaction protocols include questions tailored to ethnic communities.

Narrative summarizing how the "culturally competent" principle will be strengthened in plan year 2002-2002:

VI. Least restrictive/least intrusive

The Principle: *Services take place in settings that are the most appropriate and natural for the child and family and are the least restrictive and intrusive available to meet the needs of the child and family.*

The Indicators for County Mental Health Programs:

YES	NO	
[ ]	[ ]	Review of service data over the past several years shows a decrease in out-of-state and out-of-county placements; a decrease in inpatient days; a decrease in residential treatment days; an increase in community-based utilization, especially use of natural supports.
[ ]	[ ]	The county maintains a list of available local resources.
[ ]	[ ]	County staff communicate with children and their families to ensure there is comfort with the intensity and frequency of services, especially those services that are provided in the home, the school, or other natural locations.
[ ]	[ ]	Family-friendly consolidation by county staff in the scheduling of appointments is apparent so that it is efficient for the family both in time and location.
[ ]	[ ]	In-home, in-school and in-community resources are considered by the county before out-of-home placement, or as part of a discharge plan when returning from placement.
[ ]	[ ]	Justification for each service or placement considered for children and adolescents is documented by the county.
[ ]	[ ]	The family has a voice in the process of identifying appropriate providers and staff for various in-home services.

Other county level indicators:

All	Most	Some	Few		All	Most	Some	Few	
[ ]	[ ]	[ ]	[ ]	county funded agencies demonstrate	[ ]	[ ]	[ ]	[ ]	of the following:

The Indicators for Agencies:

- Family-friendly consolidation in the scheduling of appointments is apparent so that it is efficient for the family both in time and location.
- The community integration questionnaire is used to ensure the use of least restrictive services.
- In-home, in-school and in-community resources are safely used first before out-of-home placement is considered or as part of a discharge plan when returning from placement.
- Justification for each service or placement considered is documented.
- The family has a voice in the process of identifying appropriate providers and staff for various in-home services.

Narrative summarizing how the "least restrictive/least intrusive" principle will be strengthened in plan year 2001-2002:

COMMONWEALTH OF PENNSYLVANIA

DEPARTMENT OF Human Services

OFFICE OF MENTAL HEALTH AND SUBSTANCE ABUSE SERVICES

Indicators of the Application of CSP Principles

For County Mental Health Programs

Instructions: The Local CSP Advisory Committee should receive a copy of the Indicators of the Application of the CSP Principles Checklist from the County Administrator for completion. In the event that there is no functioning local CSP Advisory Committee, a committee composed of equal representation of family members, consumers, and professionals should be convened for this purpose. The CSP Advisory Committee shall then forward the completed document to the MH/MR Administrator's Office for inclusion in the County Plan for submission to OMHSAS.

Please complete the following checklist by denoting the presence of CSP indicators in the county programs.

1. The first set of indicators address the county programs on a whole. Please indicate a "yes" or "no" response.
2. The second set is applicable to individual agencies. Please indicate the responses "All", "Most", and "Some", or "Few", that best describe the presence of the agency indicators in the county program.
3. In addition to checking a response, please provide: a) any necessary explanation in the margins, especially for "no" responses, b) any additional county program indicators that were not included in the checklist, and c) a one paragraph narrative summarizing how the principle will be strengthened.

I. ***Consumer-center/Consumer-empowered***

The Principle:

Services are organized to meet the needs of each consumer, rather than the needs of the managed care program or needs of service providers. Services incorporate consumer self-help approaches and are provided in a manner that allows persons to retain the greatest possible control over their own lives.

The Indicators for County Mental Health Programs:

YES	NO	
[ ]	[ ]	County office staff are courteous, respectful, and willing to assist consumers and family members either in person or on the telephone.
[ ]	[ ]	There is a county staff person designated as the CSP Liaison.
[ ]	[ ]	County staff overseeing adult mental health services reflect appropriate qualifications, including orientation to and training in CSP principles.
[ ]	[ ]	The county has integrated orientation to CSP values for all has become an integrated new county administrative, supervisory, and direct service staff.
[ ]	[ ]	County staff, including case managers, consider consumer choice and preference in the selection of services and treatment.
[ ]	[ ]	Consumers are included in CSP meetings.
[ ]	[ ]	Data elements collected by the county during program evaluations include factors identified in the state Performance Outcome Management System (POMS) and reflects outcomes important to consumers (e.g., employment, housing, transportation, and social supports).
[ ]	[ ]	The CSP Liaison is provided opportunity for training in adult mental health issues.
[ ]	[ ]	County staff encourage family members to participate in service and treatment decisions.
[ ]	[ ]	Consumers are integrally involved in planning, developing, and implementing new services and in the evaluation of services.
[ ]	[ ]	Consumers and families are involved in the county plan development.
[ ]	[ ]	Consumer and families participate in the budget meetings with county and state mental health staff.
[ ]	[ ]	The county program promotes and funds consumer self-help and consumer-run alternatives.
[ ]	[ ]	County personnel policies and practice encourage the hiring of consumers as staff, consultants, and trainers.

[ ] [ ] The county program uses people first language in all written materials (e.g., people with schizophrenia, not schizophrenics).

[ ] [ ] The county program makes information available to consumers on the self-help philosophy and statewide and local consumer organizations.

[ ] [ ] Notice of public/special hearings is widespread throughout the mental health community as well as in newspapers at least two weeks prior to the event.

[ ] [ ] Public/special hearings are held in locations accessible to public transportation, or transportation is arranged where no public transportation exists.

[ ] [ ] County staff are trained on consumer self-help approaches and the concept of recovery from mental illness.

[ ] [ ] Consumers are involved in all service and treatment decisions affecting their lives and given choice and preference in accessing/utilizing services.

Other county level indicators:

[ ] [ ] Consumers with special needs, including but not limited to persons who are deaf, hard of hearing, deafblind, elderly, etc and their families, are involved in county plan development, program assessment of need, implementation and evaluation of services, and participate in budget meetings with county and state mental health staff.

[ ] [ ] County staff are familiar with and utilize special communication tools such as qualified interpreters, TTY, large print, braille, readers, etc. in assisting consumers with special needs from initial intake, through assessment, planning, intervention and after care services, and that the communication tool of the consumer's choice is utilized.

All Most Some Few **All Most Some Few**
[ ] [ ] [ ] [ ] county funded agencies demonstrate [ ] [ ] [ ] [ ] of the following:

The Indicators for Agencies:

- Consumers are integrally involved in designing and evaluating services.
- Consumer preferences are honored whenever possible (e.g., therapist/case manager, decor, living arrangements, programming, food selection, etc.).

- Consumer self-help and consumer-run alternatives are promoted and funded.
- Individual strengths, interests and resources are identified in assessments, treatment plans and progress notes.

- Treatment/service plans reflect consumer involvement in goal setting and decisions regarding services. Consumers' signatures appear on all treatment/service plans, or an explanation of why the consumer has not signed is noted.
- Personnel policies encourage the hiring of consumers as staff, consultants, trainers.
- Consumer confidentiality is honored.
- People First language is used in all written materials (e.g., people with schizophrenia not schizophrenics).

Information is available to consumers on self-help philosophy and statewide and local consumer organizations.

YES NO

- Data collection reflects outcomes important to consumers (e.g., employment, housing, social supports).
- Provider staff are trained on the concept of recovery from mental illness and promote recovery concepts to consumers

Narrative summarizing how the "consumer-centered/consumer-empowered" principle will be strengthened:

II. Culturally Competent

The Principle:
Culture determines our world view and provides a general design for living and patterns for interpreting reality that are reflected in our behavior. Therefore, services that are culturally competent are designed and delivered to recognize and respect the behavior, ideas, attitudes, values, beliefs, customs, language, rituals, ceremonies and practices of an individual or a particular group of people.

The Indicators for County Mental Health Programs:

YES NO

[ ] [ ] A County CSP Committee meets regularly and includes persons reflective of the county cultural/ethnic groups.

[ ] [ ] The county office has resources and materials that reflect the cultural diversity of the county.

[ ] [ ] Persons from minority cultures have input into county plans.

[ ] [ ] Training includes a component on cultural competence for administrators, supervisors, and direct service staff.

[ ] [ ] Training teams represent the ethnic groupings of the county.

[ ] [ ] Orientation procedures to county staff include cultural competence values and issues along with other CSP values.

[ ] [ ] Consumer satisfaction surveys include a request for persons of cultural minorities to comment on the cultural appropriateness of the service they received.

[ ] [ ] Assessment of the cultural diversity and competencies of local staff and clients are used in the development of strategies to move toward a culturally competent system of care.

[ ] [ ] Local CSP network mailing list includes ministers, churches, cultural centers, and community leaders who represent/serve African, Latino, Asian, Native American, or other local cultural groups.

[ ] [ ] Administrative staff represent the cultural diversity of the county.

[ ] [ ] Consumer and family satisfaction protocols include questions tailored to ethnic communities.

Other county level indicators:

[ ] [ ] County staff are trained in Deaf Culture and other cultures, communication skills and the nuances related to language, syntax, and expression of feelings in the culture.

[ ] [ ] County staff are trained in the protocol and use of interpreters.

All	Most	Some	Few		All	Most	Some	Few	
[ ]	[ ]	[ ]	[ ]	county funded agencies demonstrate	[ ]	[ ]	[ ]	[ ]	of the following:

The Indicators for Agencies:

- Staff resources, consisting of literature (books, magazines and brochures), video and/or audio tapes, reflect the diversity of the population the agency serves.
- Waiting room and offices have literature reflecting the ethnic groups in the community.

- The schedule of regular staff training includes cultural competency development, and related topics.
- Introductory cultural competency trainings for staff incorporate the following elements:
    - overview of cultural diversity
    - the principles of cultural competency development
    - conducting psychiatric and psychological assessments applicable to the individual's cultural context
    - treatment planning appropriate to the individual, family, and cultural context
    - integrating community supports and resources
    - considering and using non-traditional methods and services
    - direct service provision and effectively engaging minorities in treatment
- Service delivery reflects:
    - psychiatric assessments which incorporate an appreciation of the consumer's culture and level of acculturation
    - treatment plans/consultations which involve or reflect the family's cultural perspective
    - up to date information on medications through current literature/studies on psychotropic medications and how they relate to minority populations
    - recognition of the importance of religion, religious expression and religious institutions
    - services available from clinical staff who speak the language understood by the consumer or who use interpreters
    - interagency meetings which welcome extended family members
    - recognition of culturally relevant holidays
    - tracking of completion rate for appointments by ethnicity, age and gender
- Administrative and treatment staff represent the cultural diversity of the community the agency serves.
- Minority members participate at the policy-making and administrative/monitoring levels.
- Advisory boards include minority membership.
- Consumer satisfaction protocols include questions tailored to ethnic communities.

Narrative summarizing how the "culturally competent" principle will be strengthened:

III. **Flexible**

The Principle: *The development and delivery of services and supports are flexible as possible in order to meet the needs of a wide diversity of persons in the geographic area. Flexibility includes having a wide variety of services, of variable intensity available at a wide range of times, and delivered in a wide range of environments.*

The Indicators for County Mental Health Programs:

YES	NO	
[ ]	[ ]	The county, through its provider system, delivers a full array of services and treatment.
[ ]	[ ]	The county ensures consumer choice in treatment plans and support services.
[ ]	[ ]	County staff are accessible and available during non-business hours.
[ ]	[ ]	County staff credentialing standards support the provision of rehabilitative, self-help, and alternative treatment services, as well as traditional mental health approaches.
[ ]	[ ]	The county has an outreach team to identify people in need of mental health services.

Other county level indicators:

[ ]	**[ ]**	**The county has an outreach team to identify elderly people and other people with special needs who are in need of mental health services.**

All	Most	Some	Few		All	Most	Some	Few	
[ ]	[ ]	[ ]	[ ]	county funded agencies demonstrate	[ ]	[ ]	[ ]	[ ]	of the following:

The Indicators for Agencies:

- A full array of treatment, rehabilitation and support services are available in accessible locations.
- Day, evening and weekend hours are available.
- Services are delivered at a variety of locations, including the consumer's home or community as appropriate.
- Type and duration of service is based on consumer need.
- Staff credentialing standards recognize expertise in rehabilitative, self-help and alternative treatment approaches.

Narrative summarizing how the "flexible" principle will be strengthened:

IV. Meet Special Needs

The Principle:
Services are adapted to meet the special needs of people with mental illness who are affected by one or more of such factors as old age, substance abuse, physical disability, loss of sight/hearing, mental retardation, homelessness, HIV/AIDS, and involvement in the criminal justice system.

The Indicators for County Mental Health Programs:

YES	NO	
[ ]	[ ]	The county program actively collaborates with other human service agencies to meet the needs of consumers with special needs.
[ ]	[ ]	The county program supports creative inter-agency agreements, collaborative funding, and cross-system training of staff.
[ ]	[ ]	The county program tracks and/or coordinates outreach to special needs populations.
[ ]	[ ]	The county solicits input from other service agencies when planning, developing, or expanding services.
[ ]	[ ]	County staff training includes modules on special populations.
[ ]	[ ]	The county program has designated staff specialists for special populations.

Other county level indicators:

[ ] [ ] The county program actively seeks and utilizes input from persons with special needs, their family members and advocates, in the development of county plans.

[ ] [ ] The county program provides the necessary communication tools/qualified interpreters/large print materials/assistive hearing devices, etc. to enable persons with special needs to participate in the county plan development.

[ ] [ ] The county program ensures that a discharge plan for those being discharged from the criminal justice system involves networking with the criminal justice system and all systems which will enable a successful transition.

All Most Some Few **All Most Some Few**
[ ] [ ] [ ] [ ] county funded agencies demonstrate [ ] [ ] [ ] [ ] of the following:

The Indicators for Agencies:

- Representatives from other service systems are involved in developing/implementing the treatment/service plan of persons with special needs.
- Staff specialists are available/trained to meet the diverse needs of consumers, as outlined above.
- Timely mobile outreach is provided to specialty populations including persons who are elderly, homeless and involved in the criminal justice system.
- Data systems track service utilization and outcomes specific to special populations.
- TDD telephone access, sign language interpreters, Braille materials and other assistive devices are available, as needed.
- Creative interagency agreements and funding focus on the total needs of the individual (cross-training of staff, co-location of staff, etc.).

Narrative summarizing how the "meet special needs" principle will be strengthened:

V. Accountable

The Principle:
Service providers are accountable to the users of the services. Consumers and their families are involved in planning, implementing, monitoring and evaluating services.

The Indicators for County Mental Health Programs:

YES	NO	
[ ]	[ ]	The county program supports CSP activities at local, regional, and state levels.
[ ]	[ ]	The county ensures consumers understand service options and how to access services.
[ ]	[ ]	County documents including county annual plans, reports, and newsletters are written in language that is understandable to consumers.
[ ]	[ ]	The county program provides a consumer-friendly complaint, grievance, and appeal system.
[ ]	[ ]	The county program collects consumer satisfaction data, and prepares and distributes reports to consumers, advocates, and providers.
[ ]	[ ]	The county maintains a continuous quality improvement plan for services, outcomes, and access.
[ ]	[ ]	The county has a consumer satisfaction team (which is independent of county providers, staffed by consumers/family members, and where members earn competitive wages.)
[ ]	[ ]	Consumer satisfaction data indicates that consumers and families are treated with respect and dignity.

Other county level indicators:

[ ]	**[ ]**	**Consumer satisfaction data indicates that input has been sought from consumers with special needs, such as persons who are deaf, hard of hearing, deafblind, elderly, having HIV/AIDS, etc. and that the data indicates that consumers with special needs are treated with respect, dignity, and that they understand service options, and how to access services.**
[ ]	**[ ]**	**The county has open/closed captioned videos, large print materials, assistive hearing devices and other communication tools available to help consumers with special needs understand their rights, service options and how to access services.**

All Most Some Few **All Most Some Few**
[ ] [ ] [ ] [ ] county funded agencies demonstrate [ ] [ ] [ ] [ ] of the following:

The Indicators for Agencies:

- Consumers and families are integrally involved in the design, development and evaluation of services. This includes:
    - Consumer satisfaction teams.
    - Consumer/family membership on governing/advisory boards.
    - Information on services, diagnoses, medications, etc. is available and written in consumer friendly language.
- The member handbook/policies and procedures, which includes grievance and appeal procedures, is written in clear and understandable language.
- Personnel ensure that consumers receive copies of the member handbook/policies and procedures and understand who to call for help with questions.

- The agency has positive outcome measures aimed towards stabilization/growth in functioning, increased consumer satisfaction, etc.
- The agency has a balanced focus on cost, quality, outcome and access, when evaluating program success.
- Data and standards related to demographics, budgets/expenditures, criteria for service authorizations, complaints/appeals, outcomes, etc. are provided to consumers/families and advocates for review.

Narrative summarizing how the "consumer-centered/consumer-empowered" principle will be strengthened:

VI. **Strengths-Based**

The Principle:
Services build upon the assets and strengths of consumers to promote growth and movement toward independence.

The Indicators for County Mental Health Programs:

YES	NO	
[ ]	[ ]	The county program promotes recovery from mental illness.
[ ]	[ ]	The county program facilitates opportunities for consumer growth and independence.
[ ]	[ ]	The county program assures that assessments, treatment/service plans, and progress notes highlight and capitalize on each individual's strengths, assets, skills and talents.
[ ]	[ ]	The county program assures that written materials support People First language and the role of the consumer as a key partner in the recovery process.
[ ]	[ ]	The county maintains a continuum of services allowing individuals to maintain the highest level of independence possible.
[ ]	[ ]	Self-help and consumer run services are funded and available.

Other county level indicators:

[ ]	**[ ]**	**The county continuum of services allows individuals who have special needs to maintain the highest level of independence possible and the county networks with advocacy groups for persons with special needs to identify all resources available for the consumer to maintain the highest level of independence possible.**

All	Most	Some	Few		All	Most	Some	Few	
[ ]	[ ]	[ ]	[ ]	county funded agencies demonstrate	[ ]	[ ]	[ ]	[ ]	of the following:

The Indicators for Agencies:

- Service interventions promote a wellness, not illness, focus.
- Assessments, treatment/service plans and progress notes highlight and capitalize on each individual's strengths, assets, skills and talents.
- Written materials support People First language and the role of consumer as a key partner in the recovery process.

- Staff are trained in the concept of recovery from mental illness.
- The concept of recovery is promoted by providers.

Narrative summarizing how the "strengths-based" principle will be strengthened:

VII. Community-Based/Natural Supports

The Principle:
Services are offered in the least coercive manner and most natural setting possible. Consumers are encouraged to use the natural supports in the community and to integrate into the living, working, learning, and leisure activities of the community.

The Indicators for County Mental Health Programs:

YES	NO	
[ ]	[ ]	County office maintains a list of resources within the zip code or within 10 miles.
[ ]	[ ]	Local resource pamphlets describing natural community supports are available in the county office.
[ ]	[ ]	Natural and community resources are used in service plans, such as family, neighbors, work, leisure and church activities, and service and community organizations.
[ ]	[ ]	Orientation to and support for public transportation are available to families.
[ ]	[ ]	The data system tracks the use of local/community resources.
[ ]	[ ]	The county funds outreach programs.
[ ]	[ ]	The staff training schedule includes topics on community resources and understanding the community in which the staff works.
[ ]	[ ]	The county has identified gaps in the service system and has developed a plan to address them.
[ ]	[ ]	The county maintains records of community involvement and participation in activities including public meetings, hearings, and discussions.

Other county level indicators:

[ ] [ ] The county office insures that its staff and the contract provider staff are knowledgeable of and utilize natural and community supports which benefit consumers with special needs. Staff training includes presentations from consumers with special needs, as well as their family members and advocates.

All	Most	Some	Few		All	Most	Some	Few	
[ ]	[ ]	[ ]	[ ]	county funded agencies demonstrate	[ ]	[ ]	[ ]	[ ]	of the following:

The Indicators for Agencies:

- Community based resources/services within the zip code or within 10 miles are used.
- Pamphlets/information on local resources and services are made available through administrative entities and provider agencies.
- Training and support in finding and using transportation is available to consumers.
- Natural resources are used in each treatment plan, such as housing, work, leisure and church activities.
- Consumers are encouraged to develop advance directives in preparation for crises for staff/family to follow.
- Individuals identified by the consumer as supports should be incorporated into the treatment/service plan.
- The data system tracks the use of local/community resources.
- There is a policy/procedure to reach out to consumers and their families when needed.
- The staff training schedule includes topics on community resources and understanding the community in which the staff works.

Narrative summarizing how the "community-based/natural supports" principle will be strengthened:

VIII. **Coordinated**

The Principle:
Services and supports are coordinated on both the local system level and on an individual consumer basis in order to reduce fragmentation and to improve efficiency and effectiveness with service delivery. Agencies must work in collaboration to meet the variety of needs that people with psychiatric disabilities have.

The Indicators for County Mental Health Programs:

County staff orientation and training includes an overview of various human services agencies.

YES	NO	
[ ]	[ ]	County program staff are designated as liaisons with other human service systems.
[ ]	[ ]	County staff are available to provide orientation to other agencies regarding mental health services.
[ ]	[ ]	The county program ensures that written agreements/plans for coordination are in place with providers and agencies including: state-hospitals, medical services providers, social services agencies, and police and corrections offices.

Other county level indicators:

[ ]	**[ ]**	**The county staff and contracted provider staff receive and provide orientation to agencies serving persons who have special needs. These agencies include but are not limited to the Office for the Deaf and Hard of Hearing, The Department of Aging and the Area Agencies on Aging, the Coalition for the Homeless, etc.**

All	Most	Some	Few		All	Most	Some	Few	
[ ]	[ ]	[ ]	[ ]	county funded agencies demonstrate	[ ]	[ ]	[ ]	[ ]	of the following:

The Indicators for Agencies:

- Written agreements/plans for coordination are in place with the following:
  - State hospitals.
  - Medical services providers/insurers. (This should include a good baseline medical work-up, coordination in monitoring physical and neurobiological services, etc.)
  - Social service agencies (Offices of aging, vocational rehabilitation, housing authorities, drug and alcohol programs, homeless shelters, legal services, etc.)
  - Police departments, district justices, jails and prisons, etc.
- Staff are designated as liaisons to other service agencies in order to plan and facilitate services.

- Staff development/training involves overview of service agencies in area (e.g., policies, procedures, mission statement, regulations, etc.).

Narrative summarizing how the "coordinated" principle will be strengthened:

DEPARTMENT OF DRUG AND ALCOHOL PROGRAMS
Principles of Effective Treatment

Background

Alcohol and other drug abuse and dependency treatment services must be provided by facilities licensed by the Department of Drug and Alcohol Programs, Division of Drug and Alcohol Licensure, to ensure that minimum standards are being maintained to protect the health, safety and welfare of the individual.

Philosophy

Substance abuse and dependence are primary diseases, not symptoms of other underlying conditions. Substance use disorders can be diagnosed, are responsive to treatment and are complex behavioral disabilities usually having chronic medical, social and psychological components, which result in multiple negative consequences. Substance abuse and dependence related problems affect not only the dependent individual, but other family members, particularly children. Denial is a central characteristic or symptom of substance abuse and dependence that complicates an individual's ability to acknowledge a problem.

Principles

- **Treatment needs to be readily available**. Because individuals diagnosed with a substance use disorder may be uncertain about entering treatment, taking advantage of opportunities when they are ready for treatment is crucial. Potential treatment applicants can be lost if treatment is not immediately available or is not readily accessible.

- **No single treatment is appropriate for all individuals**. Matching treatment settings, interventions, and services to each individual's particular problems and needs is critical to his or her ultimate success in returning to productive functioning in the family, workplace, and society.

- **Effective treatment attends to multiple needs of the individual, not just his or her substance use**. To be effective, treatment must not only address the individual's substance use but any associated medical, psychological, social, vocational, and legal problems.

- **Individuals diagnosed with a substance use disorder and with a coexisting mental disorders should have both disorder treated in an integrated way**. Because addictive disorders and mental disorders often occur in the same individual, persons presenting for either condition should be assessed and treated for the co-occurrence of the other type of disorder. Both disorders are considered primary.

- **Treatment should be person specific** and guided by an individualized treatment plan based upon a face to face comprehensive biopsychosocial evaluation of the person and when possible, a comprehensive evaluation of the family as well.

- **Counseling (individual and group) and other behavioral therapies are critical components of effective treatment for substance use disorder**. In therapy, the person addresses issues of motivation, build skills to resist substance use, replace substance-using activities with constructive and rewarding nonsubstance-using activities, and improve problem-solving abilities. Behavioral therapy also facilitates interpersonal relationships and the individual's ability to function in the family and community.

- **Self-help groups such as Alcoholics Anonymous, Narcotics Anonymous and Double Trouble are essential adjuncts to the treatment process**. Attendance should be encouraged when appropriate.

- **Medications are an important element of treatment for many individuals,** especially when combined with counseling and other behavioral therapies. Methadone and buprenorphine are very effective in helping individuals dependent upon opiates stabilize their lives and reduce their illicit drug use. Naltrexone is also an effective medication for some individuals diagnosed with opiate dependency as well as a co-occurring alcohol dependence. For persons dependent upon nicotine, a nicotine replacement product (such as patches or gum) or an oral medication (such as bupropion) can be an effective component of treatment. For individuals diagnosed with mental disorders, both behavioral treatments and medications can be critically important.

- **Treatment programs should provide assessment for HIV/AIDS, Hepatitis B and C, Tuberculosis and other infectious diseases**, and counseling to help individuals modify or change behaviors that place themselves or others at risk of infection. Counseling can help individuals avoid high-risk behavior. Counseling also can help people who are already infected manage their illness.

- **Remaining in treatment for an adequate period of time is critical for treatment effectiveness**. The appropriate duration for an individual depends on his or her problems and needs. Research indicates that for most people, the threshold of significant improvement is reached at about 3 months in treatment. Treatment may include Residential care followed by Intensive Outpatient care or Partial treatment followed by Outpatient care, or any movement through the level of care continuum. After this threshold is reached, additional treatment can produce further progress toward recovery. Because people often leave treatment prematurely, programs should include strategies to engage and keep people in treatment.

- **Recovery from substance use disorders can be a long-term process and frequently requires multiple episodes of treatment**. As with other chronic illnesses, relapses to substance use can occur during or after successful treatment episodes. Individuals diagnosed with a substance use disorder may require prolonged treatment and multiple episodes of treatment to achieve long-term abstinence and fully restored functioning. Participation in self-help support programs during and following treatment often is helpful in maintaining long-term abstinence.

- **Treatment does not need to be voluntary to be effective**. Strong motivation can facilitate the treatment process. Sanctions or enticements in the family, employment setting, or criminal justice system can increase significantly both treatment entry and retention rates and the success of substance use treatment interventions.

- **Persons recovering from substance use disorders are viewed as important resources in the statewide service system**. As representatives of the recovering community, persons in recovery serve as an inspiration to the individuals struggling with a substance use disorder. As a practicing professional they provide an empathetic and knowledgeable approach to treatment philosophy, offer valuable input into the recovering community network, and serve as a voice for advocacy.

- **The majority of the above Principles are adapted from the National Institute of Drug Abuse (NIDA).**

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BEHAVIORAL HEALTH MANAGED CARE ORGANIZATIONS (BH-MCOs) PERFORMANCE/OUTCOME MANAGEMENT SYSTEM (POMS)

A. OVERVIEW

The POMS consists of a database that is updated on a periodic basis through batch data file extracts that are obtained from a variety of data sources (see attached table of outcome measures and data sources). The database, which is maintained and managed by the Department of Human Services (DHS), contains an extensive array of raw data concerning enrollees in the BH-MCOs. The primary purpose of the database is to serve as the basis for producing a set of performance measures/indicators. The Department will utilize the performance measures/indicators as its primary tool for continuously evaluating the effectiveness of the BH-MCO contractors in achieving a variety of systems level outcomes.

The POMS serves the following primary functions:

(1) Provides accountability for public funds expended through the Department's capitation payments to the BH-MCO contractors.

(2) Provides a fair and objective evaluation of the BH-MCOs that the Department can use for implementing outcome oriented incentives and sanctions.

(3) Supports the Department and the BH-MCO contractors to implement a collaborative continuous Quality Improvement process.

B. DATA COLLECTION PROCESSES

Raw data concerning BH-MCO enrollees, obtained from a variety of sources, will be transmitted via batch file extracts to the POMS central database (see attached flow chart). The data will be linked and integrated for each BH-MCO enrollee based on unique identifiers. The integrated database will provide the basis for DHS to derive quantitative performance indicators/measures that reflect systems level outcomes achieved by each BH-MCO primary contractor. The primary data sources and data collection processes are as follows:

1. BH-MCO Encounter Data - BH-MCOs, through a process similar to what DHS required for the HealthChoices PH-MCOs, will submit data files on a regular schedule to DHS. The data will be edited and then loaded into DHS's Enterprise Data Warehouse. The Office of Mental Health and Substance Abuse Services (OMHSAS) will, on a regular schedule, receive a file of all DHS accepted encounter records and will perform additional edits before loading to the POMS central database.

2. Enrollee Eligibility and Demographic Data - DHS will on a regular schedule move enrollee eligibility and demographic data from its Client Information System (CIS) into the Enterprise Data Warehouse. OMHSAS will subsequently pull a subset of eligibility and demographic data elements via data file extracts into the POMS central database.

3. Secondary Data - OMHSAS will develop data exchange agreements with other state agencies, as feasible, to obtain regularly scheduled data file extracts that will be loaded into the POMS central database. Data exchanges with state agencies such as the Department of Corrections, State Police and the Department of Education are under development.

4. Consumer/Family Satisfaction Reports - There will be standardized measures administered by the BH-MCO. A Co-occurring Disorder (COD) question must be included on the survey and a sampling of COD consumers must be surveyed. The BH-MCO will submit reports of findings to the DHS. A survey will be conducted annually.

5. BH-MCO Consumer Registry File - BH-MCOs will maintain a computerized registry of their enrollees who have accessed behavioral health services. The registry is comprised of a minimum data set including clinical descriptions such as priority population and critical dates during the episode of care such as date of first service request, registration date and termination date. These data will be submitted by the BH-MCOs to the POMS central database.

6. BH-MCO Quarterly Status File - BH-MCOs will maintain a computerized file concerning the status of priority populations. The file will be updated on a calendar quarter basis for each enrollee in the priority population. The quarterly status file is comprised of a minimum data set including outcome measures such as vocational/educational status and independence of living arrangement. These data will be submitted by the BH-MCOs to the POMS central database on a regular schedule.

7. Performance Indicator Reports - On a regular schedule, DHS will produce from the POMS central database a set of performance indicators that measure the performance of each BH-MCO consistent with the outcome dimensions outlined in the attached table of outcome measures. The performance indicator reports will be issued by DHS on a regular schedule to all relevant DHS monitoring staff, the BH-MCOs and other stakeholder groups.

C. CONTINUOUS QUALITY IMPROVEMENT (CQI) PROCESS

The Department encourages the BH-MCOs to implement a Continuous Quality Improvement (CQI) process based upon Deming's 14-point program for managed adapted to the health care industry, and Joint Commission on Accreditation of Health Care Organization (JCAHO) guidelines. The overall process should include:

- Delineating the scope of the services to be monitored and improved.

- Identifying the important aspects of the services whose quality should be examined and improved.

- Identifying indicators (including but not limited to the performance indicators established by DHS) that will be used to monitor the quality, accessibility and appropriateness of the important aspects of services.

- Establishing thresholds (including but not limited to the thresholds established by DHS) for the review of indicators that become "flags" signaling the need for further analysis of the causes for the data reported to DHS.

Collecting data pertaining to each indicator and comparing the aggregate level of performance with the threshold for analysis. If the threshold is not reached, further analysis may not be necessary.

- Initiating analyses of other important aspects of services when thresholds have been reached.

- Taking actions to improve the aspects of services.

- Reporting the findings to the organizations involved, including a report of findings to DHS on a regular schedule. Monitoring and analysis are continued in order to identify any future deficiencies in services and to improve quality.

DHS monitoring staff will review the CQI reports of findings submitted by the BH-MCOs. DHS monitoring staff will provide feedback to BH-MCOs indicating:

(1) Concurrence with the BH-MCOs explanation/cause of the performance indicator findings and actions proposed by the BH-MCOs to improve performance (and/or correct deficiencies); or
(2) Offer alternative explanations/causes for the performance indicator findings and/or recommended alternative actions to improve performance (and/or correct deficiencies).

BEHAVIORAL HEALTH MANAGED CARE ORGANIZATIONS PERFORMANCE/OUTCOME MANAGEMENT SYSTEM

OUTCOME DIMENSIONS	DATA SOURCE(S)
*1. Increase Community Tenure and Less Restrictive Services** ▪ Increase the appropriate use of behavioral health inpatient days. ▪ Decrease criminal incarcerations. ▪ Increase the appropriate use of MH residential care. ▪ Decrease out-of-home placements. ▪ Decrease homelessness. ▪ Increase residential stability. ▪ Decrease patient days in state mental hospitals. *To be reported/compiled only for priority group consumers by age group (under age 21, 21-64 and age 65+).	1. Quarterly Status File (QSF)[1] 2. Criminal incarceration data sets from state correctional institutions, county jails and juvenile court records. 3. BH encounter data and SMH data set (PCIS).
*2. Increase Vocational and Educational Status** ▪ Increase school attendance (full time regular classroom) ▪ Increase school retention. ▪ Increase school performance. ▪ Improve school behavior. ▪ Increase vocational status for adults. *To be reported/compiled only for priority group consumers by age group.	1. Quarterly Status File (QSF)[1] 2. Employment tax records.

OUTCOME DIMENSIONS	DATA SOURCE(S)
*3. Reduce Criminal/Delinquent Activity** ▪ Reduce number of arrests. ▪ Reduce positive drug screens. ▪ Improve probation/parole status. ▪ Reduce status offenses. (focus on truancy) *To be reported/compiled only for priority group consumers by age group.	1. Quarterly Status File (QSF)[1] 2. Arrest records (state police) 3. Probation and Parole records 4. Automated Health Systems 5. AOPC records
*4. Improve Health Care** ▪ Meet or exceed DHS' EPSDT screening targets. ▪ Increase % of consumers with annual physical exams. ▪ Reduce hospital medical ER use. *To be compiled only for priority group consumers by age group.	1. Encounter data from physical health HMOs. 2. 837I HIPAA Compliant Transaction Institutional. 3. 837P HIPAA Compliant Transaction Professional.
5. *Increase "Penetration Rates"* (i.e., percent of enrollees who received behavioral health treatment through the behavioral health contractor) ▪ Increase appropriate utilization by priority group and type of service. ▪ Increase appropriate utilization by age and type of service.	1. Consumer Registry File (CRF)[2] 2. 837I HIPAA Compliant Transaction Institutional. 3. 837P HIPAA Compliant Transaction Professional. 4. Automated Health Systems
*6. Increase Consumer/Family Satisfaction** *To be reported/compiled only for priority group consumers.	1. Consumer Registry File (CRF)[1] 2. Consumer/Family Satisfaction Measurement Instruments

OUTCOME DIMENSIONS	DATA SOURCE(S)
7. *Implement Continuous Quality Improvement (CQI) Actions*	1. CQI Periodic Reports – Behavioral health contractor must submit to DHS periodic narrative reports detailing its CQI activities, delineating deficiencies and areas for improvement, actions taken to improve performance (or remedy deficiencies) and the effectiveness/outcome of actions taken. CQI reports must address performance indicator reports issued by OMH.
8. *Increase Range of Services and Improve Utilization Patterns* ▪ Improve/increase the array of treatment, support and rehabilitative service options. ▪ Decrease % of priority group consumers using only inpatient and/or ER services. ▪ Reduce inpatient re-hospitalization rate. ▪ Reduce rate of perinatal addictive disorders. ▪ Reduce "drop-out" rate.	1. 837I HIPAA Compliant Transaction Institutional. 2. 837P HIPAA Compliant Transaction Professional. 3. Encounter data from physical MCOs.
9. *Implement co-occurring disorder (COD) Performance Indicator or QA measure* ▪ *Improve/increase identification of co-occurring recipients* ▪ *Increase the percentage of network providers that routinely screen and assess for co-occurring psychiatric and substance use disorders.*	1. BH-MCO self reporting

[1]Reporting requirements and Data elements for QSF are in the Proposers' Library.
[2]Reporting Requirements and Data elements for CRF are in the Proposers' Library.

** *HIPAA Implementation Guides* and *Addenda* for the various types of transactions are available, free of charge, from the Washing Publishing Company at www.wpc-edi.com/hipaa/. These documents constitute the official HIPAA reporting standards as defined by the Accredited Standards Committee (ASC) X12.

*** *Pennsylvania PROMISe Companion Guides* for each of the types of transactions may be obtained, free of charge, by contacting OMHSAS directly. The *Companion Guides* provide detailed information specific to the submittal of claims and encounter transactions to Pennsylvania's PROMIS*e* system.

HealthChoices COD Performance Indicators/QA Measures

Please use the following operational definitions and reporting specifications for required DHS COD performance indicators/QA measures referenced in Appendix K.2

Operational definitions:

Co-occurring disorder: Individuals with a co-occurring disorder have one or more mental disorders as well as one or more disorders relating to the use of alcohol and/or other drugs.

Screening: A formal process that is typically brief and occurs soon after the individual presents for services. The purpose of the screening process is to determine the likelihood that a person has a co-occurring disorder, not to establish the presence or specific type of disorder, but to determine the need for an assessment. (No mandated instrument)

Assessment: A formal process of gathering information and engaging with the individual that enables the provider to establish the presence or absence of a co-occurring disorder that may involve clinical interviews, administration of standardized instruments, and/or review of existing information. The purpose of the assessment is to establish the existence of a clinical disorder or service need and to work with the individual to develop a treatment plan. (No mandated instrument)

Specific reporting criteria:
(unduplicated count, quarterly review and annual report)

1. Increase the percentage of network providers that routinely screen and assess for co-occurring mental health and substance use disorders:

Total number of network providers: _____
Number of network providers that have a written policy/procedure requiring individuals to be screened and assessed for co-occurring disorders: _____
Total number of individuals screened and/or assessed for a co-occurring disorder: _____

2. Increase identification of co-occurring recipients (prevalence):
   Per Network provider:

Total number of individuals admitted to the program: _____
Total number of individuals determined to have a co-occurring disorder that have been admitted to the program: _____
Total number of individuals determined to have a co-occurring disorder referred to another treatment provider: _____

GUIDELINES FOR CONSUMER/FAMILY SATISFACTION TEAMS AND MEMBER SATISFACTION SURVEYS

The Department of Human Services (DHS) values and encourages the input of consumers and families in all aspects of the HealthChoices Program and expects that such input will be incorporated in quality improvement. In addition the Office of Mental Health and Substance Abuse Services (OMHSAS) encourages input from consumers, persons in recovery, and families regarding the services and supports received in the mental health and drug and alcohol service system. Consumer and family feedback helps inform Providers, counties and Behavioral Health Managed Care Organizations (BH-MCO) about how services can support recovery for adults, resilience in children and adolescents and be more effective. Consumers and families have specialized knowledge and sensitivity about how respect, dignity and responsiveness of services can affect the process of recovery and preserve resilience. Members are more likely to feel safe in describing their experience with someone who is not their service Provider. Soliciting feedback on satisfaction with services empowers consumers and families and allows them to have a greater role in determining the quality of behavioral health care and recommending system improvements DHS therefore requires Primary Contractors to implement a comprehensive approach for the measurement of consumer/family satisfaction, including but not limited to:

- A Consumer/Family Satisfaction Team (C/FST) Program
- An Annual Mailed/Telephonic Survey of Member Satisfaction

A. CONSUMER and FAMILY SATISFACTION TEAM PROGRAM

1. <u>Purpose</u>

The purpose of the C/FST Program is to determine whether adult behavioral health service recipients and children and adolescents with serious emotional disturbance and/or substance abuse disorders and their families are satisfied with services and to help ensure that problems related to service access, delivery and outcome are identified and resolved in a timely manner. Surveys should identify consumer and family member satisfaction with the services of a specific Provider as well as the level of satisfaction with the behavioral health system and all of the treatment, services and supports each consumer is receiving. This is primarily accomplished by gathering information through face-to-face discussions with Recipients of behavioral health services and the families of child and adolescent service Recipients, with follow-up reports, dialogue, and problem resolution feedback with the Primary Contractor.

It is the responsibility of the Primary Contractor (the Primary Contractor refers to the responsible party that holds the HealthChoices contract or agreement with DHS) to provide the support, encouragement, and resources necessary to build a strong, independent, conflict free C/FST Program. In a recovery oriented service system support and encouragement would be evidenced by a Primary Contractor that:

- Communicates the importance of listening to and acting upon the results of satisfaction feedback from C/FSTs;
- Supports and encourages C/FSTs so that they are considered a respected and valuable service;
- Requires timely Provider action in response to survey results;
- Has a Provider network that works in partnership with C/FSTs to continuously improve service responsiveness using survey results in their internal quality management program;
- Identifies system improvement needed based on survey results;
- Actively provides direction and feedback to C/FSTs about how to improve their program and acquire the skills needed to move toward the independent operation of a satisfaction survey program; and
- Provides the resources necessary to accomplish the requirements outlined in this document.

2. Organizational Requirements of Consumer/Family Satisfaction Team Programs

In order to determine whether or not behavioral health services are meeting the needs and expectations of adults, young adults, children and adolescents and their family members, the Primary Contractor shall ensure that the C/FST Program is organized and operates in compliance with the following:

The Primary Contractor either directly, or via a BH-MCO or other sub-contractor, must have systems and procedures to routinely assess service Recipient satisfaction. The C/FST Program may be either a single or a multi-county program based upon the nature of the contract between DHS and the Primary Contractors. The family satisfaction component may be accomplished either as a separate administrative entity or as a component of the C/FST Program that is specifically responsible for family satisfaction activities.

(a) The Primary Contractor for HealthChoices and/or the BH-MCO must have a contract or a written and signed agreement with each C/FST Program and fiduciary, if applicable, that delineates roles and responsibilities of all parties. Designation of who holds the responsibility for advocacy and follow-up on behalf of Members should also be included.

(b) Under the contract or written agreement, and consistent with the requirements of the Mental Health Procedures Act (Chapter 5100), the C/FST members will act as agents of the Primary Contractor, and are, therefore, to have the same access to consumers and family members as the Primary Contractor and service Providers, insofar as it is necessary to perform their responsibilities.

(c) Each C/FST Program must have a Director who may be full or part time depending upon the size of the program. The Director must be a person who self-identifies as a consumer, person in recovery, or family member as stated in 3(a) and (b) as of January 1, 2005. If the current Director hired prior to January 1, 2005 does not meet this requirement, he or she may continue to serve until such time as the position is vacant and a new Director is hired.

(d) C/FST members must be paid at least as much as other persons in the general workforce doing similar work in the same community.

(e) C/FSTs must be independent from any Provider of behavioral health services or any other agency that might create a conflict of interest. C/FSTs that do not have accounting capabilities may contract with a provider as its fiduciary provided the contract safeguards the independence of the C/FST for program direction including budget priorities, satisfaction surveys, findings and recommendations.

(f) The Primary Contractor shall work with the C/FST to establish an annual plan for conducting face-to-face interviews. The plan will include goals such as: the number of interviews to be completed, the levels of care to be surveyed and special focus surveys to address specifically identified special populations. If the C/FST Program identifies barriers to accessing Members to be surveyed, the Primary Contractor will assist to resolve the issue. Priority populations should be given priority for face-to-face interviews.

(g) The Primary Contractor will ensure that the C/FST Program has adequate financial resources, training, support, and necessary equipment for the program to produce high quality quarterly reports.

3. <u>Consumer and Family Satisfaction Team Minimum Requirements</u>

(a) Persons performing adult satisfaction activities must be, or have been, consumers of behavioral health services, persons in recovery, or family members.

(b) Persons performing family satisfaction activities must include family members of children and adolescents with serious emotional disturbance and/or substance abuse disorders who are receiving or have received behavioral health services in the publicly funded system, and may also include older adolescents and/or young adults who are receiving or have received behavioral health services as a child or adolescent in the publicly funded system.

(c) Family satisfaction team members must have child abuse and criminal history clearances in accordance with the Child Protective Services Law, Chapter 63, Sections 6303 and 6344, and are mandated reporters for child abuse.

(d) The family satisfaction component may be a separate and distinct administrative entity, or may be at least one team of a C/FST Program or one member of a team dedicated to family satisfaction activities.

(e) Young adults (18-22) may be interviewed by either consumer or family satisfaction team members, as appropriate, depending on the services being received.

4. <u>Conducting Satisfaction Surveys</u>

Consumer and family satisfaction interviews serve as a means for early identification and resolution of problems related to service access, and timeliness of service delivery, appropriateness of services and recovery and resilience outcomes. Face-to-face interviews afford Members the opportunity to communicate openly with peers on an on-going basis. Additionally, satisfaction surveys assist in determining the level of satisfaction with respect, dignity and hopefulness as integral components of the entire service delivery system. These activities also provide a further check to ensure that the service system is consistent with the principles of recovery in adults, resilience in children and adolescents, of the Community Support Program (CSP), the Child and Adolescent Service System Program (CASSP), cultural competence, and Drug and Alcohol (D&A) Treatment Principles. The Primary Contractor shall ensure:

(a) Consumer/family satisfaction should be assessed through face-to-face interviews with adult behavioral health service Recipients; children and adolescents with serious emotional disturbance and/or substance abuse disorders and their families. Interviews should be face-to-face whenever possible however, telephone or mailed surveys may be used if preferred by the Member.

(b) The Primary Contractor shall establish mechanisms in their contract or written agreement to inform the C/FST Program of newly enrolled Members receiving behavioral health services and on-going Members who may wish to participate in satisfaction interviews. The first mechanism below is to be used when member names, addresses and telephone numbers are provided to the C/FST. The second mechanism describes the process if the Primary Contractor does not wish Member names to be provided to the C/FST without Member consent. It is the Primary Contractors responsibility to select the mechanisms for notifying Members about the C/FST Program as follows:

i) The Primary Contractor periodically provides the names and addresses of Members newly enrolled in mental health services to the C/FST and at least annually updates the list for Members who continue to remain enrolled, and notifies Members receiving drug and alcohol services as stated in 4 (b) ii below; or

ii) The Primary Contractor informs all newly enrolled Members receiving mental health and/or drug and alcohol services about the C/FST Program. The names of members receiving mental health services who wish to be interviewed can be provided to the C/FST without a release of information. Members receiving drug and/or alcohol services must sign a release of information in order for their name, address and telephone number to be provided to the C/FST. A mechanism must be established to provide an opportunity to be interviewed at least annually for Members that remain enrolled in mental health and drug and alcohol services.

(c) Service Providers must provide C/FSTs with comfortable private space for interviews to ensure an environment in which behavioral health consumers and children and adolescents with serious emotional disturbance and/or substance abuse disorders and their families feel free to express any concerns they may have.

(d) C/FSTs solicit input from Recipients of behavioral health services and the families of children and adolescents receiving behavioral health services in order that satisfaction and areas of concern can be identified and recommendations for systems improvement can be developed. This can be accomplished through individual and/or group discussions, upon discharge from a service, and as focus groups with behavioral health consumers, persons in recovery, children and adolescents with serious emotional disturbance and/or substance abuse disorders and their families, including visits to programs where members receive their services or to their homes. Family members may be more easily accessed when interviews are conducted by telephone. Information about the C/FST Program is best shared in face-to-face presentation with individuals or groups, however, such methods as videotapes, telephone or written material may also be used.

(e) Some of the C/FST survey questions should address satisfaction with the Provider(s) and the mental health and drug and alcohol service(s) the consumer is receiving. The findings of the C/FST shall be organized to identify the Provider, or special population in the case of a focused survey for three purposes: 1) to allow the managed care organization to include C/FST information in Provider profiling, 2) to provide feedback to the individual Provider about their program, and 3) to allow the Primary Contractor (County and/or Managed Care Organization) to direct the Provider to take corrective action to address a Member concern or concerns about the Provider operation or program. The face-to-face surveys and monthly problem solving process ensure action is taken on an on-going basis and resolution for the Member is timely and responsive. Both the on-going surveys and the annual survey described in Section B can be used to identify trends that may require system improvement.

(f) The Primary Contractor will identify and request the C/FST to conduct outreach efforts to under-served or un-served groups of consumers and families in order to conduct satisfaction surveys and identify system improvements that will increase the access, engagement and retention of these individuals in needed behavioral health services.

5. Areas for Consumer and Family Satisfaction Team Observation and Discussion with Recipients of Behavioral Health Services and the Families of Child and Adolescent Service Recipients

Consumers, persons in recovery, and families of children and adolescents shall have input into the questions asked in satisfaction surveys. The survey tool should allow identification of the Provider(s) and the service(s) provided as well as general satisfaction with the service system. Satisfaction surveys shall include but not be limited to the following areas:

BH-MCO Related Issues:

- Knowledge of and satisfaction with member services
- Knowledge of benefits and treatment options
- Awareness of complaint and grievance process (and satisfaction with outcome if process was used)
- Satisfaction with level of dignity and respect conveyed to Members by the BH-MCO staff

Service Delivery:
- Interagency Team Process for children and adolescents and their families
- Choice of Providers
- Satisfaction with timeliness and convenience of the service delivery system
- Perception of accessibility and acceptability of services (i.e., denial of preferred services, geographic, language/culture, problems resulting in discontinuation of services by Recipient)

Treatment:
- Service Recipient involvement in treatment planning and decisions
- Child or adolescent and their family members involvement in treatment planning and decisions
- Interagency Team Process for children and adolescents and their families
- Perception of effectiveness/outcomes of treatment
- Perception of changes in quality of life as a result of treatment
- Satisfaction with dignity, respect and hopefulness offered during treatment
- Satisfaction with physical health care

Overall Satisfaction:
- Degree to which services were consistent with CSP**,** CASSP and D&A principles, and facilitate recovery and resilience
- Freedom from sense of coercion or fear of retribution for Recipients of mental health services
- Satisfaction and comfort level with physical environment of facility or site where services were provided.
- Satisfaction with dignity, respect and hopefulness offered by all levels of the service system.

DHS may from time to time require specific questions to be added to C/FST satisfaction surveys in order to conduct statewide quality assurance activities.

6. Confidentiality

All employees of C/FST Programs must comply with applicable state and federal laws, regulations, and rules regarding the confidentiality of mental health consumers and recipients of drug and alcohol treatment services. The contract or written agreement will address confidentiality requirements including the following:

(a) All C/FST members must receive training in confidentiality regulations for mental health and substance abuse services. All family satisfaction team members must also receive training in confidentiality issues relevant to the child and adolescent population in both mental health and substance abuse services.

(b) All C/FST members must sign a confidentiality agreement, and personnel policies must address disciplinary procedures relevant to violation of the signed confidentiality agreement.

(c) Mental Health Confidentiality: For purposes of the HealthChoices program, C/FSTs are agents of the Primary Contractor, and have the delegated authority to collect and disseminate the needed information. C/FST members must be considered as equal to all other mental health professionals with regard to access to mental health consumers, children and adolescents with serious emotional disturbance and their families. There should be no special written permission required to engage consumers and families receiving mental health, whether in state hospitals or community programs.

(d) Mental Health Confidentiality: If the Recipient of mental health services is a child (up to 14 years of age), he or she may be interviewed but only in the presence of a responsible family member or authorized caregiver, and the family member or caregiver must also be interviewed. If the Recipient of mental health services is an adolescent (14 to 18 years of age), the adolescent should be interviewed independently and responsible family members or an authorized caregiver could also be offered the opportunity to be interviewed. It is preferable but not necessary to receive the adolescent's consent before interviewing family members or caregivers.

(e) Drug and Alcohol Confidentiality: A service agreement between the C/FST Program and each Drug and Alcohol Provider outlining Drug and Alcohol confidentiality rules, rights, regulations and laws that govern Drug and Alcohol Providers in Pennsylvania is also required. This is consistent with the current practice of Drug and Alcohol Providers to require such an agreement be signed by representatives of the Departments of Health and Human Services, Joint Commission on Accreditation of Healthcare Organizations, and Single County Authorities for Drug and Alcohol services.

(f) Drug and Alcohol Confidentiality: Prior to a drug and alcohol service Provider contacting a C/FST Program to provide the name of a person who wishes to be surveyed, a consent to release information form must be signed by the Member requesting their name, address and telephone number be provided to the C/FST Program. A copy of the signed consent to release information form must be retained in the Member's treatment file and a copy given to the Member and the C/FST. Consent to release information forms for Members receiving drug and alcohol treatment services are not required when the C/FST conducts surveys without receiving the persons name and reports data in the aggregate

(g) Drug and Alcohol Confidentiality: Recipients of drug and alcohol treatment services, regardless of age, must give their written consent for a parent or other family member to be interviewed, or to be present while the Recipient of services is being interviewed.

(h) C/FSTs must be afforded the opportunity to meet with mental health consumers and Recipients of substance abuse services and the family members of child and adolescent service Recipients to describe and explain the purpose and function of C/FSTs.

7. Problem Identification and Recommendations for Action

C/FSTs must provide feedback to the Primary Contractor through written quarterly reports and monthly problem resolution meetings that allow for dialogue and review of findings. The Primary Contractor is responsible for timely reports back to the C/FST on specific actions and problem resolution resulting from identified issues, concerns and problems. The contract or written agreement shall identify the process the Primary Contractor will use to resolve problems and address suggestions identified by the C/FST including the following:

(a) Process for problem identification and resolution that includes the C/FST Program, consumers, persons in recovery, parents, adolescents, children, designated county staff, staff of the managed care organization, and advocates as appropriate to the problem identified.

(b) The problem resolution process must include how often problem resolution meetings will occur, with whom, and the responsibilities of all parties (County, C/FST, managed care organization, and Providers). This process will identify actions to be taken by the Primary Contactor if resolution is not reached. There must also be a process in place for responding to urgent matters identified by Members.

(c) The Managed Care Organization sub-contracts with Providers of behavioral health services in their network shall include the timeframe in which the Provider must respond to the recommendations made by the C/FST as directed by the County, Managed Care Organization or the C/FST. Providers of behavioral health services should be required to use C/FST feedback in their quality management program.

(d) The Primary Contractor must provide a timely response to the C/FST on actions taken in response to reported problems and concerns resulting from service Recipient interviews for inclusion in the next quarterly report.

(e) Mechanisms must be in place to address identified trends or system changes that may require the Primary Contractor to study in more depth to understand the issue and resolve. This may include focus meetings on specific topics or collaboration with other involved service systems. The results of these focus studies will be provided to the C/FST for inclusion in their reports.

8. Knowledge, Training and Orientation of Consumer and Family Satisfaction Teams

The Primary Contractor will ensure that C/FST members have both an initial orientation to and on-going training in the following areas:

(a) C/FST members must have basic knowledge of mental illness and addictive diseases and an understanding of the concept of recovery and resilience in relation to both for adults and children and adolescents. Persons performing Family Satisfaction activities must also have an understanding of serious emotional disturbance and substance abuse disorders in children and adolescents.

(b) Training for C/FST members must include confidentiality regulations for mental health and substance abuse services. Family satisfaction team members must also receive training in confidentiality issues relevant to the child and adolescent population in both mental health and substance abuse services. Training must include an understanding of responsibilities, as applicable, under the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

(c) C/FST members must also have an understanding of the cultural diversity of the individual and community being served in order to ensure culturally sensitive interactions. Training shall include the basic concepts of recovery and resilience.

(d) Family satisfaction team members must have training in the responsibilities of being mandated reporters for child abuse.

(e) The Primary Contractor shall arrange a minimum of two (2) hours orientation/training on the BH-MCO operations, policies and procedures for satisfaction team members.

9. Quarterly Reports

The Primary Contractor shall provide the Department with the C/FST Program's quarterly report summarizing consumer and family satisfaction findings, as well as improvement actions and system changes implemented by the Primary Contractor in response to those findings. The Primary Contractor shall provide support and direction to the C/FST to ensure the report contains not only the

numeric results of surveys conducted but also information about the actions taken in the previous quarter by the Primary Contractor or behavioral health service Provider, trends observed, and other relevant information that can be used by Providers and others about ways to improve treatment and supports.

10. <u>DHS Annual Review of Consumer/Family Satisfaction Team Programs</u>

DHS will conduct an annual review of the C/FST program that will include a review of the following:

(a) Results of satisfaction surveys;

(b) Actions taken to resolve identified issues and system changes;

(c) Role and effectiveness of the Primary Contractor in problem resolution and direction to the C/FST program;

(d) Adequacy of the budget, staff, and training opportunities to carry out the requirements of the program;

(e) Role of the fiduciary, if applicable, in supporting the program and financial priorities established by the C/FST program; and

(f) Progress on gaining skills and abilities of the C/FST program to move toward operating as an independent, conflict free, satisfaction program, as applicable

B. ANNUAL MEMBER SATISFACTION SURVEYS

1. <u>Consumer and Family Satisfaction Annual Mailed/Telephonic Survey</u>

The Primary Contractor is responsible for ensuring that an annual satisfaction survey of a representative sample of persons served by the behavioral health program is conducted by mail or telephonically. The purpose of the Annual Mailed/Telephonic Consumer and Family Member Satisfaction Survey is to determine the extent to which the BH-MCO adult Members and family members of children and adolescents are satisfied with overall BH-MCO operations and services, and to identify areas which need improvement. Surveys are developed and used by the BH-MCO to gather information to determine whether the BH-MCO adult Members and family members of children and adolescents are knowledgeable about and satisfied with the behavioral health program including core functions such as member services as well as to assess whether service availability, service access, and services provision and effectiveness are meeting the Member's needs and expectations.

(a) Surveys of Recipients of substance abuse services, regardless of age, must be distributed by Providers at service delivery sites in order to protect the confidentiality of persons being surveyed.

(b) A separate survey instrument must be developed for children and adolescent service Recipients and their families.

(c) Findings and resulting recommendations from the survey and consumer/family satisfaction activities are to be incorporated into the Primary Contractor's ongoing quality management and improvement program.

(d) The County may directly conduct the annual survey or direct the managed care organization, C/FST Program, or another entity that would be conflict free, to conduct the annual survey.

2. <u>Areas Covered by the Consumer and Family Satisfaction Survey</u>

Consumers, persons in recovery, and families of children and adolescents shall have input into the questions asked in satisfaction surveys. Satisfaction surveys shall include but not be limited to the following areas:

<u>BH-MCO Related Issues</u>:
- Knowledge of and satisfaction with member services
- Knowledge of benefits and treatment options
- Awareness of complaint and grievance process (and satisfaction with outcome if process was used)
- Satisfaction with level of dignity and respect conveyed to Members by the BH-MCO staff

<u>Service Delivery</u>:
- Interagency Team Process for children and adolescents and their families
- Choice of Providers
- Satisfaction with timeliness and convenience of the service delivery system
- Perception of accessibility and acceptability of services (i.e., denial of preferred services, geographic, language/culture, problems resulting in discontinuation of services by Recipient)

<u>Treatment</u>:
- Service Recipient involvement in treatment planning and decisions
- Child or adolescent and their family Members involvement in treatment planning and decisions
- Interagency Team Process for children and adolescents and their families
- Perception of effectiveness/outcomes of treatment
- Perception of changes in quality of life as a result of treatment
- Satisfaction with dignity, respect and hopefulness offered during treatment
- Satisfaction with physical health care.

Overall Satisfaction:

- Degree to which services were consistent with CSP**,** CASSP and D&A principles, and facilitate recovery and resilience
- Freedom from sense of coercion or fear of retribution for Recipients of mental health services
- Satisfaction and comfort level with physical environment of facility or site where services were provided.
- Satisfaction with dignity, respect and hopefulness offered by all levels of the service system.

Miscellaneous:

- Items required by the Department as a result of the Department's ongoing monitoring and program evaluation.
- Knowledge of and satisfaction with the Medical Assistance Transportation Program
- Satisfaction of consumers with special needs e.g. deaf and hard of hearing, older adults, people who are homeless, etc.
- Suggestions for improvement

3. Sampling Procedure

The Annual Mailed/Telephonic Consumer and Family Satisfaction Survey must be sent to, or conducted with, a representative sample of behavioral health service Recipients with a statistically valid sampling of Members in the adult priority population groups, family members of child and adolescent service Recipients, and special needs populations, as well as a sampling of Members who filed complaints and grievances. The survey of Members receiving drug and alcohol services must be anonymously distributed through service Providers.

4. Frequency of Survey and Reporting Results

A report of the survey findings and resulting recommendations for quality improvement must be submitted to the Department as part of the annual quality management summary report, quality management plan for the upcoming year. The Consumer and Family Satisfaction Mailed/Telephonic Survey will be conducted at least annually.

HealthChoices Behavioral Health
Data Reporting Requirements
(Non-Financial)

File/Report Name	Description	Frequency	Data Format Transfer Mode Due Date
Transition Monitoring	Reports on data needed for OMHSAS monitoring of the transition to a new contractor or subcontractor.	Weekly, during start-up or transition to a new BH-MCO. Time-limited.	File transfer via SeGOV data exchange or alternate OMHSAS-specified secure data transfer method. Due by close-of-business on Wednesday following the reporting week.
Quarterly Monitoring	Reports on data needed for on-going monitoring of the HealthChoices Behavioral Health contract.	Quarterly	File transfer via SeGOV data exchange or alternate OMHSAS-specified secure data transfer method. File transfer via SeGOV data exchange. Due 45 days after the end of the reporting quarter.
837 Transactions	Reports each time a consumer has an encounter with a provider. Format/data based on HIPAA compliant 837 format.	Monthly (or more frequently, as scheduled by submitter)	File transfer via Secure eGOV data exchange. Each encounter record is due by the last calendar day of third month after the Primary Contractor paid/adjudicated the claim/encounter.
Alternative Payment Arrangement (APA) reporting	Reports any payment arrangement with a provider other than Fee For Service.	Varies	File transfer via SeGOV data exchange or alternate OMHSAS-specified secure data transfer method. Due 30 days after the end of a payment cycle.
Complaints and Grievances	Reports aggregate data on complaints, grievances and resolutions. Also includes detail records on grievances.	Monthly	File transfer via SeGOV data exchange or alternate OMHSAS-specified secure data transfer method. Due 30 days after the end of the reporting month.
Consumer Data: Consumer Registry/Quarterly Status (included in Performance Outcome Management System	Reports person-specific demographic/clinical data at registry and closure; i.e. birth date, priority group, service request date, independence of living. Reports status and outcome data on priority group consumers, i.e. independence of living, voc/ed, residential moves.	Quarterly	ASCII files via eGovernment Secure Data Exchange; due 30 days after the end of the reporting quarter.

HealthChoices Behavioral Health
Data Reporting Requirements
(Non-Financial)

File/Report Name	Description	Frequency	Data Format Transfer Mode Due Date
MCO Provider File	Reports all providers within the network.	Monthly	File transfer via SeGOV data exchange. Due by the second Monday of the month.
Monthly BHRS Services Report	Report tracks Therapeutic Staff Support (TSS) hours and recipients authorized and TSS hours and recipients paid.	Monthly	File transfer via SeGOV data exchange or alternate OMHSAS-specified secure data transfer method. Due 4 months after the authorization month.
Denial Log	Reports each time a requested service was denied, as well as any alternatives approved.	Monthly	File transfer via SeGOV data exchange or alternate OMHSAS-specified secure data transfer method. Due 15 days after end of reporting month.

* Does not cover financial reporting requirements. The file specifications, formats, data elements and reporting requirements are subject to change by the Department.

** *Pennsylvania PROMISe Companion Guides* for each of the types of transactions may be obtained, free of charge, by contacting OMHSAS directly. The *Companion Guides* provide detailed information specific to the submittal of claims and encounter transactions to Pennsylvania's PROMISe system.

HealthChoices Behavioral Health Program
Requirements for County Reinvestment Plans

Primary Contractors in the HealthChoices program, including those behavioral health managed care organizations (BH-MCOs) under direct contract with the Department of Human Services (DHS), are allowed to retain Capitation revenues and investment income that was not expended during the Agreement period to reinvest in programs and services in their County. These funds, called Reinvestment Funds, must be spent in accordance with a DHS, Office of Mental Health and Substance Abuse Services (OMHSAS) approved reinvestment plan.

Reinvestment Funds provide a unique opportunity for a financial incentive to reward sound financial management practices and allow the creative use of funds to fill identified gaps in the service system, test new innovative treatment approaches, and develop cost-effective alternatives to traditional services that may create cost offsets for State Plan Services. Reinvestment is one mechanism used to achieve the Commonwealth's expectation for the continuous quality improvement of a comprehensive treatment system that not only supports recovery for persons with mental health issues, including drug and/or alcohol treatment needs, but for the family support structure as well. This document refers to both the reinvestment plan and reinvestment plan priorities. The term "plan" refers to the entire reinvestment submission for the Agreement year. The "reinvestment plan priorities" are the individually named projects that are numbered in priority order and submitted with a program description.

This document describes the required planning process, allowable expenditures, financial reporting, and the approval process for Primary Contractors to use Reinvestment Funds. These requirements are detailed in the following documents: HealthChoices Behavioral Health Program Standards & Requirements (PSR), the HealthChoices Behavioral Health Agreement, and the Financial Reporting Requirements – HealthChoices Behavioral Health Program.

A. Planning for Reinvestment Funds

Involvement of Stakeholders

1. The planning process must include and document the involvement of members of the BH-MCO who have received or are currently receiving services, families (including families of children and adolescents), persons in recovery, MH/ID and Single County Authorities (SCA), and as appropriate, County Commissioners and local legislators.
2. In order for stakeholders to provide informed feedback about options for Reinvestment Funds, the County and BH-MCO should present the results of data analysis performed to document utilization trends, unmet needs, populations served, outcomes achieved by the HealthChoices program to date, etc. as part of the planning process in the development of the reinvestment plan.

3. Stakeholders must be involved at all stages of the planning and decision making process. Evidence of their involvement and feedback must be summarized as part of the plan submission.
4. Counties must document the planning process used at the local level to discuss behavioral health service needs.
5. Preliminary reinvestment plans should be discussed with the OMHSAS Field Office for input regarding planned use of funds prior to submission.

Timeframes for Submission and Approval

1. The timeframes for submission and approval are provided as approximate dates. The dates provided are the outside dates for when submission is required. Primary Contractors may submit plans prior to the completion of the audit using estimates of the Reinvestment Funds available. Submission timeframes are calculated from the beginning and ending dates of the annual Agreement. Dates for review and approval may vary depending on any additional information or clarification needed. The review process is summarized below, and detailed steps are provided in Attachment 1.
2. Plans for Reinvestment Funds are submitted annually based on the HealthChoices Agreement year.
3. Draft plans are submitted to the OMHSAS Field Office for review and comment once the amount of Reinvestment Funds are identified and confirmed by OMHSAS. This should be no later than the first day of the ninth (9th) month after the end of the Agreement year.
4. A BHRS exception request and service description approved by the OMHSAS Children's Bureau must be submitted along with the Reinvestment plan, when appropriate, or when a proposed service requires a BHRS program description approval. Any changes to this process must be reviewed by the OMHSAS Field Office.
5. The OMHSAS Field Office provides written feedback to the Primary Contractor.
6. Final reinvestment plans are to be submitted within thirty (30) days of receiving OMHSAS feedback.
7. The Service System Review Committee (SSRC) reviews and approves final reinvestment plans. If there are questions, the questions are provided to the Primary Contractor. Once the Primary Contractor satisfactorily responds to the questions by providing the requested additional information and/or submitting a revised plan, written approval will be provided.
8. The Primary Contractor cannot begin implementing the approved reinvestment plan until written notification is received that the plan is approved and when the funds to support the plan have been deposited into a restricted account as required (within thirty (30) days of plan approval).
9. If Reinvestment Funds from a subsequent year are intended to be used to continue funding a previously approved reinvestment plan priority, the Primary Contractor must submit the previously approved plan with updated financial information related to the request for continuation funding. There should be evidence that stakeholders continue to support the plan priority and evidence of the benefit from implementing the priority. OMHSAS will expedite the review of the plan.

10. When additional funds are identified, plans must be submitted no later than twelve (12) months from the date additional Reinvestment Funds are identified. The new plans will be reviewed at the time they are received following the same process described above. Exceeding this timeframe for submission may result in the DHS recovery of these funds.

B. Identification of Reinvestment Funds

1. Primary Contractors confirms the amount of Reinvestment Funds available with OMHSAS. Written confirmation should be received, in order to meet the above timeframes, by the middle of the (8th) month after the end of the Agreement year, in order to meet the above timeframes. Confirmation of funds available should occur before the draft reinvestment plan is submitted. It is understood that the amount of reinvestment money available is subject to change based on future reconciliation.
2. For reinvestment purposes only, adjustments made to prior year available funds two (2) years after submission of the Agreement audit will be applied to the most recent audited Agreement year.
3. When the County is the Primary Contractor, funds that would otherwise be available for reinvestment, but are being proposed for Risk and Contingency, must be identified by the County and approved by OMHSAS. The County must submit a written request to OMHSAS for approval of Risk and Contingency Funds stating the rationale for the request prior to its letter confirming the amount of reinvestment available. A written request for approval to use Risk and Contingency Funds for reinvestment purposes must be submitted to OMHSAS and approved prior to the submission of a reinvestment plan.
4. A reinvestment plan must be submitted for approval within twelve (12) months of the time additional funds are identified for reinvestment.

C. Guidance on the Use of Reinvestment Funds

Allowable Uses for Reinvestment Funds

1. Start-up costs for State Plan Services, during capacity building, including provider assistance. Any unmet service access standards should be considered for reinvestment funds as a priority. Any billable State Plan Services must be submitted to the BH-MCO for payment during the start-up of the service.
2. Development and/or purchase of Medical Assistance (MA) eligible Supplemental Services that are in-lieu of or in addition to.
3. Behavioral health supports that are not MA eligible (non-medical**)** such as purchase or renovation of a facility, employment supports, housing development, or rental subsidies.
4. Training and consultation that is required to implement a new service or support for MA eligible individuals.
5. Expenditures must be consistent with the conditions of the Center for Medicare and Medicaid Services (CMS) waiver, the HealthChoices PSR and Agreement.

6. DHS will provide a listing of MA eligible Supplemental Services. Primary Contractors may request approval of a new MA eligible Supplement Service.

Reinvestment Funds Cannot be used for:

1. Incentives payment to a BH-MCO.
2. Payment of State Plan Services.
3. Administrative costs such as medical management, quality management activities, outcome studies, etc.
4. Training not connected to the development of a specific service or program (see Allowable Expenditures for Training) detailed below.
5. Transportation costs that are available under the Medical Assistance Transportation Program (MATP).
6. Services targeted primarily for non-Medical Assistance (MA) eligible persons or to the community at large.
7. Expenditures that do not comply with the Review and Approval Guidelines for Reinvestment Plans that Provide for Costs for Facility or Real Estate Purchase, Renovation or Purchase of Fixed Assets (Attachment 5).

Allowable Expenditures for Training

Training is an important component of any new service. In developing a budget as part of a reinvestment plan, the training component should be identified in the overall budget of the service. The training must be tied to a new service and not a stand-alone budget item. For example, if the Primary Contractor has determined that there is a need for a Mental Illness Substance Abuse (MISA) program, Reinvestment Funds could be allocated to cover the costs of training for the implementation of this program. However, if the Primary Contractor decided that they would like to train all County staff in MISA "best practice," the Primary Contractor would need to use administrative dollars to fund this training since it is not tied to a specific program developed to provide services targeted for MA eligible consumers.

Allowable Expenditures for Purchase, Renovation and Fixed Assets

1. The reinvestment plan must address additional information specified in the Review and Approval Guidelines for Reinvestment Plans that Provide for Costs for Facility or Real Estate Purchase, Renovation or Purchase of Fixed Assets (Attachment 5) when a plan priority includes these Non-Medical services or supports. These guidelines specify the additional information that must be included in the reinvestment plan priority submitted and in the agreement entered into between the Primary Contractor and Subcontractor. These include:

    A. Additional areas that must be addressed in the reinvestment plan description regarding ownership, analysis of the need for Non-Medical Services, availability of an on-going revenue source, etc.

B. A detailed budget of the costs associated with purchase of a facility or property, renovation, fixed assets, personnel, operating expenses, etc. must be submitted following the guidelines in Attachment 5.

C. The Primary Contractor/Provider Agreement should ensure that if the property is sold that any proceeds from the sale would be returned to the Primary Contractor. In this case a new reinvestment plan for these funds must be submitted within twelve (12) months or the funds will be considered Discretionary Funds which must be returned to the Department.

D. Costs for Non-Medical Services are not considered in the HealthChoices rate setting process and DHS has no obligation to continue to fund priorities that were approved as one-time expenditures for the purchase or renovation of a facility.

D. OMHSAS Plan Parameters

Format for Submission of Reinvestment Plans

1. The reinvestment plan must be submitted in accordance with OMHSAS established parameters.
2. A standardized format for submission of both the draft and final reinvestment plan is provided in Attachment 3. **Each reinvestment plan priority for the Agreement year must be numbered in priority order and must be submitted on a separate form using this format.** The same priority number based on the Agreement year must always be used on all reports to facilitate tracking. One (1) set of budget forms must be submitted listing each reinvestment plan by priority number (Attachment 4).
3. The reinvestment plan title is to include the Primary Contractor name and contract year from which the funds are identified as available for reinvestment.
4. The reinvestment plan priority format identifies the: Primary Contractor; the date of submission; the type of service to be funded (State Plan-start-up, Supplemental-In-Lieu of, Supplemental- In Addition to, or Non-Medical Only); indicate if it is a new, continuation, or amended plan and indicate the numeric priority assignment of the reinvestment plan.
5. Reinvestment plan priorities can include expenditures up to three (3) years, with a maximum of five (5) years, subject to SSRC approval, with the exception of State Plan Start-up which should be completed within six (6) months, up to a maximum of one (1) year.
6. Each reinvestment plan priority must state the Agreement years in which Reinvestment Funds will be spent. Primary Contractors should ensure the dates for expenditure are realistic to avoid requests for extensions.

7. When determining the Agreement year in which the reinvestment plan priority funds will be spent, the Primary Contractor should consider the time it will take to accomplish the plan priority and the date of OMHSAS approval. If the time to approve the plan priority was delayed, the final date for spending may need to be adjusted.
8. Expenditures for a reinvestment plan priority cannot be incurred until the effective date of the OMHSAS approval letter.
9. OMHSAS reserves the right to request additional information, if necessary, in order to approve a reinvestment plan priority.

Target Population

1. The reinvestment plan must identify that it is targeted for the unmet or under-met needs of mental health and drug and alcohol MA eligible individuals.
2. It is understood that some non-MA eligible consumers may receive services in a program established to target MA eligible members. DHS assures that the federal funds flowing to the counties under the HC BH Agreement will be used to provide services that primarily benefit MA beneficiaries. Reinvestment plan priorities must identify the priority populations to be served.
3. Describe the population that is targeted for the reinvestment plan priority, e.g. adults with serious mental illness, adolescents with drug and alcohol treatment needs, etc. Include an estimation of the number of persons to be served by the reinvestment plan priority.

Description of Program or Service

1. Reinvestment plans must include a detailed narrative description of each program or service that is consistent with, and supports the definition of the service as being either State Plan start-up, Supplemental Services- In-Lieu of Supplemental-In-Addition to; or Non-Medical Only.
2. Describe the program or service to be funded by the reinvestment plan priority and why this service or approach is expected to improve the health outcomes for the persons targeted. Evidenced Based Practice Models should be considered for inclusion in a reinvestment plan.
3. If a Primary Contractor is requesting the approval of a new MA eligible Supplemental Services, identify the service or services that are expected to generate cost offsets once the Supplemental Service is available.

Description of Fund Expenditures

1. Provide a brief summary of what the reinvestment plan priority will fund.
2. Each reinvestment plan priority must contain a description of the major budgeted items (personnel, equipment, operational costs, etc.) and the cost associated with each item. The qualifications of both training and experience for staff and a break out of each position being funded should be included in the plan.
3. If the reinvestment plan priority is funding start-up costs for an State Plan Service, list the specific start-up costs expenditures that will be funded, and the length of time start-up costs will be required e.g. six months, with a maximum of one year, of staff salaries, staff training, etc. Include an offset for estimated billable services.
4. Identify how the reinvestment plan priority will be financed for continuation once Reinvestment Funds have been expended. Sustainability must be discussed with some detail as to the funding options in the future and a description of how the service will continue or a justification as to why the services will end.
5. Reinvestment plan priorities with requests for Non-Medical facility, land or property purchase and/or fixed asset expenditures require submission of the specific information outlined in Review and Approval Guidelines for Reinvestment Plans that Provide for Costs for Facility or Real Estate Purchase, Renovation or Purchase of Fixed Assets (Attachment 5).

Data Analysis Supporting Request

1. Include a summary of the data analysis that supports why the target population has been chosen and why the specific service has been chosen for Reinvestment Funds. Identify the number of HC members in the target population.
2. Identify the outcomes to be achieved by the service and the data to be collected to measure the outcomes.
3. For continuation or expansion requests the outcome data and any findings need to be included with the submission as well as any updates or changes to the services being implemented.

Description of Stakeholder Involvement in Decision Making

1. Requests must summarize stakeholder involvement in the planning and decision making process for each request.
2. It is expected that stakeholders will be provided information about the outcomes achieved by the HealthChoices program to date. This might include the current strengths and opportunities for improvement as seen by the County and BH-MCO. Such information will allow stakeholders to provide informed feedback about priorities for Reinvestment Funds**.**

Reinvestment Budget Forms

1. Four (4) budget forms must be submitted which break out costs based on eligibility category for HealthChoices recipients, MA recipients, Non-MA

recipients and total expenditures. One set of budget forms is to be completed, listing each reinvestment plan priority submitted (Attachment 4).

2. Primary Contractors should use their best estimates to determine the number of clients in each of these three (3) categories. It is understood that members move in and out of eligibility categories.

E. Financial Requirements for Reinvestment Funds

1. Primary Contractors must place Reinvestment Funds in a separate restricted account. Bank statements for the account must be submitted monthly. Bank statements are to be reconciled monthly.
2. Reinvestment Funds can be deposited when identified, but must be placed in a restricted account within **thirty (**30) days of the OMHSAS written approval of the reinvestment plan(s).
3. Report #12 Reinvestment Report is the format used for the monthly report as outlined in the Financial Reporting Requirements-HealthChoices Behavioral Health Program document (Attachment 6, updated annually).
4. Report #12 must be prepared on a cash-basis (report deposits and payments in the month in which they occur). No accruals for services should be reflected in this report.
5. A separate report is required for HealthChoices recipients and for Other, non-HealthChoices or non-identifiable recipients.
6. Expenses are to be reported based on HealthChoices recipients and for Other, non-HealthChoices or non-identifiable recipients. To the extent that is not possible and the expenses must be allocated, then an allocation methodology will need to be submitted and received before written approval from DHS will be generated
7. If Reinvestment Funds from more than one (1) Agreement year are being utilized, a separate set of reports must be filled out for each Agreement year's Reinvestment Funds.
8. Interest earned from the reinvestment account must be reported on Report #12. Expenditures of interest earned must be consistent with an approved plan.
9. Funds are withdrawn from the reinvestment account in accordance with a plan approved by OMHSAS. No funds can be distributed, or expenditures incurred, prior to the date of the OMHSAS approval letter.
10. Primary Contractors must return any unexpended Reinvestment Funds to DHS within six (6) months of the date by which funds were approved to be spent, unless the timeframe for expenditure of these funds was extended by OMHSAS. After that time, unexpended Reinvestment Funds must be returned to DHS.
11. In the event the Agreement with the Department ends and is not renewed, all funds, except for those in DHS approved reinvestment plans, or Reinvestment Funds in a plan submitted to DHS but which DHS has not taken a positive or negative action, remaining in the Primary Contractor's Special Revenue Fund or Enterprise Fund, or held by any Subcontractor, inclusive of Risk and Contingency Funds, not expended for the HC BH transaction, must be returned to the Department within fourteen (14) months from the expiration of the Agreement.

Funds identified in a reinvestment plan submitted to DHS, but on which DHS has not taken a positive or negative action, are not considered Discretionary Funds.

F. Modifications to Approved Reinvestment Plans

1. Proposed changes or modifications to an approved reinvestment plan priority must be submitted in writing. Written confirmation of approval of a change will be issued by OMHSAS within the approval timelines described below.
2. Changes may include a request to: extend the timeframe for expenditure of funds, revise the approved program, withdraw an approved plan and propose a new plan for use of the funds, or change the amount of expenditure when approval of such a change is required.
3. A request for an extension of an approved reinvestment plan (numbered by priority) must be received forty-five (45) days prior to the end of the final contract expenditure year stated on the OMHSAS reinvestment approval letter and must indicate the reason extension. OMHSAS will provide a written response to a request for extension. Failure to meet this 45-day requirement may result in DHS's recovery of these funds**.**
4. If program or service plan modifications are requested after a reinvestment plan priority has been approved by OMHSAS, the Primary Contractor must use this same format (Attachment 3) to submit a request for change. Stakeholder involvement, and documentation of such, must occur if a new reinvestment plan priority is being proposed to substitute for a previously approved priority.
5. Any revisions to the amount approved for an individual reinvestment plan priority which is the greater of twenty-five percent (25%) or $50,000 for the priority being revised, must be approved by OMHSAS in advance. Examples include:
   a. A plan has been approved for $100,000. The Primary Contractor wishes to decrease the plan by $40,000. This change could be made without approval since the greater of 25% or $50,000 has not been exceeded, or;
   b. A plan is approved for $1M. The county wishes to increase the plan by $300,000. This change would have to be approved since the change is the greater than 25% (25% equals $250,000).
6. The Reinvestment Report-Budget forms (Attachment 4) will be used to track approved changes for expenditures and reinvestment plan priorities from a contract year.

G. Annual Report on HealthChoices Reinvestment Plans

1. Submission of an Annual Report on HealthChoices Reinvestment Plans for approved reinvestment plans from the previous contract year and those plan

priorities that continue to be funded with reinvestment dollars is required. The annual report of Reinvestment Funds is to include a program summary for each reinvestment plan priority that continues to be funded with reinvestment dollars.

2. The Annual Report on HealthChoices Reinvestment Plans is due on the last day of the thirteenth (13th) month from the end of the contract year. The required format for submission is attached (Attachment 7). An updated budget is required to be submitted annually.
3. OMHSAS provides a summary of all approved reinvestment plans to stakeholders. The summary is published in the OMHSAS HealthChoices Behavioral Health Program Annual Report.
4. A summary of the Annual Report on HealthChoices Reinvestment Plans is also distributed to stakeholders.

Instructions for Completing the Reinvestment Budget Form (Initial Budget Submission and Revisions):

The HealthChoices reinvestment plan must include a budget form. It is understood that adjustments to IBNRs, interest, and other items may impact the amounts available. Changes to the amount available and the corresponding budget should be handled as follows:

The **initial budget submission** should be included with the reinvestment plan and should reflect the exact amounts specified in the reinvestment plan. These amounts should be shown in the "Initial/Previous Budget" column.

Subsequent to the initial budget submission, **revisions** to the budget must be submitted as follows:

- An updated budget **must** be submitted with the annual reinvestment update.
- If a change is being proposed to any item within the budget, approval must be given by OMHSAS for the change if it is greater than 25% of the current priority amount or $50,000, whichever is higher. The request for approval must include a revised budget reflecting the proposed changes.
- Any changes due to IBNR adjustments or interest earned since the last budget was submitted should be reflected in the "Revision Amount" column.

Anytime revisions to the budget are being submitted, the most recent budget amounts should be reflected in the "Initial/Previous Budget" column.

When reporting actual reinvestment expenditures on Financial Report #12, the budget amounts should reflect the most recent budget amounts submitted.

County – The County HealthChoices Behavioral Health program for which the reinvestment budget is being submitted.

Date – The date the budget form is being prepared.

Reinvestment Funds from – The contract year that the reinvestment funds are applicable to.

Category of Eligibility – There are four separate forms:

HealthChoices Recipients – provide amounts that will be targeted to individuals who are enrolled in the HealthChoices Behavioral Health program.

MA Recipients – provide amounts that will be targeted to individuals who are eligible for medical assistance benefits but NOT enrolled in the HealthChoices Behavioral Health program.

Non-MA Recipients – provide amounts that will be targeted to individuals who are not eligible for medical assistance benefits.

Total – provide totals for amounts provided on individual forms.

Allocations/Contributions – Indicate the amount anticipated to be available.

Investment/Interest Income – Indicate an estimate of any interest to be earned over the course of the reinvestment spending period. This line item cannot be $0; an estimate **must** be provided.

Total Available – Add Allocations/Contributions and Investment/Interest Income.

Reinvestment Services (Identify) – List each reinvestment plan item, along with the specific budget amount. Please use the same description and amount used in the reinvestment plan.

Total Reinvestment Services – Sum of the individual reinvestment services.

Remaining Balance – Allocations/Contributions plus Investment/Interest Income minus Total Reinvestment Services.

Step #	Responsible Entity	Step Description	Due Date
1	Contractor	HealthChoices Contract Audit Completed	CY May 15 SFY November 15
2	Contractor	Identifies amount of reinvestment funds available	CY August 15 SFY February 15
3	Contractor	Confirm with OMHSAS amount of reinvestment funds available. Submit draft reinvestment plans to OMHSAS Field Office.	CY September 1 SFY March 1
4	OMHSAS Field Office	Provide feedback to Contractor on draft plans	
5	Contractor	Submit final reinvestment plans to OMHSAS Field Office	30 days after receiving OMHSAS feedback on draft plan
6	OMHSAS/BPPD	Distribute plans to DHS Reinvestment Review Team	
7 8	DHS Reinvestment Review Team OMHSAS Field Office	Identifies any additional information needed **or** approves if no additional information is required Provides feedback on final plans	
9	OMHSAS Field Office	Prepares summary of County responses received. Prepares draft approval letter.	
10	OMHSAS	Sends final approval letter to County	
11	Contractor	Implementation begins when approval letter is received and funds have been deposited	
12	Contractor	Annual Report on HC Reinvestment Plan for approved plan	CY January 31 SFY July 31

COMMONWEALTH OF PENNSYLVANIA
DEPARTMENT OF Human Services
OFFICE OF MENTAL HEALTH AND SUBSTANCE ABUSE SERVICES
BUREAU OF OPERATIONS AND QUALITY MANAGEMENT
P.O.BOX 2675
HARRISBURG, PENNSYLVANIA 17105-2675

BOQM Director
Telephone: (717) 772-6650
Fax: (717) 772-6737
E-Mail:

Example

Date
County MH/MR Administrator

Dear Administrator:

The_____County HealthChoices reinvestment plan for funds generated during calendar year_____has been approved. Acceptance of the following initiatives is confirmed.

Type of Service	Budget Amount	In-Plan-Start-up, Supplemental, Or Non-Medical	Contract Expenditure Year(s)
Priority 1 Continuation of Funding for Community Treatment Teams	$600,000	Supplemental	2002 – 2003
Priority 2 Psychiatric Rehabilitation Services	$400,000	Supplemental**	2002 – 2003

HealthChoices reinvestment funds need to be kept in a separate, restricted bank account and statements for the account must be submitted to the Department each month. Funds must be deposited no later than 30 days after the date of this approval. Also, an annual report on the use of reinvestment funds during_____will be due on _____.

[Note: Plans that contain Bricks and Mortar will be annotated with two asterisks and will include the following statement: "**The County reinvestment plan submission is in compliance with the DHS requirements as stated in the Review and Approval Guidelines for Reinvestment Plans that Provide Costs for Facility or Real Estate Purchase, Renovation or Purchase of Fixed Assets. The HealthChoices reinvestment funds are one-time only funds and start-up costs of these services are not considered in the HealthChoices rate setting process. The Department of Public Welfare has no obligation to continue to fund services approved for this reinvestment plan."]

Reinvestment plans should be implemented in accordance with the approved timeframes. Any delay in implementing the plan should be communicated to OMHSAS. The monitoring of HealthChoices reinvestment funds will be discussed during monthly HealthChoices monitoring meetings. However, if you have questions or concerns that require immediate attention, please be in contact with your Monitoring Team leader or Community Program Manager.

Sincerely,

Director

HEALTHCHOICES REINVESTMENT PLAN PRIORITY

County_____

Reinvestment Plan from contract year_____ Date of Submission_____

Name of Service_____

New Plan_____ Continuation Plan_____ Amended Plan _____

Reinvestment Service or Program – (check all categories that apply)

In-Plan Start-up _____ TOTAL Reinvestment $ Requested:	**Non-Medical Only _____** TOTAL Reinvestment $ Requested:
Supplemental – In Lieu of _____ Approved_____Procedure Code_____ Newly Proposed_____ Budget a. Clinical/Operating $_____ Budget b. One-time costs $_____ TOTAL Reinvestment $ Requested:	**Supplemental – In Addition to _____** Budget a. Clinical/Operating $ _____ Budget b. One-time costs_____ TOTAL Reinvestment $ Requested: _____

Priority_____of_____submitted **Year(s) in which funds are to be spent _____**

Target Population: (MA eligible target population, population characteristics, number people served annually)

Description of Program or Service: (Describe program, for: In-Plan start up- under one year. Indicate service is to be licensed; Supplemental In-Lieu of- why service is a cost effective alternative, staffing FTEs/qualifications; Children's Supplemental requires BHRS program exception application; Supplemental- In Addition to – why expected to be cost effective or appropriate but not cost effective, staffing FTEs/qualifications; and Non-Medical Only- used when all costs are non-medical)

Description of Fund Expenditures: (Narrative identifying major budgeted items for clinical and operating expenses and total costs. Identify on-going funding source for program/services. Provide Attachment 5 information as applicable).

Clinical Costs* – Narrative and major budgeted items, includes personnel and benefits

Operating Costs** – Narrative and major budgeted items, includes operating incurred during the course of normal business, rent, travel, telephone, office supplies, etc.

Facility or land Purchase or Renovation**:** (Attachment 5: Summarize what is being purchased/ renovated and ownership arrangement including who owns title. Indicate agreement for disposal of assets upon sale.)

Fixed Assets: (Identify fixed assets to be purchased - vehicles, computers, furniture, equipment, etc. Indicate County Code for purchasing will be followed for items requiring competitive bid. See Attachment 5, if applicable.)

Data Analysis and Expected Outcomes: (Identify number of HC members in target population, describe unmet or under-met needs, what is expected to be achieved by the service and data to be collected to measure outcomes. For Supplemental In-Lieu of services identify the service from which cost offsets will be achieved.)

Stakeholder Involvement in Decision Making: (Stakeholder participation summarized and demonstrated support)

Reinvestment Funds from_____
(Contract Year)

Category of Eligibility -____HealthChoices Recipients

Reinvestment Account	Initial/Previous Budget	Revision Amount*	Revised Budget
Allocations/contributions			
Investment/interest income			
TOTAL AVAILABLE			
Less: Approved distributions for:			
Reinvestment Services (Identify)			
TOTAL REINVESTMENT SERVICES			
REMAINING BALANCE			

*Revisions to any item that represent a change of >25% or $50,000 require approval from OMHSAS. An explanation **must** be provided for all budget revisions, regardless of the amount.

Reinvestment Budget 060306 Prepared by OMHSAS /DMFR

Reinvestment Funds from_____
(Contract Year)

Category of Eligibility -____MA Recipients

Reinvestment Account	Initial/Previous Budget	Revision Amount*	Revised Budget
Allocations/contributions			
Investment/interest income			
TOTAL AVAILABLE			
Less: Approved distributions for:			
Reinvestment Services (Identify)			
TOTAL REINVESTMENT SERVICES			
REMAINING BALANCE			

*Revisions to any item that represent a change of >25% or $50,000 require approval from OMHSAS. An explanation **must** be provided for all budget revisions, regardless of the amount.

Reinvestment Budget 060306 Prepared by OMHSAS /DMFR

Reinvestment Funds from_____
(Contract Year)

Category of Eligibility -____Non-MA Recipients

Reinvestment Account	Initial/Previous Budget	Revision Amount*	Revised Budget
Allocations/contributions			
Investment/interest income			
TOTAL AVAILABLE			
Less: Approved distributions for:			
Reinvestment Services (Identify)			
TOTAL REINVESTMENT SERVICES			
REMAINING BALANCE			

*Revisions to any item that represent a change of >25% or $50,000 require approval from OMHSAS. An explanation **must** be provided for all budget revisions, regardless of the amount.

Reinvestment Budget 060306 Prepared by OMHSAS /DMFR

Reinvestment Funds from_____
(Contract Year)

Category of Eligibility -____Total

Reinvestment Account	Initial/Previous Budget	Revision Amount*	Revised Budget
Allocations/contributions			
Investment/interest income			
TOTAL AVAILABLE			
Less: Approved distributions for:			
Reinvestment Services (Identify)			
TOTAL REINVESTMENT SERVICES			
REMAINING BALANCE			

*Revisions to any item that represent a change of >25% or $50,000 require approval from OMHSAS. An explanation **must** be provided for all budget revisions, regardless of the amount.

Reinvestment Budget 060306 Prepared by OMHSAS /DMFR

Review and Approval Guidelines for Reinvestment Plans that Provide for Costs for Facility or Real Estate Purchase, Renovation or Purchase of Fixed Assets

All reinvestment plan priorities containing costs for facility or real estate purchase, renovation, housing development, vehicle acquisition, and/or purchase of fixed assets must adhere to these Reinvestment Plan Guidelines and applicable provisions of the local County Code.

Reinvestment Plan Submission:

Conditions that apply to reinvestment plan priorities that contain costs for facility or real estate purchase, renovation, housing development, vehicle acquisition, and or purchase of fixed assets are:

1. Primary purpose of the reinvestment plan priority must be to serve MA eligibles with mental health and/or drug and alcohol treatment service needs.

2. The reinvestment plan priorities must contain a statement of the rationale for the development of the program and related capital costs.

3. The reinvestment plan priority must explain the financial strategy for acquiring the property, facility or vehicle and why that method is cost effective. Identify whether the facility/vehicle will be purchased or leased or will facility costs be built into the service rate.

   Each County will describe the housing capital development strategy and why acquisition by a housing organization is cost effective from a housing finance perspective. The housing development strategy shall also specify the following: amount of reinvestment resources budgeted, types of rental housing (e.g. new construction or rehabilitation), and plan to adminster the housing development funds.

4. The reinvestment plan priority must summarize the ownership arrangement between the County and provider and specify the party that holds title to fixed assets. Identify related parties when there is common ownership. Provide a detailed data analysis supporting the request as part of the reinvestment plan. The data analysis must support the need for the project proposed. The analysis should include, for example, analysis of the provider network demonstrating a gap in service, rationale for cost effectiveness of the purchase, description of underserved target population to be served, etc.

5. The County may enter an agreement to provide capital resources with a qualified housing organization in exchange for the set-aside of specific number of rental units for MA eligible consumers protected by a long term use restriction. The ownership arrangement for any capital development for supportive housing should identify the property to be acquired or replaced, number of set-aside units within the overall development that the county will have priority access over a specified period of time, how consumer access will be assured, the affordability of the rents to be paid by the MA eligible consumer, how the county will be reimbursed or be assured that the use restriction for these set-aside units remains in place in the event the property goes into foreclosure or the owner violates the terms of the agreement or the use restriction. Rental subsidies assigned to these set-aside rental units to ensure affordability for a specified period of time can be considered in exchange for investment based on a financial analysis that the exchange is of like or greater value.

6. The reinvestment plan priority must include a budget in sufficient detail to demonstrate how the amount identified in the reinvestment plan priority request was determined. This should include budgeted items (e.g. personnel, equipment, operating costs, transportation, repairs, etc.) and associated costs as well as any pertinent assumptions.

7. The reinvestment plan priority must contain information about the source of operating funds for the continuation of the program or service after one-time reinvestment plan funds are expended.

   For housing development plans, identify the number of units that will be available for a specified period of time. If the County intends to retain a housing agency to administer the housing development funds on their behalf, the reinvestment plan must include detailed information on the County's selection process, the selection criteria to be used, the administrator's duties/responsibilities, and the expected administrative fee to be paid to the administrator.

8. Purchase of vehicles is not permitted for transportation to MA services of MA eligible members otherwise served by the Medical Assistance Transportation Program (MATP).

County-Provider Reinvestment Plan Agreement:

Any agreement entered into between the County and a provider for the purpose of implementing a reinvestment plan priority, which contains costs for facility or real estate purchase, renovation, vehicle acquisition, and/or purchase of fixed assets, must:

1. Be reduced to writing

2. Be targeted to Medical Assistance eligibles with mental health and/or drug and alcohol service needs. For a housing development strategy the eligibles must be included as a priority population for housing services.

3. Assure that the acquisition or renovation is likely to be used in the HC program for at least five years and be subject to specified disposition requirements.
4. Identify any related parties and the relationship of the related parties regarding the accomplishment of the reinvestment plan.

5. Specify ownership rights, use of the facility, and the process for disposition of fixed assets in the event a sale should occur.

   For housing development funds, the funds must be secured by legally binding documents that are in acceptable forms. Such forms include but are not limited to: mortage, promissory note, loan agreement and restrictive covenant.

   These legally binding housing documents will address how the restriction of use will be passed on to the future owner in the event of property transfer as well as how the County will be reimbursed or be assured the use restriction for the set-aside units will stay in place in the event the property goes into foreclosure or the owner violates the terms of the agreement or the use restriction.

6. In the event of a sale, proceeds from the sale are to be returned to the County HealthChoices program for reinvestment in programs or services for MA eligible members**.** This provision is not applicable to housing development plans.

7. Specify the accounting method to be used in expensing, depreciating or amortizing costs. This provision is not applicable to housing development plans

8. Require maintenance, repair and insurance of fixed assets.

   In the case of a facility being purchased for housing, the County should specify the required maintenance and insurance of fixed assets. To ensure a property is maintained, the County or its designee will require or conduct periodic inspections to ensure compliance with HUD's Housing Quality Standards (HQS). Failure of inspection may trigger foreclosure or other actions as specified by the

County. The County should be named on the insurance of fixed assets to order for the County to be notified if coverage ceases and failure to maintain insurance of fixed assets can also trigger foreclosure or other action as specified by the County.

9. Require competitive bidding or written estimates as required by County Code or prudent business practices.

10. Be reviewed and approved by the County Solicitor and/or other appropriate County official (e.g. MH/MR legal counsel) to ensure compliance with these Reinvestment Plan Guidelines and applicable County Code provisions.

11. Contain a budget that details the costs associated with the facility renovation or purchase of fixed assets as submitted in the County's reinvestment plan priority. This provision is not applicable to housing development plans

3.12 Report #12 - Reinvestment Report

The purpose of this report is to monitor reinvestment activity. All approved allocations to and distributions from the reinvestment account are to be shown on this report. This report must be prepared on a cash-basis (report deposits and payments in the month in which they occur). No accruals for services should be reflected on this report.

Reinvestment funds can be deposited when identified, but **must** be placed in a restricted account within 30 days of the OMHSAS written approval of the County's reinvestment plan(s).

IMPORTANT NOTE: The services reported on this report should NOT be reported on Report #9. Report #9 should only reflect those medical services being provided under the current year's capitation revenue.

Columns are provided for reporting the number of unduplicated recipients served, current month units of service provided and dollar amount paid for those services, as well as cumulative year to date and contract to date units of service provided and dollar amount paid. A separate report must be provided for each of the following categories of aid:

1. All HealthChoices(all HealthChoices eligible recipients)
2. Other (non-HealthChoices recipients or non-identifiable recipients)
3. Total (total of the two categories above)

A methodology for allocating costs that are not attributable to a specific category of aid must be submitted and approved by DHS prior to implementation.

In addition, if reinvestment funds from more than one contract year are being utilized, a separate set of reports must be filed for each contract year's reinvestment funds.

The count of unduplicated recipients should be unduplicated by each individual reinvestment service and should reflect unduplicated recipients on a contract to date basis.

The Prior Period Balance is the reinvestment account balance as of the last day of the prior calendar month for the "Current Period" column; the reinvestment account balance as of the last day of the prior year for the "Year to Date" column; and $0 for the "Contract to Date" column.

Allocations/contributions are funds transferred into the reinvestment account.

Investment Revenue is income generated by the undistributed funds retained in the reinvestment account. Reinvestment revenue represents earnings on prior year funds and should appear on Report #12 only.

Approved Distributions are funds withdrawn from the reinvestment account in accordance with the DHS-approved Reinvestment Plan. A written plan for reinvestment must be submitted to and approved by DHS prior to making any distribution. Administrative costs, such as bank fees, should be reported on a separate line. Any administrative costs reported **must** be disclosed in detail in the footnotes to these reports.

Ending Balance is the reinvestment account balance as of the end of the last day of the calendar month.

The Budgeted Amount column should reflect the amounts and services contained in the DHS-approved reinvestment plan. Budgeted Investment/Interest Income should reflect either estimated interest to be earned on HealthChoices funds deposited in the reinvestment bank account and included in the Budget Forms submitted with your reinvestment plans to DHS for approval or interest earned on funds deposited in the reinvestment bank account and allocated to approved reinvestment plans. Budgeted Amounts are not required to be allocated by rating group and can be reported only on the Total page. For electronic reporting, Budgeted Amounts may be reported in total as "Other".

The HealthChoices Behavioral Health Program Requirements for County Reinvestment Plans requires that revisions to an individual reinvestment plan priority, which are the greater of twenty-five percent (25%) or $50,000 for the priority being revised, be approved by OMHSAS in advance. Revisions less than the preceding requirements can be made without OMHSAS approval. All revisions to budget amounts made without OMHSAS approval must be included in the footnotes to the reports.

The bank statements for the reinvestment account, as well as the bank reconciliation that reconciles the general ledger to the reinvestment account bank statements, must be submitted with each month's report. The Department reserves the right to request additional documentation.

Reinvestment Report Form

Appendix N
Attachment 6b

Statement as of: _____(Reporting Date)

County: _____(County Name)

Reported By: _____(Reporting Entity)

For: _____(Year of Reinvestment Funds)

Rating Group: _____(Rating Group)

Reinvestment Account Activity	Unduplicated Recipients	Current Period Units of Service Provided	Current Period $ Amount	Contract to Date Units of Service Provided	Contract to Date $ Amount	Budget Amount
1. Prior Period Balance						
2. Allocations/contributions						
3. Investment/interest income						
4. SUBTOTAL (Lines 2 and 3)						
5. TOTAL (Lines 1 and 4)						
Less: Approved distributions for Reinvestment Services (identify):						
6. TOTAL						
7. Ending Balance (Line 5 minus Line 6)						

THIS REPORT FORMAT SHOULD BE USED FOR REPORTING MONTHS BEGINNING WITH 1/03.

COUNTY ANNUAL REPORT ON HEALTHCHOICES REINVESTMENT PLANS

_____ COUNTY

Name of Service: _____ In-Plan-Start-up_____Supplemental_____Non-medical _____ Bricks and Mortar_____ Priority_____of_____ for Reinvestment Funds from Contract Year _____
Description of Program Service:
Progress in Implementing the Program or Service Including Expenditure of Funds:
Impact on Target Population:
Describe how the Program or Service is meeting the goals of HealthChoices (access, quality of life, improved health outcomes, cost effectiveness, etc.)

Note: An updated budget (Attachment 4) must be submitted with this report.

Prepared by: _____ Date: _____

HealthChoices Behavioral Health
Data Support Files and Resources
for Behavioral Health Managed Care Organizations

ON-LINE INQUIRY ACCESS:
Each Behavioral Health Managed Care Organization (BH-MCO) will be required to connect to the Pennsylvania Open System Network (POSNet) for the purpose of on-line inquiries and file transfers. Specifications and limited technical assistance will be made available through the Department's Business Partner Help Desk. No information made available to the BH-MCO is to be used for any purpose other than supporting their work program under HealthChoices.

OMHSAS will provide hands-on training on the use and interpretation of Inquiry information found on the system.

- Client Information System (CIS)
  The Department will make available to each BH-MCO access to the Department's CIS database. This database provides eligibility history and demographic information to support the BH-MCO in meeting their obligations.

- Provider Database System
  Each BH-MCO has access to provider base information, including provider number, location, enrollment status, provider type and specialty.

- Reference Transactions System
  This system allows BH-MCO inquiry into drug, procedure code and diagnosis code information.

ELIGIBILITY VERIFICATION:
The Department provides the BH-MCO with an option for verifying Medical Assistance and HealthChoices eligibility, other than CIS inquiry.

- Eligibility Verification System (EVS)
  Each BH-MCO will be provided access to the Department's EVS. Telephone, Personal computer and Point of Sale device methods can be used to access the system. EVS can be used to verify Medical Assistance Eligibility, PH-MCO and BH-MCO coverage, primary care practitioner, TPL resources and other information.

DATA SUPPORT FILE TRANSMISSIONS:
The Department provides the BH-MCO with many data files for use in managing their program. These files are critical to the effective management of the program. Additional files, other than those listed as follows, may be made available by the Department as business needs evolve. The Department will transfer files via Secure eGOV. The file formats are subject to change by the Department and by HIPAA mandates.

HealthChoices Behavioral Health
Data Support Files and Resources
for Behavioral Health Managed Care Organizations

Capitation Payment/Reimbursement Files:

File Description	File Name	Purpose	Frequency	From	To
820 Capitation	PMMRCCSS.MM.zip (P=constant; MM=Plan Code; R=Capitation; CC=Financial Cycle Number; SS=Sequence number	File of actual recipients paid for by DHS.	Monthly; Sent by the 5th of the month	PROMISe	BH-MCOs
MCO Payment Summary File	MPSMYJJJ.MM.zip (MPSM=Constant; YJJJ=Last Digit Year Julian Year; MM=Plan Code)	Summary file of capitation payments by county group rate cell and date of service up to 36 months.	Monthly; Sent by the end of the 2nd week of the month	PROMISe	BH-MCOs

Data Files:

File Description	File Name	Purpose	Frequency	From	To
PH/BH Pharmacy File	BHPHpharmMMDDYY.txt (BH=receiving BH-MCO; PH=submitting PH-MCO; pharm=pharmacy data; MM=Month; DD=Day; YY=Year)	Pharmacy data from physical health plans to the behavioral health plans.	Sent according to schedule developed by PH-MCO; at least twice a month.	PH-MCOs	BH-MCOs
FFS Pharmacy File	XX80pharmMMDDYY.txt (XX = Receiving PH-MCO, 80= indicates information is coming from FFS, pharm = pharmacy data, MM = Month, DD=Day, YY=Year, .txt = file extension for ASCII)	Pharmacy data from FFS to the physical health and behavioral health plans.	Weekly; Wed.	PROMISe	BH-MCOs

HealthChoices Behavioral Health
Data Support Files and Resources
for Behavioral Health Managed Care Organizations

Eligibility Files/CIS-Related Files:

File Description	File Name	Purpose	Frequency	From	To
ARM568 File	xxARM568.ddd (XX=MCO Code; ARM568=Constant; ddd=Julian Date)	Report file of CIS eligibility statistics by county/ district.	Monthly; Sent on the Monday following the first full weekend of the month	DHS	BH-MCOs
834 Daily Eligibility File	FDXXJJJS.MM.zip (F=Constant; D=Daily; XX=Plan Code; JJJ=Julian Day; S=Sequence Number)	File of any change affecting address, category of assistance, county and district indicators, and plan coverage that day for a managed care recipient.	Daily; sent every state work day.	HP Translator	BH-MCOs
834 Monthly Eligibility File	FMXXJJJS.MM.zip (F=Constant; M=Monthly; XX=Plan Code; JJJ=Julian Day; S=Sequence Number; X12=Constant)	File of all MA eligible recipients who are covered by the plan at some point in the next month only. One record per recipient (most recent).	Monthly; created on the next to the last Saturday of the month.	HP Translator	BH-MCOs
TPL File	xxTPL766 (xx=MCO Code; TPL766=Constant)	TPL data for each MCO's members.	Monthly; Sent by the 25th of the month, regardless of holidays or weekends.	DHS	BH-MCOs

HealthChoices Behavioral Health
Data Support Files and Resources
for Behavioral Health Managed Care Organizations

Provider Files:

File Description	File Name	Purpose	Frequency	From	To
List of Active and Closed Provider files	PRV414W.MM.zip PRV415M.MM.zip (PRV414 or PRV415=Constant; M=Monthly, W=Weekly; MM=Plan Code)	File of statewide MA providers.	Weekly; Tuesdays Monthly; Sent on the 1st of the month	PROMISe	BH-MCOs
Quarterly Network Provider File	PRV640Q.MM.zip (PRV640= Constant; Q=Quarterly; MM = Plan Code	File of MCO's providers, as returned to the MCO.	Quarterly; Sent on the 1st of the following months – January, April, July and October.	PROMISe	BH-MCOs
Response to the PRV640M Provider File	PRM640M.MM.rpt (PRM640=Constant; M=Monthly; MM=Plan Code)	Report of MCO provider records returned by DHS due to error.	Monthly; Sent within 48 hrs. of receiving the PRV640M. MM.zip	PROMISe	BH-MCOs
NPI Crosswalk	PRV430W	File of all active NPI records.	Weekly; Fridays	PROMISe	BH-MCOs
Special Indicator File	PRV435W	File of provider/service locations and special indicators.	Weekly; Fridays	PROMISe	BH-MCOs

HealthChoices Behavioral Health
Data Support Files and Resources
for Behavioral Health Managed Care Organizations

Reference Files:

File Description	File Name	Purpose	Frequency	From	To
Reference Diagnosis Code File	DIAGYJJJ.MM.zip (DIAG=Constant; YJJJ =Last Digit Year; MM=Plan Code)	ICD-9	Monthly; Sent on the 1st of the month.	PROMISe	BH-MCOs
Procedure Code Extract	PROCYJJJ.MM.zip (There are 5 files within this file.) They are: mcmod01.dat mcproc01.dat mctype01.dat mcprst01.dat mcprel01.dat (PROC=Constant; YJJJ=Last Digit Year Julian Day; MM=Plan Code)	The procedure Code File contains 5 files within the zip file: Modifier Max Fee, Procedure Code, Provider Type, Restricted, and Related.	Monthly; Sent on the 1st of the month	PROMISe	BH-MCOs

HealthChoices Behavioral Health
Data Support Files and Resources
for Behavioral Health Managed Care Organizations

HIPAA Transaction Reports/Files:

File Description	File Name	Purpose	Frequency	From	To
ZZZ Full File Reject Report	Original File Name.zzz.zip	This report is sent from the translator in response to incoming HIPAA transaction files from the MCOs.	Daily	HP Translator	BH-MCOs
997 Full File Reject Report	Original File Name.997.zip	This report is sent from the translator in response to incoming HIPAA transaction files from the MCOs.	Daily	HP Translator	BH-MCOs
Record Accept/Reject Report	Original File Name.txn.zip	This report is sent from the translator in response to incoming HIPAA transaction files from the MCOs.	Daily	HP Translator	BH-MCOs
Record Accept/Reject File	Original File Name.ext.zip	This report is sent from the translator in response to incoming HIPAA transaction files from the MCOs.	Daily	HP Translator	BH-MCOs

HealthChoices Behavioral Health
Data Support Files and Resources
for Behavioral Health Managed Care Organizations

Notes:

*The Department reserves the right to occasionally modify the transmission schedule of data support files, based on operational need. Advance notice will be provided to business partners. Primary Contractors must refer to the Pennsylvania HealthChoices Managed Care website for the latest file specifications and file transfer schedules. https://dpwintra.dpw.state.pa.us/HEALTHCHOICES/custom/schedule/dpwfilespecs/dpwfilespecs.asp

**HIPAA Implementation guides and Addenda for the various types of transactions are available from the Washington Publishing Company at www.wpc-edi.com/hipaa/. These documents constitute the official HIPAA reporting standards as defined by the Accredited Standards Committee (ASC) X12.

***Pennsylvania PROMISe Companion Guides for each of the types of transactions may be obtained, free of charge, by contacting OMHSAS directly. The Companion Guides provide detailed information specific to the elements within the 834 and 820 files from the PROMISe system.

HEALTHCHOICES BEHAVIORAL HEALTH PROGRAM

PROGRAM STANDARDS AND REQUIREMENTS
PRIMARY CONTRACTOR

APPENDIX P

HealthChoices Behavioral Health Financial Reporting Requirements (FRR's)

The current FRR is located at:

http://www.dhs.state.pa.us/publications/healthchoicesbehavioralhealthpublications/index.htm

HEALTHCHOICES BEHAVIORAL HEALTH SERVICES

PRIORITY POPULATIONS

MENTAL HEALTH *Reference: Mental Health Bulletin, OMH-94-04*
Adult *Serious Mental Illness: Adult Priority Group*

In order to be in the Adult Priority Group, a person: must meet the federal definition of serious mental illness[1]; must be age 18+, (or age 22+ if in Special Education); must have a diagnosis of schizophrenia, major affective disorder, psychotic disorder NOS or borderline personality disorder (DSM-IV or its successor documents as designated by the American Psychiatric Association, diagnostic codes 295.xx, 296.xx, 298.9x or 301.83); and must meet at least one of the following criteria: A. (Treatment History), B. (Functioning Level) or C. (Coexisting Condition or Circumstance).

A. Treatment History

1. Current residence in or discharge from a state mental hospital within the past two years; or

2. Two admissions to community or correctional inpatient psychiatric units or residential services totaling 20 or more days within the past two years; or

3. Five or more face-to-face contacts with walk-in or mobile crisis or emergency services within the past two years; or

4. One or more years of continuous attendance in a community mental health or prison psychiatric service (at least one unit of service per quarter) within the past two years; or

5. History of sporadic course of treatment as evidenced by at least three missed appointments within the past six months, inability or unwillingness to maintain medication regimen or involuntary commitment to outpatient services; or

6. One or more years of treatment for mental illness provided by a primary care physician or other non-mental health agency clinician, (e.g., Area Agency on Aging) within the past two years.

B. Functioning Level

Global Assessment of Functioning Scale (DSM-IV-R, pages 12 and 20) rating of 50 or below.

[1] Adults with serious mental illness are persons age 18 and over, who currently or at any time during the past year, have had a diagnosable mental, behavioral, or emotional disorder of sufficient duration to meet diagnostic criteria specified within DSM-IV that has resulted in functional impairment which substantially interferes with or limits one or more major life activities. (See Reference for additional detail)

C. Coexisting Condition or Circumstance

1. Coexisting Diagnosis:

a. Psychoactive Substance Use Disorder; or
b. Intellectual Disabilities; or
c. HIV/AIDS; or
d. Sensory, Developmental and/or Physical Disability; or

2. Homelessness[2]; or

3. Release from Criminal Detention[3].

In addition to the above, any adult who met the standards for involuntary treatment (as defined in Chapter 5100 Regulations - Mental Health Procedures) within 12 months preceding the assessment is automatically assigned to the high priority group.

MENTAL HEALTH
Child and Adolescent

Reference: "Child and Adolescent Target Groups 1, 2, &3" in 1994 Community Mental Health Services Block Grant Application

I. The Child and Adolescent Priority Group 1 includes persons who meet all four criteria below:

A. Age: birth to less than 18 (or age 18 to less than 22 and enrolled in special education service).

B. Currently or at any time in the past year have had a DSM-IV diagnosis (excluding those whose sole diagnosis is intellectual disabilities or psychoactive substance use disorder or a "V" code) that resulted in functional impairment which substantially interferes with or limits the child's role or functioning in family, school or community activities.

C. Receive services from mental health and one or more of the following:

1. Intellectual Disabilities
2. Children and Youth
3. Special Education
4. Drug and Alcohol
5. Juvenile Justice
6. Health (the child has a chronic health condition requiring treatment)

D. Identified as needing mental health services by a local interagency team, e.g., CASSP Committee, Cordero Workgroup.

[2] Homeless persons are those who are sleeping in shelters or in places not meant for human habitation, such as cars, parks, sidewalks or abandoned buildings.

[3] Applicable categories of release from criminal detention are jail diversion; expiration of sentence or parole; probation or Accelerated Rehabilitation Decision (ARD).

In addition to the above, any child or adolescent who met the standards for involuntary treatment within the 12 months preceding the assessment (as defined in Chapter 5100 -Mental Health Procedures) is automatically assigned to this priority group.

II. Second priority[4] is associated with children at-risk of developing a serious emotional disturbance by virtue of :

A. A parent's serious mental illness.
B. Physical or sexual abuse.
C. Drug dependency.
D. Homelessness.
E. Referral to the Student Assistance Programs.

DRUG AND ALCOHOL

Reference: Commonwealth of Pennsylvania Federal Fiscal Year 1996, Substance Abuse Prevention and Treatment Block Grant Application

The priority population for drug and alcohol treatment services includes:

- Pregnant Females and Women with Children
- Intravenous Drug Users
- Adolescents
- Persons with Severe Medical Conditions, such as Tuberculosis and HIV/AIDS.
- Mentally Ill Substance Abusers

[4] See reference for additional detail.

Encounter Data Submission Requirements

and Application of Sanctions for Noncompliance

I. CERTIFICATION REQUIREMENT

Each Behavioral Health Managed Care Organization (BH-MCO) or other entity intending to submit encounter data on behalf of a HealthChoices Behavioral Health Primary Contractor (Primary Contractor) must be certified through the Pennsylvania Reimbursement Operations and Management Information System in electronic format (PROMISe) prior to the submission of production encounter data. The Office of Mental Health and Substance Abuse Services (OMHSAS) will work with each submitter to ensure that the submitter can successfully receive, process, create, submit and reconcile HIPAA-compliant file transactions that meet Pennsylvania's requirements. Information on the certification process can be obtained by contacting OMHSAS at: OMHSAS-837Issues@pa.gov

II. SUBMISSION REQUIREMENTS

A. Timeliness

All encounters must be submitted and approved in PROMISe (i.e., pass PROMISe edits) on or before the last calendar day of the third month following the date that the BH-MCO paid/adjudicated the provider's claim or encounter. The Primary Contractor and its subcontractor(s) shall be responsible for maintaining appropriate systems and mechanisms to obtain all necessary data from its health care providers to ensure its ability to comply with encounter data reporting requirements.

1. Timeliness Performance Measures:

- In calendar year 2015, failure to consistently maintain a 96% compliance status of all BH-MCO-paid encounters having been PROMISe-submitted and PROMISe-paid within the required time frames may be subject to a sanction.
- In calendar year 2016, failure to consistently maintain a 98% compliance status of all BH-MCO-paid encounters having been PROMISe-submitted and PROMISe-paid within the required time frames may be subject to a sanction.
- In calendar years 2017 and forward, failure to consistently maintain a 100% compliance status of all BH-MCO-paid encounters having been PROMISe-submitted and PROMISe-paid within the required time frames may be subject to a sanction.

Encounter submissions adversely affected by PROMISe system deficiencies will not be included by the Department in the calculation of compliance percentages. Primary Contractors, BH-MCOs and other HealthChoices Behavioral Health business partners will be notified of the specific types of encounters which will excluded from penalty consideration under the timeliness performance measures.

B. Accuracy and Completeness

Accuracy and completeness are based on the consistency between encounter information submitted to the Commonwealth and information for the same service maintained by the BH-MCO in their claims/service history database.

1. Accuracy and Completeness Performance Measures:

- Accuracy and completeness will be determined through a series of analyses applied to BH-MCO claims history data and encounters received and processed through PROMISe.
- These analyses will be conducted annually by the Department (or its contractor), but more frequently, if necessary.
- The analyses will consist of a sample of records drawn from the BH-MCO service history and compared against encounters processed through PROMISe. Samples will be requested of the BH-MCO by the Department (or its contractor), with the sample size proportionally based on the BH-MCO financial expenditures for each transaction type submitted during the review period. Each analysis will be based on a statistically valid sample of no less than 200 records.

III. SANCTION PROVISIONS

Identified non-compliance with the Department of Human Services (Department) requirements, followed by either a failure to submit an acceptable corrective action plan for OMHSAS approval, or failure to fully implement an OMHSAS approved plan of corrective action, will result in the Department imposing sanctions on the Primary Contractor.

The Department will impose a sanction for failing to meet the Timeliness requirement and/or the Completeness and Accuracy requirement of encounter data reporting, regardless of whether any non-encounter data reporting-related sanction is being imposed on the Primary Contractor during, or for that same time period.

A. Timeliness

Effective January 01, 2015, failure to comply with the encounter data timeliness requirements will result in the following monthly sanctions:

Calendar Year 2015 - 1% of Monthly Paid Admin. Revenue (or $1,000, whichever is greater), to a maximum of $15,000 per month.

Calendar Year 2016 and beyond - 2% of Monthly Paid Admin. Revenue (or $2,000, whichever is greater), to a maximum of $25,000 per month.

B. Completeness and Accuracy

Effective January 01, 2015, errors in accuracy or completeness that are identified by the Department in the data analysis will result in sanctions as follows. An error in accuracy, or an error in completeness, or an error in both areas, within the same sample, counts as one error. The percentage of the sample that includes an error is calculated by dividing the total number of encounters within the sample that include an error by the total number of encounters in the sample.

Percentage of the sample that includes an error	Sanction
Less than 1.00%	None
1% – 4.99%	1.0% of Monthly Paid Admin. Revenue (or $2,000, whichever is greater), to a maximum of $10,000 per month.
5% – 7.49%	2.0% of Monthly Paid Admin. Revenue (or $2,000, whichever is greater), to a maximum of $25,000 per month.
7.50% - 9.99%	2.5% of Monthly Paid Admin. Revenue (or $2,000, whichever is greater), to a maximum of $50,000 per month.
10% or higher	5.0% of Monthly Paid Admin. Revenue (or $2,000, whichever is greater), to a maximum of $75,000 per month.

Medical Necessity Guidelines for Applied Behavioral Analysis Using Behavioral Specialist Consultant-Autism Spectrum Disorder and Therapeutic Staff Support Services for Children and Adolescents with Autism Spectrum Disorder

DESCRIPTION OF APPLIED BEHAVIORAL ANALYSIS

Applied behavioral analysis (ABA) is the design, implementation and evaluation of environmental modifications, using behavioral stimuli and consequences, to produce socially significant improvement in human behavior or to prevent loss of attained skill or function, including the use of direct observation, measurement and functional analysis of the relations between environment and behavior.

ABA is used to develop needed skills (behavioral, social, communicative, and adaptive functioning) through the use of reinforcement, prompting, task analysis, or other appropriate interventions in order for a child or adolescent to master each step necessary to achieve a targeted behavior.

ABA can be used to treat autism spectrum disorder (ASD). ABA can be delivered through Behavioral Health Rehabilitation Services (BHRS) using Behavioral Specialist Consultant (BSC)-ASD (Doctoral Level), BSC-ASD (Master's Level), and Therapeutic Staff Support services.

WHEN TO USE THESE GUIDELINES

If the BH-MCO prior authorizes ABA using BSC-ASD services and TSS services for children and adolescents under age 21 with ASD, these medical necessity guidelines are to be used to review the request for ABA.

I. ADMISSION

The following documentation is required to support a request for BSC-ASD and TSS services to provide ABA for children and adolescents with ASD:

1. The most recent face-to-face strengths-based evaluation or re-evaluation completed by a Board Certified or Board eligible child and adolescent psychiatrist, developmental pediatrician, or licensed psychologist specializing in children or adolescents. In the absence of these practitioners, the evaluation or re-evaluation may be completed by any Board Certified or Board eligible psychiatrist or a licensed psychologist. The evaluation or re- evaluation must be signed by the evaluator/prescriber and performed not more than 60 days prior to the requested begin date of services.

2. A prescription for ABA.

   If the prescription for ABA does not differentiate between BSC-ASD and TSS services, include the specific hours per week of BSC-ASD and TSS services needed to deliver ABA, or identify the treatment setting (e.g., home, school, or identified places in the community) in which services will be provided, additional information should be requested.

3. An individualized, behavioral-based treatment plan that includes the interventions needed to address specific skills and targeted behaviors for improvement. The treatment plan must include measurable, achievable, and realistic goals for improving any identified behavioral challenges. The treatment plan must also include strategies for assessing and measuring the frequency of baseline deficits, adaptive behaviors, or skill development and use research-supported behavioral interventions.

4. One or more completed Interagency Service Planning Team (ISPT) Sign- In/Concurrence Form(s) including an explanation for any disagreement among team members with planned service intervention.

5. A Plan of Care Summary, which includes all Medical Assistance (MA)-funded services and non-MA funded services the child or adolescent is receiving or is expected to receive during the authorization period.

When evaluating a request for prior authorization of BSC-ASD and TSS services to provide ABA for children and adolescents with ASD, the determination of whether the requested services are medically necessary must take into account whether the documentation indicates the following:

A. 1. The child or adolescent has a diagnosis of ASD, per the most recent version of the Diagnostic and Statistical Manual of Mental Disorders.

2. The use of ABA is reasonably expected to reduce or ameliorate the presence of the child's or adolescent's maladaptive or restricted behaviors, impairments in communication, or impairments in social interaction or relationships.

or

The use of ABA is necessary to assist the child or adolescent with achieving or maintaining the skills needed for maximum functional capacity in performing activities of daily living.

3. The child's or adolescent's behaviors indicate that there is a manageable risk for safety to self and others while in the community and the child or adolescent does not require 24/7 medical oversight or a more restrictive level of care, such as inpatient treatment or a psychiatric residential treatment facility.

4. The amount of hours of services prescribed are reasonably expected to reduce or ameliorate the behavioral or developmental effects of ASD, enable the child or adolescent to achieve or maintain maximum functional capacity, or acquire the skills needed to perform developmentally appropriate activities of daily living.

OR

B. If the documentation does not support that the above has been met, but the individual reviewing the request for services determines that ABA is medically necessary to meet the behavioral needs of the child or adolescent, the requested services must be authorized.

II. CONTINUED CARE

The following documentation is required to support a request for continued use of BSC-ASD and TSS services to provide ABA to children and adolescents with ASD:

1. The most recent face-to-face strengths-based re-evaluation completed by a Board Certified or Board eligible child and adolescent psychiatrist, developmental pediatrician, or licensed psychologist specializing in children or adolescents. In the absence of these practitioners, the re-evaluation may be completed by any Board Certified or Board eligible psychiatrist or a licensed psychologist. The re-evaluation must be signed by the evaluator/prescriber and performed not more than 60 days prior to the request to continue services. The re-evaluation should indicate if the number of hours of BSC-ASD and TSS services should be reduced, increased, or remain the same and the reason a change in the number of hours of services is needed or not needed.

2. A prescription for ABA.

   If the prescription for ABA does not differentiate between BSC-ASD and TSS services, include the specific hours per week of BSC-ASD and TSS services needed to deliver ABA, or identify the treatment setting (e.g., home, school, or identified places in the community) in which services will be provided, additional information should be requested.

3. An updated individualized, behavioral-based treatment plan that includes the interventions needed to address specific skills and targeted behaviors for improvement. The updated treatment plan must include measurable, achievable, and realistic goals for improving any identified behavioral challenges. The updated treatment plan must also include strategies for assessing and measuring the frequency of baseline deficits, adaptive behaviors, or skill development and use research-supported behavioral interventions.

4. One or more ISPT Sign-In/Concurrence Forms.

   a. If an ISPT meeting was required, the completed ISPT Sign- In/Concurrence Form(s) including an explanation for any disagreement among team members with planned service intervention.

   b. If only ISPT input was required, the ISPT Sign-In/Concurrence Form(s) reflecting input (including an explanation for any disagreement among team members) and the completed ISPT Sign-In/Concurrence Form from the initial ISPT meeting.

5. A Plan of Care Summary, which includes all MA-funded services and non- MA funded services the child or adolescent is receiving or is expected to receive during the authorization period.

When evaluating a request for continued used of BSC-ASD and TSS services to provide ABA for children and adolescents with ASD, the determination of whether the requested services are medically necessary must take into account whether the documentation indicates the following:

A. 1. The child or adolescent continues to meet the admission guidelines for BSC-ASD and TSS services.

2. The child or adolescent shows measured improvement and/or begins to demonstrate alternative/replacement behaviors.

or

The child or adolescent shows increased or continued skill deficits or challenging behaviors with expectation for improvement.

or

There is a reasonable expectation that the child or adolescent will continue to benefit from the continuation of ABA.

OR

B. If the documentation does not support that the above has been met, but the individual reviewing the request for continued services determines that ABA continues to be medically necessary to meet the behavioral needs of the child or adolescent, the requested services must be authorized.

III. DISCHARGE AND SERVIACE TRANSITION

BSC-ASD and TSS services to provide ABA to children and adolescents with ASD should be discontinued for any of the following reasons:

1. Prescriber, with the participation of the interagency services planning team, determines that the expected response to ABA has been achieved and BSC- ASD and TSS services are no longer necessary.

2. BSC-ASD and TSS services are no longer effective to address targeted skills and behaviors.

3. The child's or adolescent's dependency on BSC-ASD and TSS services interferes with the child's or adolescent's progress toward his/her highest functional level and the benefit of continuing BSC-ASD and TSS services is outweighed by the potential problems continuation of services may cause.

4. The parent, guardian or other legally responsible caregiver, or adolescent, if the adolescent is 14 years old or older, requests that services be terminated.

5. ABA is no longer medically necessary to meet the behavioral needs of the child or adolescent.

Appendix T

HEALTHCHOICES BEHAVIORAL HEALTH SERVICES

GUIDELINES for MENTAL HEALTH MEDICAL NECESSITY CRITERIA

ADULT

PSYCHIATRIC INPATIENT SERVICES

Admission (must meet criteria I, II, and III):

A physician has conducted an evaluation and has determined that:

I. The person has a psychiatric diagnosis or provisional psychiatric diagnosis, excluding mental retardation, substance abuse or senility, unless these conditions coexist with another psychiatric diagnosis or provisional psychiatric diagnosis,

and

II. The person cannot be appropriately treated at a less intense level of care because of the need for:

* 24 hour availability of services for diagnosis, continuous monitoring and assessment of the person's response to treatment,
* availability of a physician 24 hours a day to make timely and necessary changes in the treatment plan,
* the involvement of a psychiatrist in the development and management of the treatment program, and
* 24 hour availability of professional nursing care to implement the treatment plan and monitor/assess the person's condition and response to treatment.
* 24 hour clinical management and supervision,

and

III. The severity of the illness presented by the person meets one or more of the following:

* The person poses a significant risk of harm to self or others, or to the destruction of property.
* The person has a medical condition or illness which cannot be managed in a less

intensive level of care because the psychiatric and medical conditions so compound one another that there is a significant risk of medical crisis or instability.

* The person's judgment or functional capacity and capability has decreased to such a degree that self-maintenance, occupational, or social functioning are severely threatened.
* The person requires treatment which may be medically unsafe if administered at a less intense level of care.
* There is an increase in the severity of symptoms such that continuation at a less intense level of care cannot offer an expectation of improvement or the prevention of deterioration, resulting in danger to self, others, or property.

***Continued stay* (must meet criteria I and II):**

I. The severity of the illness presented by the person meets one or more of the following:

* persistence of symptoms which meet admission criteria; or
* development of new symptoms during the person's stay which meet admission criteria; or
* there is an adverse reaction to medication, procedures, or therapies requiring continued hospitalization; or
* there is a reasonable expectation based on the person's current condition and past history, that withdrawal of inpatient treatment will impede improvement or result in rapid decompensation or the re-occurrence of symptoms or behaviors which cannot be managed in a treatment setting of lesser intensity.

and

II. The person continues to need the intensity of treatment defined under Admission Criterion II; and

* a physical examination is conducted within 24 hours after admission; and
* a psychiatrist conducts a psychiatric examination within 24 hours after admission; and
* the person participates in treatment and discharge planning; and
* treatment planning and subsequent therapeutic orders reflect appropriate, adequate and timely implementation of all treatment approaches in response to the person's changing needs.

Discharge Indicators (must meet I or II):

I. The person no longer needs the inpatient level of care because:

* The symptoms, functional impairments and/or coexisting medical conditions that necessitated admission or continued stay have diminished in severity and the person's treatment can now be managed at a less intensive level of care; and
* The improvement in symptoms, functional capacity and/or medical condition has been stabilized and will not be compromised with treatment being given at a less intensive level of care; and
* The person does not pose a significant risk of harm to self or others, or destruction of property; and
* There is a viable discharge plan which includes living arrangements and follow-up care

or

II. Inpatient psychiatric treatment is discontinued because:

* A diagnostic evaluation and/or a medical treatment has been completed when one of these constitutes the reason for admission; or
* The person withdraws from treatment against advice and does not meet criteria for involuntary commitment; or
* The person is transferred to another facility/unit for continued inpatient care.

PARTIAL HOSPITALIZATION

***Admission* (must meet criteria I, II, and III):**

I. A mental health professional, as defined in Chapter 5210.3 of the Partial Hospitalization regulations, has conducted an evaluation and has determined that the person meets one of the following:

* The person has an established history of a psychiatric disorder, excluding mental retardation, substance abuse or senility, unless these conditions co-exist with other psychiatric symptomatology, and is presenting symptoms which require this level of care; or
* The person does not have an established psychiatric history, but a psychiatrist, or physician, or a licensed clinical psychologist has been consulted and has confirmed the presence of a psychiatric disorder that requires this level of care; or
* The person has had an evaluation by a psychiatrist, a physician, or a licensed clinical psychologist at another mental health treatment facility, (e.g., inpatient, outpatient or crisis intervention) and is being directly referred to this level of care; or

* The person needs a diagnostic evaluation that cannot be performed at a lesser level of care.

and

II. The partial hospital level of care is appropriate because:

* The person has the capacity to participate in the partial hospitalization level of care; and
* The person has a community based network of support that enables him/her to participate in the partial hospitalization level of care; and
* The person exhibits sufficient control over his/her behavior such that he/she is judged not to be an imminent danger to self, others or property.

and

III. The severity of the symptoms presented by the person meets one or more of the following:

* The person's judgment or functional capacity and capability is compromised to such a degree that self-maintenance, occupational, educational or social functioning are significantly impaired, and the severity of the presenting symptoms is such that the success of treatment at a less intense level of care is unlikely; or
* The person requires treatment which may be unsafe if administered at a less intense level of care; or
* Sufficient clinical gains have not been made within a less intensive level of care, and the severity of presenting symptoms is such that the success of treatment at a less intense level of care is unlikely; or
* Co-existing, non-psychiatric medical conditions preclude treatment at a less intensive level of care because the psychiatric and medical conditions so compound one another that there is a significant risk of medical crisis or instability.

Continued Stay Criteria **(must meet criteria I and II)**

I. One or more of the symptoms or conditions which necessitated admission persist, or new symptoms develop which meet admission criteria, and the person meets one or more of the following:

* The person has not completed the goals and objectives of the Individualized Treatment Plan that are necessary to warrant transition to a less intensive level of care; or

* The person demonstrates a current or historical inability to sustain/maintain gains without a comprehensive program of treatment services provided by the partial hospital program; or
* Attempts to reduce the intensity and structure of the therapeutic program have resulted in, or are likely to result in, exacerbation of the psychiatric illness as manifested by regression of behavior and/or the worsening of presenting symptomatology; or
* Attempts to increase the person's level of functioning or role performance in the areas of interpersonal, occupational or self-management functioning have resulted in exacerbation of psychiatric illness as manifested by regression of behavior and/or the worsening of presenting symptomatology; or
* An adverse reaction to medication, procedures or therapies requires frequent monitoring which cannot be managed at a less intensive level of care.

and

II. The partial hospital program provides the following service elements:

* The person is receiving active treatment within the framework of a multi-disciplinary individualized treatment plan approach; and
* There is the involvement of a psychiatrist in the development and management of the treatment program and discharge plan; and
* The treatment plan includes a discharge plan and is reviewed and modified, as appropriate, by the treatment team to respond to changes in the person's clinical presentation or lack or progress; and
* The person is an active participant in treatment and discharge planning; and
* Where clinically appropriate, and with the person's informed consent, timely attempts are made by the treatment team, and documented in the treatment plan, to involve the family and other components of the person's community support network in treatment planning and discharge planning.

***Discharge Indicators* (must meet I or II):**

I. The person no longer needs the partial hospital level of care because:

* The symptoms, functional impairments and/or coexisting medical conditions that necessitated admission or continued stay have diminished in severity and the person's treatment can now be managed at a less intensive level of care; and
* The improvement in symptoms, functional capacity and/or medical condition has been stabilized and will not be compromised with treatment being given at a less intensive level of care; and

* There is a viable discharge plan with which service and care providers identified for after-care treatment, if needed, and support have concurred.

or

II. The partial hospital level of care is discontinued because:

* The diagnostic evaluation has been completed when this constitutes the reason for admission; or
* The person withdraws from treatment against advice and does not meet criteria for involuntary commitment; or
* The person is transferred to another facility/unit for continued care.

Admission **(must meet criteria I and II):**

I. A mental health professional determines that the outpatient level of care is appropriate and there is the potential for the person to benefit from outpatient care. The person must meet at least one of the following condition elements:

* The person has a psychiatric illness exhibited by reduced levels of functioning and/or subjective distress in response to an acute precipitating event; or
* The person is exhibiting signs or symptoms of a psychiatric illness, associated with reduced levels of functioning and/or subjective distress; or
* The person has a history of psychiatric illness and presents in remission or with a residual state of a psychiatric illness, and without treatment there is significant potential for serious regression,

and

II. A comprehensive diagnostic evaluation, including an assessment of the psychiatric, medical, psychological, social, vocational and educational factors important to the person, is conducted.

Continued Stay **(must meet criteria I, II and III):**

I. The person has a current psychiatric diagnosis or provisional psychiatric diagnosis.

and

II. The treatment team determines that:

* The person continues to exhibit one or more signs or symptoms that necessitated admission and can be expected to benefit from the outpatient level of care; or
* The person has developed new signs or symptoms that meet admission criteria and could be expected to benefit from the outpatient level of care; or
* There is a reasonable expectation based on the person's clinical history that withdrawal of treatment will result in decompensation or recurrence of signs or symptoms.

III. The services provided to the person meet the following criteria:

* The person is an active participant in treatment and discharge planning; and
* A psychiatrist reviews and approves the treatment plan; and
* The treatment plan includes a discharge plan and is reviewed and modified, as appropriate, by the treatment team to address changes in the person's clinical presentation and response to treatment; and
* The person is receiving treatment within the framework of a multidisciplinary individualized treatment plan approach.

Discharge Indicators

* The person no longer meets continued stay criteria; or
* The person withdraws from treatment against advice and does not meet criteria for involuntary treatment.

Appendix T
Part A

HEALTHCHOICES BEHAVIORAL HEALTH SERVICES
GUIDELINES for MENTAL HEALTH SERVICE NECESSITY CRITERIA

ADULT

TARGETED CASE MANAGEMENT SERVICES

Admission Criteria

An individual who meets the minimum staff requirements for an Intensive Case Manager as defined by Chapter 5221, Mental Health Intensive Case Management; a Resource Coordinator as defined by Mental Health Bulletin OMH-93-09 —Resource Coordination: Implementation; or a Blended Case Manager as defined by Office of Mental Health and Substance Abuse Bulletin OMHSAS-10-03 Blended Case Management (BCM) - Revised and has received training on the use of the environmental matrix has conducted an evaluation and has determined that:

I. The person meets either the eligibility criteria for Resource Coordination Services as defined by Mental Health Bulletin OMH-93-09 —Resource Coordination: Implementation; Intensive Case Management Services as defined by Chapter 5221, Mental Health Intensive Case Management; or Blended Case Management as defined by Office of Mental Health and Substance Abuse Bulletin OMHSAS-10-03 Blended Case Management (BCM) - Revised;

or

II. The person meets the criteria for serious mental illness (SMI) as described in *Federal Register Volume 58 No. 96, May 20, 1993, pages 29422-29425*; and cited in OMH-94-04: p. 1;

and

III. The person is in need of Targeted Case Management Services as indicated by the evaluation of the functional level through utilization of the Targeted Case Management-Adult Environmental Matrix, and in

conjunction with clinical information and the professional judgement of the reviewer.

Continued Stay and/or Change of Level of Need

The consumer must be reassessed at the point of concurrent review, but no less frequently than six month intervals, and when there are significant changes in the individual's situation that warrants a change in level of TCM services.

I. The consumer continues to meet either I or II of part A Admission Criteria.

and

II. The person is in need of Targeted Case Management Services as indicated by the evaluation of the functional level through utilization of the Targeted Case Management-Adult Environmental Matrix and in conjunction with clinical information and the professional judgement of the reviewer.

Discharge Indicators

Targeted Case Management may be terminated when one of the following criteria is met:

A. The consumer receiving the service determines that Targeted Case Management is no longer needed or wanted and the consumer no longer meets the continued stay criteria; or

B. Determination by the targeted case manager in consultation with his/her supervisor or the director of targeted case management, and with written concurrence by the county administrator that targeted case management is no longer necessary or appropriate for the adult receiving the service and the consumer no longer meets the continued stay criteria; or

C. The consumer receiving the service determines that Targeted Case Management is no longer wanted, however, the consumer does meet continued stay criteria; or

D. The consumer has moved outside of the current geographical service area (e.g., county, state, country); or

E. The consumer is undergoing long-term incarceration and/or long-term hospitalization or long-term skilled-nursing care without a discharge or anticipated discharge date.

TCM ENVIRONMENTAL MATRIX — ADULTS INSTRUCTIONS

The Environmental Matrix - Adults is a scale that evaluates the functional level of consumers on the six activities identified by regulation as Targeted Case Management activities. Cultural competency will be recognized throughout the entire evaluation process and the entire document. Individuals must be assessed in the following areas, in a face-to-face interview with the evaluator. Individuals should be reassessed as needed, but no less than every six months.

1. Assessment and Service Planning
2. Informal Support and Network Building
3. Use of Community Resources
4. Linking and Accessing Services
5. Monitoring of Service Delivery
6. Problem Resolution

The scale has a range from 0 to 5 with the following values for each activity:

0	1	2	3	4	5
No assistance Needed	Minimal assistance needed		Needs Moderate assistance in this area		Needs Significant assistance in this area

All six activities are ranked on the above scale. The evaluator must complete the environmental matrix in a face- to – face, strengths - based assessment interview with the consumer. Evaluators should incorporate in their assessment a recognition/determination of cultural strengths (i.e., extended family, allocation of family resources, the decision making process, values, etc.). The evaluator should consider the individual's strengths and needs in the following life domains for each assessment area in order to produce a score that reflects the full dimension of need:

. Housing/living situation
. Education/vocation
. Income/benefits/financial management
. Mental Health treatment
. Alcohol and other drug use.
. Socialization/support
. Activities of daily living

. Medical treatment
. Legal situation
. Transportation issues
. Criminal justice system involvement

Each area is defined at the “1”, “ 3 ”, and “ 5 ” levels (See attached Environmental Matrix) and the subtotal score is divided by 6 to obtain the EM Score (when scoring the individual, refer to the Environmental Matrix TCM Service Scoring Grid which identifies the expected frequency of TCM contact needed for the individual for that particular assessment area). Scoring levels on individual assessment areas may be gradated to the 0.5 level only; this allows for minor differentiation of consumer need without compromising the integrity of the scale.

Looking at the behavior, inclusive of the lowest level of functioning, of the consumer during the last ninety (90) days, rate the consumer’s functional level in each of the six areas. Please note that the rating for each area should be made in whole numbers; in cases where there are extraordinary factors that make the assignment of whole numbers extremely difficult, if not impossible, 0.5 points may be added to or subtracted from the base scores. The sum of the six (6) scores should then be taken and divided by 6 and the resulting subtotal score should be reviewed and compared to other known factors that may affect the consumer’s need for service. This should be noted on the scoring sheet. If after averaging the scores, the average is lower by at least 2 points than any one value given in any one assessment area (e.g., if a person’s average is 2 and he/she received a score of 4 in any one area), the evaluator must provide written justification for assignment to the level that corresponds to the average, rather than the higher value.

The Environmental Matrix score, your *professional judgement* *, and other information (e.g., cultural factors, records of past treatment, psychiatric evaluations, psychosocial summaries) that impacts on the consumer’s level of need should then be considered and the Recommended Level of TCM service should be entered on the recommended level of TCM line of the Scoring Sheet. (These levels are consistent with minimum levels of contact as defined in *Chapter 5221, Intensive Case Management* regulations and Bulletin *OMH-93-09, Resource Coordination: Implementation*.) If the recommended level of TCM service differs from the Environmental Matrix score, the difference must be justified with professional judgement in “Other Factors/Issues Affecting Score” section of the scoring sheet. **Note: The level of service indicated by the assessment represents the individual’s needs at the time of assessment. Service intensity could change as an individual’s needs and/or desires for service change.**

ENVIRONMENTAL MATRIX
TCM SERVICE SCORING GRID

MATRIX LEVEL	NEED LEVEL	INTENSITY OF CARE
4.0 –5.0	ICM	At least 1 contact every 14 days (Face to face contact strongly recommended).
1.5 – 3.9	RC	At least 1 face to face contact every two months
0.0 - 1.4	NO TCM NEEDED	Alternative services may be needed and if necessary, referrals should be made.

* ***professional judgement:*** *opinion based on a thorough and ethical analysis of facts, data, history, and issues in accordance with one's training and experience.*

ASSESSMENT & SERVICE PLANNING

The consumer is able to provide meaningful and accurate information regarding own mental health status and needs. The consumer, with possible assistance from the targeted case manager, identifies, formulates, and expresses personal goals and objectives and can correlate these into concrete service needs and activities. The TCM should take into consideration that the behavioral health system may pose a number of barriers which serve as obstacles to service planning (i.e., language, perceived/actual institutional racism/discrimination, etc.)

0	1	2	3	4	5
	Needs minimal assistance in this area		Needs moderate assistance in this area		Needs significant assistance in this area

0= Consumer does not need/or request assistance in this area.

1= Consumer is able to provide meaningful/relevant/accurate information regarding own mental health status. Consumer is able to identify and formulate and express personal goals and objectives with minimal assistance from others. Consumer is able to translate/correlate these goals and objectives, with minimal direction, into concrete service needs and activities.

3= Consumer needs and/or requests moderate assistance in identifying and conveying information regarding own mental health status/problems. Consumer needs and/or requests moderate assistance from others in order to identify, formulate, and express personal goals and objectives. Consumer needs and/or requests moderate assistance from others to translate/correlate needs and goals into concrete service needs and activities.

5= Consumer needs and/or requests significant assistance from others to provide any meaningful information regarding own mental health status and/or needs. Consumer is unable to express personal goals nor objectives without assistance. Consumer needs and/or requests significant assistance from others to design/formulate service plan and activities.

USE OF COMMUNITY RESOURCES

The consumer is able to identify, understand, and articulate daily living needs as well as those community/neighborhood resources that may be needed to meet these needs. The consumer may need additional support from the targeted case manager in utilizing the services that may go beyond the realm of traditional mental health/substance abuse services. TCM must recognize cultural and linguistic needs as an important element in articulating daily living needs and resources. Many services may not be available in the immediate community and be less effective if located outside the community.

0	**1**	**2**	**3**	**4**	**5**
	Needs minimal assistance in this area		Needs moderate assistance in this area		Needs significant assistance in this area

0= Consumer does not need/or request assistance in this area.

1= Consumer is able, when encouraged, to identify and articulate daily living needs. Consumer is able to access, navigate, and utilize community/neighborhood resources with minimal assistance. Consumer's needs may be fulfilled through the use of existing community resources such as social/religious groups, libraries, stores, directories, and public transportation and consumer is able to utilize these with minimal assistance.

3= Consumer needs and/or requests moderate assistance in identifying daily living needs as well as those community resources needed to meet these needs. When directed to community resources such as social/religious groups, libraries, stores, directories, and public transportation, the consumer may require and/or request moderate assistance to access and utilize these resources in order to accomplish a planned task.

5= Consumer is unable to identify nor understand daily living needs. Consumer is not familiar with community/neighborhood resources and has had very few, if any, positive experiences while living in the community. Consumer needs and/or requests significant assistance to access, navigate, or utilize existing community resources.

INFORMAL SUPPORT NETWORK BUILDING

The consumer identifies, communicates, and interacts with family, friends, significant others, and community groups from whom the consumer may gain informal support. The TCM should recognize that service system barriers may impede the consumer from interacting with family, friends, significant others and community groups. The consumer may need the assistance of the targeted case manager and/or others to identify, enhance and/or maintain existing relationships and the encouragement to develop new ones.

0	**1**	**2**	**3**	**4**	**5**
	Needs minimal assistance in this area		Needs moderate assistance in this area		Needs significant assistance in this area

0= Consumer does not need/or request assistance in this area.

1= Consumer is able to identify and provide meaningful/accurate/relevant information about family, friends, significant others, and social/religious groups with whom consumer interacts and from whom consumer may gain informal support. Consumer is able, with minimal assistance, to access and maintain positive relationships with these people and groups who provide personal social support and/or companionship.

3= Consumer needs and/or requests moderate assistance in identifying and communicating with family, friends, significant others, and social/religious groups from whom consumer may gain informal support. Consumer needs and/or requests moderate assistance from others in order to enhance and/or maintain existing relationships and to develop new ones.

5= Consumer is unable to identify nor interact with family, friends, significant others, and/or social/religious groups who may serve as personal supports. Consumer has few, if any, personal or familial relationships and is unable/unwilling to interact positively, if at all, with these persons or groups. Consumer needs and/or requests significant assistance from others to elicit information and support on his/her behalf.

LINKING AND ACCESSING SERVICES

The consumer is able to locate, gain access, and maintain contact and services with the service providers that have been identified as needed in the treatment or service plan. The treatment or service plan must recognize the cultural and linguistic needs of the consumer. At times, the targeted case manager may be needed to provide assistance in nontraditional and/or assertive ways to successfully gain and maintain these resources.

0	**1**	**2**	**3**	**4**	**5**
	Needs minimal assistance in this area		Needs moderate assistance in this area		Needs significant assistance in this area

0= Consumer does not need/or request assistance in this area.

1= Consumer is able, with minimal assistance from others, to locate and gain access to services identified in the treatment or service plan. Consumer is able, when encouraged, to establish and maintain appointments/services with appropriate service providers with minimal assistance. Consumer needs and/or requests minimal assistance by others to successfully gain access to and to maintain contact with community resources and services.

3= Consumer needs and/or requests moderate assistance in locating and gaining access to services identified in the treatment or service plan. Consumer may require and/or request moderate assistance, often in nontraditional ways, to access, establish, and maintain contact and services with the identified service providers.

5= Consumer is unable and/or unwilling to locate or gain access to services identified in the treatment or service plan. Consumer's identified needs are so immense or so unusual that assertive and creative efforts outside of the usual and normal practice must be employed in order to help the person gain the resources and services identified. Consumer needs and/or requests significant (frequent and continual) assistance by others to successfully gain access to and to maintain contact with community resources and services.

MONITORING OF SERVICE DELIVERY

The consumer gauges and communicates her/his satisfaction with the progress that has been made and with the services offered/delivered by the service providers identified in the treatment plan. The consumer suggests possible needed revisions and/or additions to the treatment/service plan. The TCM should recognize that language and culture has much to do with expressions of satisfaction/dissatisfaction and be prepared to assist the consumer in suggesting changes in the treatment plan/service plan or actual provider.

0	1	2	3	4	5
	Needs minimal assistance in this area		Needs moderate assistance in this area		Needs significant assistance in this area

0= Consumer does not need/or request assistance in this area.

1= Consumer is able to communicate, when encouraged, his/her opinion of the progress and satisfaction with the service provider and/or the delivered services as well as the need for revisions to the treatment/service plan. Consumer is able and willing to participate in intra- and inter-agency as well as cross-systems reviews of the need for and appropriateness of the specific services delivered. Minimal assistance from others is needed and/or requested to ensure that the consumer is satisfied with the services received.

3= Consumer needs and/or requests moderate assistance in determining and communicating his/her satisfaction with the service provider and with the services delivered. Consumer needs and/or requests moderate assistance in identifying what progress has been made and the possible need for revisions to the treatment/service plan.

5= Consumer is almost totally dependent on others to see that progress is being made and to suggest needed revisions to the treatment/service plan. Consumer needs and/or requests significant assistance to communicate effectively and realistically about her/his progress and satisfaction with the service provider and/or the services delivered.

PROBLEM RESOLUTION

The consumer is able to resolve issues and overcome barriers, including those that are cultural and linguistic in nature, that prevent her/him from receiving needed treatment, rehabilitation, and/or support services as well as entitlements. The consumer is aware of and able to utilize complaint/grievance procedures as well as additional appropriate advocacy supports. The targeted case manager, when requested and or needed, may be called upon to not only help the consumer with these tasks but also to provide information to the County Office of Mental Health and/or the BHMCO in order to overcome barriers and to assist the consumer in obtaining needed services.

0	1	2	3	4	5
	Needs minimal assistance in this area		Needs moderate assistance in this area		Needs significant assistance in this area

0= Consumer does not need/or request assistance in this area.

1= Consumer needs and/or requests minimal assistance to resolve issues and overcome barriers that prevent him/her from receiving treatment, rehabilitation and/or support services.

3= Consumer is able, with moderate assistance and encouragement, to identify issues that need to be resolved but is unable, without direct assistance from others, to formulate steps or implement actions that would overcome barriers that prevent him/her from receiving treatment, rehabilitation and/or support services.

5= Consumer needs and/or requests significant assistance, to identify and resolve issues that prevent him/her from receiving treatment, rehabilitation and/or support services. Consumer is totally dependent on others to recognize and to take steps to overcome these barriers. Resolution may require the intervention of the County Office of Mental Health and/or the modification of existing services or the development of new services.

TARGETED CASE MANAGEMENT
ENVIRONMENTAL MATRIX - ADULT

Agency **County**

CONSUMER INFORMATION:

Name :

(Last) **(First)** **(MI)**

Parent/Guardian Name:

Identifying Number(s):

Date of Birth: / /
(MM)/(DD)/(YYYY)

Social Security Number: - -

CIS/BSU/MCO Number:

PHMCO:

BHMCO:

Form Completed by:
Date Completed:

The purpose of this form is to assess what environmental and cultural factors help to determine an individual's need for the various levels of case management services. Please complete this form utilizing the individual's behavior during the last ninety days as a basis for scoring each indicator. Please see the *Scoring Sheet* for additional information on determining the Environmental Matrix Score and its meaning for level of care assignments.

ENVIRONMENTAL MATRIX ADULT SCORING SHEET

CONSUMER NAME:_____

ID#(SOCIAL SECURITY/CIS/BSU):_____

SCORES:

1. Assessment and Service Planning _____
2. Use of Community Resources _____
3. Informal Support Network Building _____
4. Linking and Assessing Services _____
5. Monitoring of Service Delivery _____
6. Problem Resolution _____

SUBTOTAL _____

ENVIRONMENTAL MATRIX SCORE = SUBTOTAL ÷ 6= _____

OTHER FACTORS/ISSUES AFFECTING SCORE:

_____

_____

_____

_____

ENVIRONMENTAL MATRIX
TCM SERVICE SCORING GRID

MATRIX LEVEL	NEED LEVEL	INTENSITY OF CARE
4.0 –5.0	ICM	At least 1 contact every 14 days (Face to face contact strongly recommended).
1.5 – 3.9	RC	At least 1 face to face contact every two months
0.0 - 1.4	NO TCM NEEDED	Alternative services may be needed and if necessary, referrals should be made.

* ***professional judgement:*** *opinion based on a thorough and ethical analysis of facts, data, history, and issues in accordance with one's training and experience.*

RECOMMENDED LEVEL OF TARGETED CASE MANAGEMENT SERVICE:_____

CONSUMER:_____ **DATE:**_____

PERSON COMPLETING THE FORM:_____ **DATE:**_____

APPROVED LEVEL OF TARGETED CASE MANAGEMENT SERVICE:_____

REVIEWER **DATE:**_____

HEALTHCHOICES BEHAVIORAL HEALTH SERVICES
GUIDELINES for MENTAL HEALTH MEDICAL NECESSITY CRITERIA

CHILDREN AND ADOLESCENTS

PSYCHIATRIC INPATIENT HOSPITALIZATION
RESIDENTIAL TREATMENT
PSYCHIATRIC PARTIAL HOSPITALIZATION PROGRAMS
PSYCHIATRIC OUTPATIENT TREATMENT

Purpose

The purpose of this document is to provide decision-making criteria for the admission of children and adolescents to four (4) treatment environments under regulation. This document provides a clear interpretive framework, in accordance with Office of Mental Health and Substance Abuse Services (OMHSAS) program, and Office of Medical Assistance Programs (OMAP) payment regulations, for deciding when to treat, continue or discontinue treatment, and refer elsewhere for other services. These criteria will serve the basis for decision-making for Managed Care Organizations (MCOs), county Mental Health/Mental Retardation/Intellectual Disabilities (MH/MR/ID) offices, and prescribers of children's mental health services in general, as well as for providers delivering their respective services to children qualifying for Medical Assistance (MA) coverage. This document provides a common set of criteria for reference by all the decision-makers in a child's care. These four (4) sets of criteria are intended to further consistency between the child's treatment needs and the broader philosophy of individualized service delivery in the most appropriate and least restrictive setting as guided, respectively, by the principles of the Child and Adolescent Service System Program (CASSP) and the Community Service Program (CSP).

Background

The Office of Mental Health and Substance Abuse Services (OMHSAS) produced Title 55 PA Code Chapters 5100, 5300, 4210, 5200, 5310, and 5210 to regulate the general delivery of services in community psychiatric inpatient, outpatient, residential, and partial hospitalization settings, while OMAP produced Title 55 PA Code, Chapters 1151 and 1153 to regulate M.A.

payment for these services. Additional clarity for psychiatric residential treatment is provided in OMHSAS's proposed Chapter 5215 regulations. However, as more mental health services are developed for delivery in the home and community, in conjunction with a growing emphasis on providing services in the least restrictive environments necessary, greater clarity is required for mental health providers, case managers, interagency teams, and third party payers, including Managed Care Organizations and their sub-contractors, to make coordinated treatment determinations concerning appropriateness of admissions, continued stay, and discharge planning. It is for this reason that the criteria provided below have been developed.

Presented in the opening section which precede the criteria, is a summary outline of the major aspects of service delivery, including: CASSP principles, the function of each of the four (4) treatment environments, and the importance of prescribing the least restrictive setting necessary. More detail is provided by the addenda in the document. Following the introduction are the individual "Admission Criteria" for each service. Each set of criteria is divided into three (3) sections, the first for determining "Admission", the second for determining the appropriateness of "Continued Stay," and the third for identifying "Discharge Criteria."

For ease of reading in the following text, "child(ren) and adolescent(s)" shall be commonly referred to as "child(ren)," unless otherwise indicated.

Introduction

The mental health system has undergone substantial structural change from an emphasis on community segregation and maintenance of children with emotional disorders, to one of community integration and fostering increasing independence of individuals (see Mental Health/Mental Retardation Act of 1966 and the Mental Health Procedures Act of 1976 with subsequent amendments). These changes are further reflected in the development of the Child and Adolescent Service System Program (CASSP) and its philosophy. The OMHSAS summary representation of CASSP, is provided below:

> The CASSP philosophy of collaborative service delivery to children, adolescents and their families undergirds all treatment methods. CASSP involves all child-serving systems including mental health, mental retardation, education, special education, children and youth services, drug and alcohol, juvenile justice, health care, and vocational rehabilitation. It should also include informal community supports and organizations. This philosophy is essential to making decisions to provide treatment for children. It is also the foundation for the development of these criteria. These principles are represented in the following six summary statements:

(1) Child-centered - Services are planned to meet the individual needs of the child, rather than to fit the child into an existing service. Services should be developmentally appropriate and child-specific, and should also build on the strengths of the child and family to meet the mental health, social and physical needs of the child.

(2) Family-focused - Services recognize that the family is the primary support system for the child. The family participates as a full partner in all stages of the decision-making and treatment planning process, including implementation, monitoring and evaluation. A family may include biological, adoptive and foster parents, siblings, grandparents and other relatives, and other adults who are committed to the child. The development of mental health policy at state and local levels should include family representation.

(3) Community-based - Whenever possible, services should be delivered in the child's home community, drawing on formal and informal resources to promote the child's successful participation in the community. Community resources include not only mental health professionals and provider agencies, but also social, religious and cultural organizations and other natural community support networks.

(4) Multi-system - Services should be planned in collaboration with all thechild-serving systems involved in the child's life. Representatives from all these systems and the family should collaborate to define the goals for the child, develop a service plan, develop the necessary resources to implement the plan, and provide appropriate support to the child and family.

(5) Culturally competent - Culture determines our world view and provides a general design for living and patterns for interpreting reality that are reflected in our behavior. Therefore, services that are culturally competent are provided by individuals who have the skills to recognize and respect the behavior, ideas, attitudes, values, beliefs, customs, language, rituals, ceremonies and practices characteristic of a particular group of people.

Note: Pennsylvania's cultural competence initiative has focused specifically on African Americans, Latinos, Asian Americans and Native Americans who have historically not received culturally appropriate services.

(6) Least restrictive/least intrusive - Services should take place in settings that are the most appropriate and natural for the child and family and

are the least restrictive and intrusive available to meet the needs of the child.

These principles encompass not only the psychological, but the physical, cognitive, and socio-cultural development of children, which include the child's dependency on family, community, and environmental influences in general. From these principles, the four services for which "Admission Criteria" are provided below, can be understood as components within a wider network of service options.

Severity of Symptoms

The child's expression of impairment in any of the following should be considered in the design of the individual's treatment: judgement, thought, mood, affect, impulse control, psychosocial, psychomotor retardation/excitation, physiological functioning and/or cognitive/perceptual abilities. Challenging behaviors closely associated with social contexts such as family, school, or other community activities must also be considered when determining an appropriate treatment design, and the concomitant discharge planning.

Intensity of Treatment

The intensity and range of treatment varies for each of the four services. Psychiatric Inpatient and Residential Treatment are out of home services which provide highly intensive treatment for the purpose of returning children home, or to a homelike setting. Partial Hospitalization and Psychiatric Outpatient provide services of varying intensity depending on the child's need for therapeutic support to remain home. The therapeutic function and emphasis of each of the four services to return a child home, or to prevent out-of-home placements, depends strongly on the interaction between the therapist, the parents/guardians, and the child, for the effectiveness of the treatment plan developed.

Psychiatric Inpatient hospitalization provides the most restrictive level of care. The setting is locked and highly focused toward the delivery of intensive, short term treatment. It serves as an appropriate placement for children expressing the sudden onset of acute symptoms, and/or requiring treatment which cannot be managed outside of a 24 hour, secure setting.

Residential Treatment facilities provide a stable, open, community living setting for the delivery of comprehensive mental health treatment with 24 hour monitoring and a strong supportive environment from which the child is able to reenter the community. This is a longer term treatment option for children who

require the comprehensive treatment and professional support of this setting to prevent a need for inpatient hospitalization.

Partial hospitalization lies between the most restrictive and community-based levels of care. A partial hospitalization treatment program offers a wide range of treatment in a setting segregated from the child's natural setting for part of the day. Effective treatment and stabilization of the child must be possible within the partial hospital program hours prescribed in the treatment plan. Partial hospitalization provides an opportunity to observe a child's behavior and the effects of treatment, for the purpose of developing and confirming a proper course of treatment designed for the effective reintegration of the child into the community.

Outpatient treatment is for children and their families who are seeking help and believe there is a need for mental health services. Services and treatment approaches include, diagnostic testing, crisis intervention services, behavior therapy, individual, group and family psychotherapy, medication, and similar services. The child should be able to maintain sufficient stability in his/her existing support network, to be treated effectively within the hours of outpatient treatment prescribed in the treatment plan. Treatment and services should be directed toward helping the child to remain integrated with his/her natural community and work to prevent the necessity of a more restrictive or intrusive service.

Least Restriction

The four services addressed in this bulletin are presented in descending order of restrictiveness and in increasing order of community integration. The need for greater or lesser restrictiveness must be adjusted to the individual's need for active treatment as reflected in the treatment plan. Increased restrictiveness of setting improves the convenience and opportunity for immediate intervention in the delivery of treatment. However, less restrictive environments should be considered to prevent the removal of children from their families, peers, and normalized settings in the community. Each service provides treatment with the object of helping a child with acute behavioral problems or serious emotional disturbance to increase his or her functional capacity, in order to increase his/her ability to reintegrate into the community. Therefore, the goals of treatment may be summarized by the following:

- amelioration of symptoms such that less restrictive and/or less intrusive services can be planned and introduced;

- stabilization of medical regimen for children requiring psychotropic medication so they may remain in the least restrictive setting possible;
- prevention of regression/recidivism by improving the child's level of functioning and ability for self maintenance;
- coordination of the treatment and discharge plan on an ongoing basis with the family and the appropriate agencies to provide the necessary community based supports, including wraparound services; and
- increase in the age-appropriate interactiveness in a variety of settings [see Community Integration Attachment in Appendix C].

Admission of a child for psychiatric inpatient treatment is most appropriately based on a diagnosis by a certified child and adolescent psychiatrist. In the absence of a child and adolescent psychiatrist, a diagnosis may be appropriately provided by a Board Certified psychiatrist. When a certified psychiatrist is not available, a diagnosis may be provided by a Board eligible psychiatrist or a licensed physician contingent on confirmation by a Board Certified psychiatrist within forty-eight (48) hours of admission, or as indicated by the regulations governing this service. However, any time the most appropriate specializing physician is unavailable to perform the necessary diagnostic services, this should be documented and explained.

Diagnostic references for the purpose of the documentation below must conform to the most current edition of the Diagnostic and Statistical Manual (DSM).

ADMISSION CRITERIA

(Must meet I and II)

I. DIAGNOSTIC EVALUATION AND DOCUMENTATION

A. Presenting illness is diagnosed on DSM IV Axis I or Axis II, as part of a complete multiaxial, face-to-face diagnostic examination (MR or D&A cannot stand alone) and in accordance to ICD-9 codes, by a licensed physician[1] contingent on confirmation by a child and adolescent psychiatrist or Board Certified psychiatrist within forty-eight (48) hours of admission.

AND

B. Psychiatric Inpatient Treatment is prescribed by the diagnosing psychiatrist, and/or as required by Pennsylvania regulation, indicating that this is the most appropriate, and least restrictive service to meet the mental health needs of the child;

AND

C. Documentation in the current psychiatric evaluation that the treatment, 24-hour supervision, and observation, provided in the Psychiatric Inpatient setting, are necessary as a result of:

[1] Diagnosis by a resident physician with training license must receive confirmation within 24 hours.

-severe mental illness or emotional disorder, *and/or*
-behavioral disorder indicating a risk for safety to self/others;

AND

D. Based on the patient's current condition and current history, reasonable, documented treatment within a less restrictive setting has been provided by a mental health professional, *and/or* careful consideration of treatment within an environment less restrictive than that of a Psychiatric Inpatient Hospitalization, *and* the direct reasons for its rejection, have been documented;

AND

E. A complete strengths-based evaluation, including identifying the strengths of child's family, community, and cultural resources, must be completed prior to admission, or within 120 hours in the event of an emergency admission.

II. SEVERITY OF SYMPTOMS

A. Significant risk of danger is assessed for any of the following,
1. child HARMING HIM/HERSELF
2. child HARMING OTHERS
3. DESTRUCTION TO PROPERTY which is:
   a. life-threatening, *OR*
   b. in combination with "B", "C", or "D" below;

OR

B. There is an acute occurrence or exacerbation of impaired judgement or functional capacity and capability, for the child's developmental level, that interpersonal skills, and/or self-maintenance in home/school/community is/are severely compromised;

OR

C. There are endangering complications in *either* of the following:
1. *complications* of the child's psychiatric illness *or* treatment would seriously threaten the child's health safety due to a lack of capacity for self-care; *OR*
2. due to a *coexisting medical condition* where the child has a medical condition or illness which, as a result of a psychiatric condition, cannot be managed in a less intensive level of care without significant risk of medical crisis or instability;

OR

D. The severity of the child's symptoms are such that continuation in a less intense level of care cannot offer either an expectation of improvement, or prevention of deterioration, as identified in the above three categories of "II."

Requirements for Continued Stay

(Must meet I and II. Complete documentation for each is required, and additional documentation as indicated in Appendix B.)

I. DIAGNOSTIC EVALUATION AND DOCUMENTATION

A. The initial evaluation and diagnosis is updated and revised as a result of a face-to-face diagnostic examination by the treating psychiatrist;

AND

B. Continued Psychiatric Inpatient Treatment is prescribed by the diagnosing psychiatrist, and/or as required by Pennsylvania regulation, indicating and documenting that this is the least restrictive, appropriate service to meet the mental health needs of the child, and the discharge implementation plan;

II. SEVERITY OF SYMPTOMS

A. Severity of illness indicators and updated treatment plan support the likelihood that: *substantial benefit* is expected as a result of continued active intervention in a psychiatric inpatient setting, without which there is *great risk of a recurrence of symptoms*; *OR severity is such that treatment cannot be safely delivered at a lesser level of care, necessitating hospitalization;*

AND

B. Although child is making *progress toward goals* in the expected treatment process, further progress must occur before transition to a lesser level of care is advisable. The necessary changes must be identified in an updated treatment plan, and the treatment team review must recommend continued stay;

OR

C. The symptoms or behaviors that required admission, *continue with sufficient acuity* that a less intensive level of care would be insufficient to stabilize the child's condition;

OR

D. Appearance of *new symptoms* meeting admission criteria.

III. DISCHARGE CRITERIA

A child not meeting criteria as established in Section II, SEVERITY OF SYMPTOMS, of the CONTINUED STAY CRITERIA, must be discharged.

Admission of a child to a JCAHO Accredited Residential Treatment Facility is most appropriately based on a diagnosis by a certified child and adolescent psychiatrist. In the absence of a child psychiatrist a diagnosis may be appropriately provided by a Board Certified psychiatrist. However, any time the most appropriate specializing physician is unavailable to perform the necessary diagnostic services, this should be documented and explained. Admission to a Non-JCAHO Accredited Residential Treatment Facility is most appropriately based on a diagnosis as described above for JCAHO accredited facilities, or by a licensed psychologist specializing in treatment for children and adolescents.

Diagnostic references for the purpose of the documentation below must conform to the most current edition of the Diagnostic and Statistical Manual (DSM).

ADMISSION CRITERIA

(Must meet I *and* II or III)

I. DIAGNOSTIC EVALUATION AND DOCUMENTATION

A. Diagnosis on DSM IV Axis I or Axis II, as part of a complete multiaxial, face-to-face diagnostic examination (MR or D&A cannot stand alone) and in accordance to ICD-9 codes, by a psychiatrist (as defined in Chapter 5200.3 of the Pennsylvania Code) for JCAHO accredited facilities, or by a psychiatrist or a licensed psychologist for Non JCAHO accredited facilities;

AND

B. Residential Treatment service is prescribed by the diagnosing psychiatrist or psychologist, as appropriate to the accreditation of the facility, indicating that this is the most appropriate, least restrictive service to meet the mental health needs of the child;

AND

C. Documentation in the current psychiatric/psychological evaluation[2] that the treatment, 24-hour supervision, and observation, provided in the Residential Treatment setting, are necessary as a result of:

- severe mental illness or emotional disorder, *and/or*
- behavioral disorder indicating a risk for safety to self/others;

AND

D. Reasonable, documented treatment within a less restrictive setting has been provided by a mental health professional, *and/or* careful consideration of treatment within a less restrictive environment than that of a Residential Treatment Facility, *and* the direct reasons for its rejection, have been documented;

AND

E. Placement in a Residential Treatment Facility must be recommended as the least restrictive and most clinically appropriate service for the child, by an interagency service planning team as currently required by the OMHSAS and OMAP. Following PA School Code, Sections 1306-1309 and 2561, when a child is removed from the school setting for the purpose of receiving mental health treatment, it is expected that the appropriate school system will be involved in the child's educational planning and the interagency team. In the event that conditions prevent the possibility of parental or child involvement, attempts to involve the child and parents and/or reasons explaining their non-involvement must be fully documented and presented to an interagency team;

AND

F. A complete strengths-based evaluation, including identifying the strengths of child's family, community, and cultural resources, must be completed prior to admission.

II. SEVERITY OF SYMPTOMS

The child's problematic behavior *and/or* severe functional impairment discussed in the presenting history *and* psychiatric/psychological examination must include at least one (1) of the following:

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[2] A current psychiatric/psychological evaluation is one which has been conducted within sixty (60) days prior to admission to the program. A psychiatric/psychological evaluation for a child placed on a waiting list during which time the thirty (30) day maximum has passed, shall continue to be "current" for an additional thirty (30) days. (updated 9/10/09)

A. Suicidal/homicidal ideation

B. Impulsivity and/or aggression

C. Psycho-physiological condition (i.e.- bulimia, anorexia nervosa)

D. Psychomotor retardation or excitation.

E. Affect/Function impairment (i.e.- withdrawn, reclusive, labile, reactivity)

F. Psychosocial functional impairment

G. Thought Impairment

H. Cognitive Impairment

III. OBSERVATION

The child's problematic behavior *and/or* severe functional impairment discussed in the presenting history *and* psychiatric/psychological examination requires further observation for clarification under section II. Allowable for up to fifteen (15) calendar days within which time the examining psychiatrist/psychologist must clarify the criteria for admission under II *AND/OR* recommend development of a discharge plan. Should it be found that the child does not fit the criteria for admission, an appropriate discharge plan is to be developed with the interagency team, and the child discharged under the provisions of that plan.

A. Troubling symptoms of the child which have been described by members of the family (and/or representatives of the community or school), persist but,
   - they are not observed on a psychiatric inpatient unit, *or*
   - they are denied by the child in outpatient or partial hospitalization treatment,

   such that the residential treatment milieu provides an ideal opportunity to observe and treat the child;

OR

B. Child's symptoms have not sufficiently improved despite responsible comprehensive treatment at a lower level of care, which has involved the participation of an interagency team.

REQUIREMENTS FOR CONTINUED STAY

(Must meet I and II)

I. DIAGNOSTIC EVALUATION AND DOCUMENTATION (see also, Appendix A)

A. The initial evaluation and diagnosis is updated and revised as a result of a face-to-face diagnostic examination by the appropriate treating psychiatrist or psychologist;

AND

B. Less restrictive treatment environments have been considered in consultation with the Interagency Service Planning Team;

AND

C. There is the clinically determined likelihood of substantial benefit as a result of continued active intervention in the Residential Treatment setting, without which there is great risk of a recurrence of symptoms;

AND

D. Any other clinical reasons supporting the rejection of other alternative services in favor of continuing Residential Treatment;

AND

E. Residential Treatment service is prescribed by the diagnosing psychiatrist/psychologist following a current face-to-face psychiatric evaluation, indicating and documenting that this is the least restrictive, appropriate service to meet the mental health needs of the child, and the discharge implementation plan.

II. . SEVERITY OF SYMPTOMS

A. Severity of illness indicators and updated treatment plan support the likelihood that: *substantial benefit* is expected as a result of continued active intervention in a psychiatric residential treatment setting, without which there is *great risk of a recurrence of symptoms*; *OR severity is such that treatment cannot be safely delivered at a lesser level of care;*

AND

B. The treatment team review recommends continued stay, documenting the need for the child's further improvement, with the corresponding modifications in both treatment plan and the discharge goals;

AND

C. Although child is making *progress toward goals* in the expected treatment process, further progress must occur before transition to a lesser level of care is advisable. The necessary changes must be identified in an updated treatment plan, and the treatment team review, in conjunction with an interagency team, must recommend continued stay;

OR

D. The symptoms or behaviors that required admission, *continue with sufficient acuity* that a less intensive level of care would be insufficient to stabilize the child's condition;

OR

E. Appearance of *new symptoms* meeting admission criteria.

III. DISCHARGE CRITERIA

A. A child admitted under Sections I and III only, of the ADMISSION CRITERIA must be discharged within fifteen (15) calendar days of admission, unless a subsequent face-to-face psychiatric evaluation clarifies child's eligibility under Section II.

B. A child not meeting criteria as established in Section II, SEVERITY OF SYMPTOMS, of the CONTINUED STAY CRITERIA, must be discharged.

Admission of a child to a Partial Hospitalization Program is most appropriately based on a diagnosis by a certified child and adolescent psychiatrist. In the absence of a child and adolescent psychiatrist, a diagnosis may be appropriately provided by a Board Certified psychiatrist. A diagnosis may otherwise be provided as indicated by the regulations governing this service. However, any time the most appropriate specializing physician is unavailable to perform the necessary diagnostic services, this should be documented and explained.

Diagnostic references for the purpose of the documentation below must conform to the most current edition of the Diagnostic and Statistical Manual (DSM).

ADMISSION CRITERIA

(Must meet I *and* II or III)

I. DIAGNOSTIC EVALUATION AND DOCUMENTATION

A. Diagnosis on DSM IV Axis I or Axis II as part of a complete multiaxial diagnostic examination (MR or D&A cannot stand alone) by a psychiatrist or psychologist (as defined in Chapter 5200.3 of the Pennsylvania Code);

AND

B. Behaviors which indicate a risk for safety to self/others, and/or decreased functioning for the child's developmental level, such that:

1. this behavioral disturbance requires regular observation and treatment, but does not require 24-hour supervision, *and*
2. reasonable treatment within a less restrictive setting has been attempted by a mental health professional, *or* treatment in a less restrictive setting has been considered and documented, but is rejected directly in favor of partial hospital treatment;

AND

C. Partial hospitalization must be recommended as the most clinically appropriate and least restrictive service available for the child, by the *treatment team* [as described in PA 55 §5100.2.] to also include: child, parent/guardian and/or caretaker, and case manager;

AND

D. Removal of a child from his/her regular classroom for all or part of the school day necessitates the incorporation of an interagency planning team (in accordance with Chapter 5210.24,(b), except when partial provides acute hospital diversion. [The interagency planning team must include the appropriate representative from the child's local school in compliance with PA School Code, Sections 1306-1309 and 2561, and establish that the child's mental health needs cannot be otherwise met with appropriate supports in a school setting];

AND

E. A treatment plan [See PA 55 §5210.35], to include a complete strengths-based assessment of the child, including identifying the strengths of child's family, community, and cultural resources, can be completed prior to admission or within five (5) days of service in the partial hospitalization program;

AND

F. In the event that conditions prevent the possibility of parental or child involvement, attempts to involve the child and parents, and/or reasons explaining their non-involvement, must be fully documented and presented to the interagency team.

II. SEVERITY OF SYMPTOMS

The child's problematic behavior *and/or* severe functional impairment discussed in the presenting history *and* psychiatric examination must include at least one (1) of the criterion in A through F with a severity level as indicated in "B" above.

A. Suicidal/homicidal ideation

B. Impulsivity and/or aggression

C. Psycho-physiological condition (i.e.- bulimia, anorexia nervosa)

E. Affect/Function impairment (i.e.- withdrawn, reclusive, labile, reactivity)

F. Psychosocial functional impairment

G. Thought Impairment

H. Cognitive Impairment

III. OBSERVATION

The child's problematic behavior *and/or* severe functional impairment discussed in the presenting history *and* psychiatric examination requires further observation for clarification under section II. Allowable for up to fifteen (15) calendar days within which time the examining psychiatrist must clarify the criteria for admission under II *AND/OR* recommend development of a transition plan. Should it be found that the child does not fit the criteria for admission, an appropriate transition plan is to be developed with the interagency team, and the child discharged under the provisions of that plan.

A. Troubling symptoms of the child which have been described by members of the family (and/or representatives of the community or school), persist but,
   - they are not observed on a psychiatric inpatient unit, *or*
   - they are denied by the child in outpatient treatment,

   such that the day treatment milieu and return to home environment daily, provides an ideal opportunity to observe and treat the child;

OR

B. Child's symptoms have not sufficiently improved despite responsible comprehensive treatment at a lower level of care, which has involved the participation of an interagency team in planning, coordinating and providing this treatment, and the interagency team currently recommends this level of treatment.

REQUIREMENTS FOR CONTINUED STAY

(Must meet I and II)

I. DIAGNOSTIC EVALUATION AND DOCUMENTATION (see also, Appendix A)

A. The initial evaluation and diagnosis is updated and revised as a result of a current face-to-face diagnostic examination by the treating psychologist or psychiatrist;

AND

B. Less restrictive treatment modalities have been considered;

AND

C. There is the clinically determined likelihood of substantial benefit as a result of continued active intervention in the Partial Hospitalization Program, without which there is great risk of a recurrence of symptoms;

AND

D. Any other reasons supporting the rejection of other alternative services in favor of continuing Partial Hospitalization;

II. SEVERITY OF SYMPTOMS

A. Severity of illness indicators and updated treatment plan support the likelihood that: *substantial benefit* is expected as a result of continued active intervention in a partial hospitalization program, without which there is *great risk of a recurrence of symptoms*; *OR severity is such that treatment cannot be safely delivered at a lesser level of care;*

B. The treatment team review recommends continued stay, documenting the need for the child's further improvement, with the corresponding modifications in both treatment plan and the discharge goals;

AND

C. Child is making *progress toward treatment goals* in the expected treatment process as evidenced by reductions in the problematic signs, symptoms, and/or behaviors the child presented upon admission; and the treatment team or interagency team review recommends continued stay, documenting the need for further improvement and the corresponding modifications in both treatment plan and the discharge goals;

OR

D. The symptoms or behaviors that required admission, *continue with sufficient acuity* that a less intensive level of care would be insufficient to stabilize the child's condition;

OR

E. The appearance of *new problems, symptoms, or behaviors* meet the admission criteria.

III. DISCHARGE CRITERIA

A. A child admitted under Sections I and III only, of the ADMISSION CRITERIA must be discharged within fifteen (15) calendar days of admission, unless a subsequent face-to-face psychiatric evaluation clarifies child's eligibility under Section II.

B. A child not meeting criteria as established in Section II, SEVERITY OF SYMPTOMS, of the CONTINUED STAY CRITERIA, must be discharged.

Admission of a child for Psychiatric Outpatient Treatment (clinic) is most appropriately based on a diagnosis by a certified child and adolescent psychiatrist. In the absence of a child and adolescent psychiatrist, a diagnosis may be appropriately provided by a Board Certified psychiatrist. A diagnosis may otherwise be provided by a developmental pediatrician or otherwise as indicated by the regulations governing this service. However, any time the most appropriate specializing physician is unavailable to perform the necessary diagnostic services, this should be documented and explained.

Diagnostic references for the purpose of the documentation below must be from the most current edition of the Diagnostic and Statistical Manual (DSM).

ADMISSION CRITERIA

(Must meet I and II)

I. DIAGNOSTIC EVALUATION AND DOCUMENTATION

A. Diagnosis on DSM IV Axis I or Axis II, as part of a complete multiaxial, face-to-face assessment (MR or D&A cannot stand alone), by a Mental Health Professional (see Title 55. Public Welfare § 5200.3) as reviewed and approved by a psychiatrist or licensed psychologist (see Title 55. Public Welfare § 5200.22(d) and § 5200.31);

AND

B. Behaviors indicate *minimal* risk for safety to self/others and child must not require inpatient treatment or a psychiatric residential treatment facility.

II. SEVERITY OF SYMPTOMS

A. Service must be recommended as the most clinically appropriate and least restrictive service available for the child, by the *treatment team director* [described in PA 55 §5100.2], as informed by the *treatment team* [described in PA 55 §5210.34]. Parent(s)/guardian(s), and/or caretaker, as appropriate, case manager (when one is assigned) and the child must be involved in the planning

process. Where a parent or the child are not or cannot be involved, the attempts to involve either or both and the reasons for non-involvement must be documented. *The treatment team should otherwise recommend the most appropriate alternatives should treatment at an outpatient clinic not be recommended*;

AND

B. There is serious and/or persistent impairment of developmental progression and/or psychosocial functioning due to a psychiatric disorder, requiring treatment to alleviate acute existing symptoms and/or behaviors; or to prevent relapse in the child with symptoms and/or behaviors which are in partial or complete remission;

OR

C. Significant psychosocial stressors and/or medical condition increasing the risk that the child's functioning will decrease for his/her developmental level;

OR

D. Symptoms improve in response to comprehensive treatment at a higher level of care, but child is still in need of outpatient treatment to sustain and reenforce stability;

OR

E. Requires prescription and monitoring of medications to mitigate the effects of the child's symptoms.

REQUIREMENTS FOR CONTINUED STAY

(Must meet I and II)

I. DIAGNOSTIC EVALUATION AND DOCUMENTATION

A. Revised and updated diagnosis by a Mental Health Professional (see Title 55. Public Welfare § 5200.3) as reviewed and approved by a psychiatrist or licensed psychologist (see Title 55. Public Welfare § 5200.31);

AND

B. There is significant family (including the child) cooperation and involvement in the treatment process, except where the involvement of family members other than the child would be clinically counter-productive or legally prohibited.

II. SEVERITY OF SYMPTOMS

A. Child is making *progress toward goals*, and the treatment team review recommends continued stay;

OR

B. The *presenting conditions, symptoms or behaviors continue* such that natural community supports alone are insufficient to stabilize the child's condition;

OR

C. The appearance of *new problems*, *symptoms*, or behaviors meet the admission criteria.

III. DISCHARGE CRITERIA

A child not meeting criteria as established in Section II, SEVERITY OF SYMPTOMS, of the CONTINUED STAY CRITERIA, must be discharged.

FUNCTION OF THE FOUR SERVICES

Inpatient Hospitalization:

- Inpatient hospitalization provides a locked setting for the delivery of acute care.

- Inpatient hospitalization combines security and restrictiveness with intensive treatment, for the purpose of ameliorating symptoms and reducing the need for such intensity of service by establishing within the child the self-control ***and/or*** capacity for constructive expression and more adaptive interpersonal skills necessary to continue treatment in a more natural and less restrictive setting.

- Inpatient hospitalization provides service for children with serious mental and/or serious emotional or behavioral problems who require the coordinated, intensive and comprehensive treatment available from a multi-disciplinary team within a secure setting.

- The inpatient hospitalization process and treatment must meet the conditions set forth in the MH/MR Act of 1966 and the MH Procedures Act of 1976.

- Treatment components include: major diagnostic assessments, medical and psychiatric treatment, and psychosocial rehabilitation (to include educational components, as appropriate to the child's development).

Residential Treatment Facilities:

- Residential Treatment Facilities provide a safe environment within a restrictive setting for the delivery of psychiatric treatment and care. However, it is an unlocked, and otherwise, less restrictive, more flexible alternative than inpatient hospitalization for the delivery of acute care and for the provision of transitional care from an acute inpatient setting.

- Residential Treatment Facilities offer the comprehensive and intense services needed for the purpose of ameliorating symptoms, by establishing within the child the self-control, the capacity for constructive expression, and the adaptive interpersonal skills necessary to continue in a more natural and less restrictive setting.

- Residential Treatment Facilities provide service for children with serious mental and/or serious emotional or behavioral problems who require the coordinated, intensive and comprehensive treatment available from a multi-disciplinary team within a structured, residential setting.

- Treatment components include: major diagnostic assessments, psychiatric and other medical treatment, and psychosocial rehabilitation. Psychosocial rehabilitation is an

important vehicle through which psychiatric residential treatment facilities provide culturally competent service. These services provide the child with community linkages and the real world competency necessary for his/her successful return to the community.

- Residential Treatment Facilities must collaborate with the school district of residency, and, if different, the school district where the child in treatment is enrolled, to ensure the child receives educational instruction in the least restrictive setting appropriate to meet their needs while accommodating their behavioral and psychiatric difficulties (see Commonwealth of Pennsylvania, OMH-95-07; BEC 19-93; OCYF.

- Parents/guardians are actively involved in the treatment planning process and provided the opportunity to address the treatment of the child in the broader context of the family system. They may receive other additional supports necessary to develop the therapeutic environment the child needs to return home or to other community settings, including training and family therapy. Also, parents/guardians are to be informed of the appropriate parent support and advocacy groups available [see addendum], or any other involvement consistent with the applicable regulations.

Partial Hospitalization Programs:

- Partial hospitalization provides a less restrictive, more flexible alternative than inpatient hospitalization for the delivery of acute care, *by providing* transitional and diversionary care from an acute inpatient setting.

- Partial hospitalization provides a short-term, intensive outpatient treatment as a transition to Outpatient Clinic services. Its purpose is to reduce the child's need for restrictive therapeutic settings for treatment, and help the child develop the necessary self-control *and/or* capacity for constructive expression, including more adaptive interpersonal skills, to make the transition to interacting more fully in family and community environments.

- Partial hospitalization provides service for children with serious mental and/or psychosocial disorders who require the coordinated, intensive and comprehensive treatment available from a multi-disciplinary team within a single setting (see **"Settings"** below).

- Partial hospitalization provides day, after school**,** weekend, and evening service for children with mental and/or psychosocial disorders, so that :
  - the child receives the additional support necessary to interact effectively and cooperatively with family members, thereby helping to insure the family bond;
  - parents/guardians can receive family therapy/treatment consistent with the treatment of their child.

- Partial hospitalization uses group approaches to the treatment of children with serious mental and/or psychosocial disorders.

- Treatment components include: major diagnostic assessments, medical and psychiatric treatment, psychosocial rehabilitation (to include educational and prevocational components, as appropriate to the child's development), individual and group therapies and opportunities for family therapy. Recognizing the responsibility of the school districts to provide an educational program for all children, full day or school day partial hospitalization programs must collaborate with the school district of residency and the school district where the child in treatment is enrolled, to incorporate an educational program within the therapeutic milieu.

Program Range- Partial hospitalization programs vary in the intensity and purpose of the services offered. The range of programs includes, on the one end, those serving a more acute population as a step-down from inpatient treatment, or as a preventive for a more restrictive treatment setting. On the other end are programs serving those with more long standing impairments, where clinical judgement suggests that partial hospitalization is therapeutically necessary to return the child or maintain the child in a stable condition while providing effective treatment.

Settings- Child partial hospitalization programs serve a range of age groups from pre- school to late teens, and they also occur in a variety of settings. Typical settings may be characterized individually or in combination by place, such as, school settings, clinics, and free-standing units; by specified time of service, such as, morning, afternoon, all day, after-school, and evening, and some have 24 hour emergency phone service; and by established age categories, such as, pre-school, children, and adolescents. In those provided in public and private school settings serving the general population, the school system and the mental health system collaborate closely in meeting the educational and mental health needs of the child. Many facilities described as "free-standing" are designed specifically for those children who require a secure setting for mental health treatment, and the coordination of education and treatment in the same setting. In other settings, such as a mental health agency, the educational component must be designed and developed to meet the child's needs in collaboration with the mental health agency.

Outpatient Treatment:

- Provision of services which are less restrictive, more flexible yet effective supports for patients discharged from in-patient or partial hospitalization. In this way outpatient services provide for the delivery of transitional care from a more restrictive setting.

- Prevent the need for more intense services, or accompany more enhanced or community based services, to help the child develop the necessary self-control, *and/or* capacity for constructive expression, including cultivating more adaptive interpersonal skills for effective participation in the child's natural setting.

- Provision of service for children with mental and/or psychosocial disorders who require the periodic support provided by this treatment, to remain stable and ensure the effectiveness of a treatment plan.

- Provision of after school service for children with mental and/or psychosocial disorders, so that :
  - parents/guardians can receive the additional support necessary to maintain a therapeutic environment for the child;
  - parents/guardians can receive family therapy consistent with the treatment of their child.

  Should service require removing the child during regular school hours, this service, and any subsequent plan to continue service during this time, must be documented with an explanation of the child's condition which necessitates such intervention.

- Treatment components include: major diagnostic assessments, medical and psychiatric treatment. Recognizing the responsibility of the Department of Education to provide an educational program for all children, the therapist must collaborate with the school or school district, but only when appropriate and as necessary to assist in the child's Individualized Education Plan when one has been or should be developed. Where such collaboration is problematic, the reasons must be clearly documented.

Treatment Range- Outpatient treatment varies in both intensity and purpose. Intensity may be reflected in the number and length of visits as well as the duration and types of service offered. The range of service provides support for a more acute population and for those without long standing impairments, where clinical judgement suggests that outpatient treatment is therapeutically necessary to return the child to or maintain the child in a stable condition. Outpatient treatment may serve as a step-down from inpatient treatment and partial hospitalization, and to prevent the need for a more restrictive treatment setting. It also serves children, and their families, experiencing distress who may need the support of short term services to ameliorate the presiding condition or

stress.

Outpatient treatment is clearly identified by the setting from which it is offered. In concordance with Title 55 Public Welfare, Chapter 5200 *Psychiatric Outpatient Clinics*, the domain of this level of treatment for the scope of this document is the clinic, exclusive of partial hospitalization and other day-treatment programs.

Continued Stay Service Documentation

The following list of information should be documented for all four services.

1. Routine assessments and treatment updates chart child's progress.

2. The establishment and documentation of active treatment must include, the implementation of the treatment plan, the therapy provided, documentation of the family's participation and interagency collaboration, cultural competency, and active discharge planning.

3. Current active treatment is focused upon stabilizing or reversing symptoms necessitating admission.

4. Current active treatment is focused on ameliorating symptoms and increasing the child's level of functioning.

5. The level of professional expertise and intervention are appropriate to address the child's current condition(s).

6. The initial discharge criteria formulated for the child have been reviewed and revised, as necessary in the course of developing the discharge plan.

7. The treatment plan and strengths-based evaluation has been updated to reflect the child's progress, medication status, continuing needs and the provider's efforts to meet the identified needs. The treatment plan addresses any necessary supports for the child's successful transition into the community, including mental health and other community-based services, and the natural resources of the family. It incorporates a plan to form appropriate transitional linkages in preparation for discharge to a less restrictive setting.

8. The treatment team programmatically reduces intensity of treatment as the child progresses toward the expected date of discharge, and forms linkages with community and family supports.

9. Type, duration and frequency of services provided to the child, and the outcome of each service must be well documented, i.e.- individual, group and family therapy; education, training and community involvement; family participation in treatment; any special activities; and medication administration and monitoring.

10. As the child improves clinically, active treatment facilitates and increases contact of the child with the community (including home and school) to which the child will return.

11. The provision of services supports the child's involvement in age appropriate activities and interests.

12. In special programs where the child does not attend the local school, there must be a current Individualized Education Plan *and/or* plan to provide the child an educational program in collaboration with the local school or school district on record at the PRTF.

13. Family (parent, guardian or custodian) is actively involved in the treatment planning and/or process. Should conditions prevent the possibility of such involvement, attempts to involve parents and/or reasons explaining their non-involvement must be fully documented and presented to an interagency team.

14. Continued inpatient hospitalization **must** be recommended by the treatment team (to also include child, parent/guardian, case manager [when one is assigned], current treating or evaluating therapist).

15. All appropriate documentation follows the child as the child makes the transition to other therapeutic services, be they more *or* less intense.

Community Integration Questionnaire

1. Are the **child's interest areas?** and **strengths?** documented, with a plan to **explore new interests and strength's** for the child?

2. Have the **child's community and family support network, and cultural resources** been explored for the purpose of involving the child in his/her own community, and recorded?

3. Has there been **recruitment of family members, or other significant individuals,** to participate as designated support persons

4. Do you have a list of the **available services, events and activities** in the community? [Both the child's home community and the community surrounding the therapeutic center, if different].

5. What activities has the child been **involved in** over the past two months? Is there a plan to **continue** this involvement?

6. Does the **treatment plan** include community integrative activities, such as:
   - planned parental supervised activities?
   - age appropriate, child independent participation in planned community activities [such as: Traditional events; school sponsored clubs and gatherings; extra-curricular classes (ie. dance, music, martial arts, etc); church or community center picnic, etc.]?
   - opportunity for child-peer interaction in the community [such as: visits to neighborhood friends (including overnight visits); participation in peer group activities [such as: neighborhood "hoops", stick ball, parties and informal gatherings].
   - [other activities- specify in treatment plan].

   OR, for children who may be more severely impaired:
   - staff oversite of planned parental supervised activities?
   - staff supervised activities for parent/child interaction?
     for child/community peer interaction?
   - staff supervised activities in the community?
   - planned reentry into the regular classroom (independently, or with a therapeutic staff support)?

7. Do you have a **plan of reenforcement** for a child's successful participation outside of the treatment setting? and a **crisis intervention plan** for the child while outside of the

treatment setting?

8. Do the **progress notes** detail the outcome of the home/community integrative activity?

9. Do you have a data gathering form or instrument to **measure the outcome** of a child's participation in a home/community activity?

10. Do you have a **plan to expand** the child's home/community/cultural participation?

References

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APPENDIX T
Part B (2)

HEALTHCHOICES BEHAVIORAL HEALTH SERVICES
GUIDELINES for BEHAVIORAL HEALTH MEDICAL NECESSITY CRITERIA

CHILDREN AND ADOLESCENTS

Behavioral Health Rehabilitation
Services Under EPSDT:
Home/Community Services
(2nd Edition)

- **Serious Emotional Disturbance**
- **Intellectual Disabilities**

INTRODUCTION:

Generally absent in both regulation and the literature on behavioral health, are admission guidelines for behavioral health services delivered to children in their homes, schools, and daily community activities. The availability of these services is required under the federal ruling titled the Omnibus Budget Reconciliation Act of 1989 (Public Law 101-239) as specifically described in the section called Early and Periodic Screening, Diagnosis and Treatment (EPSDT). Implementation of OBRA '89 in Pennsylvania was established through the Medical Assistance Bulletin 1241-90-02 of October 15, 1990. While there has been a strong focus on development and expansion of needed services to respond to children with behavioral health treatment needs in multiple child serving systems, more work is required to regulate use of services. Clearly, with concerns about containing cost while enhancing the efficacy of treatment affecting decisions on service delivery, guidelines are needed to bridge the purpose, function, and expectations of these services with actual service delivery. Up to now, the primary connection has been the determination of medical necessity, in combination with the application of the Child and Adolescent Service System Program (CASSP) principles, and a variously applied understanding of the "Wraparound" philosophy of care. The guidelines and classification system presented in this document and subsequent revisions, provide a basis for admitting children and adolescents to behavioral health services delivered in the home, and school, or elsewhere in the community, under EPSDT, and within the context of multiple child serving systems. For ease of reading in the text which follows "child" will refer to both child and adolescent unless otherwise stated.

CASSP principles and the Wraparound philosophy of care provide the foundation supporting the effort to provide mental and behavioral health services to children in their homes and communities. It is understood here that home/community delivered services are not simply intended to be a replacement for all other clinic and hospital based services. These relatively new services are to address the increasingly complex needs of children receiving services in multiple child serving systems (i.e.- child welfare, juvenile justice, education, intellectual

disabilities, and drug & alcohol) and offer an alternative to some of the functions clinic/hospital based services have previously played, because home/community delivered services are considered more appropriate to specific tasks of directed treatment.

Home/community delivered behavioral health services are specifically appropriate for children and adolescents who require intervention at the sites where their problematic behaviors occur. This eliminates the necessity to understand and treat problems, behaviors, or activities in an abstract form dissociated from their actual occurrence, and allows direct intervention. In this way the clinician observes and learns directly from the child's behavior in the natural context, but it also allows the child and clinician to formulate together the language and symbolic references to the problem and the strategies for resolution. Thus the interaction between the child and clinician is not dependent on first understanding an abstract expression of the problem, and allows the child to firmly establish the practicality of the therapeutic intervention. The clinician is not solely dependent on informants and the child receiving treatment for information, nor does the child need to transfer change which occurs in the clinic or institutional setting to the family or community setting where the problem primarily manifests.

The purpose for any recommended service must be justified and clearly stated whether they are clinic or home based. Also, the recommendation for services must carefully consider not only treatment for an identified problem, but the child's multi-system involvement, willingness to engage in treatment, the confidentiality concerns of both the child and family, and whether safety issues require a certain level of restrictiveness in the treatment planning for a particular child or adolescent. Making the decision for the type and level of service is not always easy, but the rationale for the decision made is necessary. Building the rationale requires the appropriate diagnostic and life domain assessments, treatment and interagency team involvement, and the spirit of building a cooperative effort to enhance the intervention in order to achieve the goals of treatment.

Home/Community Services

The behavioral health system has undergone substantial structural change from an emphasis on community segregation and maintenance of children with emotional disorders, to one of community integration and skill development essential in fostering increasing independence of individuals and families (see Mental Health/Mental Retardation Act of 1966 and the Mental Health Procedures Act of 1976 with subsequent amendments). The change in emphasis from providing service to children exclusively in established sites, such as clinics and hospitals, and residential and day treatment centers, to serving children individually where they live, learn and play in the community is reflective of this overall change. These changes are supportive of the wraparound philosophy of care to the extent that these community delivered services are often identified as "wraparound services." Wraparound is a philosophy which promotes developmentally appropriate behavior, activities, skills, and social skills for the child in his/her natural context through focusing on his/her individualized strengths and needs. More broadly, it promotes the opportunity for family independence from professional treatment and therapeutic

supports. Family autonomy in the care of children with special needs may be fostered through skill development and assisting the family in the development of their informal support network. An understanding of the social contexts of the child or adolescent, including school and community as well as home, is essential to determining the appropriate sites for interventions and the resources available. When professional services provide a necessary treatment, the service(s) must be focused on accomplishing a set of goals, and incorporate into the planning the appropriate tapering of the service or the replacement of the service with informal and other non-behavioral health therapeutic supports.

The Office of Mental Health and Substance Abuse Services (OMHSAS) has promoted the development of expanded behavioral health services in response to the need for services delivered to children in natural community settings. In Pennsylvania these services have multiple references including, "EPSDT mental health services", "expanded mental health services," "psychosocial rehabilitative services" and "'wraparound' mental health services". However, EPSDT refers to more than the services considered in the Level of Care protocols to follow, "enhanced" is a term relative to the services currently offered and therefore not necessarily restricted to community based services, and "wraparound" is a philosophy of care and implementation within which professional services may play a role. For clarity in this paper, the services are called simply by their association with home and community. Other psychosocial rehabilitative services which are offered on provider-site, such as therapeutic summer programs and after-school programs are not incorporated into the protocol for home/community services. It is in the application that home/community services must be medically necessary, adhere to the requirement of EPSDT service provision, and should be consistent with the wraparound process.

Treatment objectives may be characterized in at least three ways, individualized, generalized, and service specific. Individualized objectives for the child and family must be created as part of a treatment process which is strengths-based and developmentally appropriate. The generalized objectives reflected in the admission guidelines for clinic and hospital based services are as follows: ameliorate symptoms such that less restrictive and/or less intrusive services can be planned and introduced; stabilization of medical regimen for children requiring psychotropic medication which helps them to effectively receive the least restrictive/least intrusive services possible; promotion of psychosocial growth and development and prevention of regression/recidivism by improving the child's level of functioning and ability for self maintenance; coordination of the treatment and discharge plan on an ongoing basis with the appropriate agencies to provide the necessary natural community based supports; and increase in age-appropriate interactivity in a variety of settings [see "Community Integration Questionnaire" in Reference Form D (p. 27)]. Some objectives more specific to the home/community services have been mentioned above, such as: development and practice of interpersonal skills as necessary to enhance parent/child, child/adult, and child/peer relations; identification of personal, family and community resources and exploring their usage; and directly relating therapeutic aims with social contexts and laying the groundwork for treatment which references the problem (a higher level of abstraction) such as occurs in clinic based treatment.

Home and community services are developed and tailored specifically to meet individualized child and family needs (see Table 2). Specialized therapeutic services on the Medical Assistance fee schedule are: Mobile Therapy, Behavioral Specialist Consultant (Doctoral Level), Behavioral Specialist Consultant (Master's Level), Therapeutic Staff Support (TSS), and Summer Therapeutic Activities Program. Each of the first four services is distinct and described in Medical Assistance Bulletin 01-94-01, issued January 11, 1994 on "Outpatient Psychiatric Services for Children Under 21 Years of Age." The last is a new program which is described in Medical Assistance Bulletin 50-96-03, issued April 25, 1996. All of these services are provided for the purpose of improving and developing the capacity of the treated child or adolescent, and the family, thereby contributing toward the independence of the family as a unit. The need for these services will vary according to the severity of the child's problems and the richness of the resources of the child, the family, and the community.

In this edition of the guidelines for behavioral health home/community services, guidelines for the delivery of home and community behavioral health services to children with intellectual disabilities have been added. The Office of Developmental Programs supports the provision of services in homes and communities. These behavioral health services provide discrete short term, goal oriented rehabilitative interventions to children with intellectual disabilities. The availability of these services helps to ensure that children with intellectual disabilities receiving services have access to additional therapeutic interventions when medically necessary and to assist them remain in their communities.

The structural changes in the behavioral health system are reflected in the development of the Child and Adolescent Service System Program (CASSP) and its philosophy. Within the body of this Bulletin is emphasized the importance of consistency in the services with the CASSP principles. The OMHSAS summary representation of the CASSP principles, is provided below.

CASSP Principles

The CASSP philosophy of collaborative service delivery to children, adolescents and their families undergirds all treatment methods. CASSP involves all child-serving systems including mental health, intellectual disabilities, education, special education, children and youth services, drug and alcohol, juvenile justice, health care, and vocational rehabilitation. It should also include informal community supports and organizations. This philosophy is essential to making decisions to provide treatment for children. It is also the foundation that motivates the development of these guidelines. These principles are represented in the following six summary statements:

(1) Child-centered - Services are planned to meet the individual needs of the child, rather than to fit the child into an existing service. Services should be developmentally appropriate and child-specific, and should also build on the strengths of the child and family to meet the mental health, social and physical needs of the child.

(2) Family-focused - Services recognize that the family is the primary support system for the child. The family participates as a full partner in all stages of the decision-making and treatment planning process, including implementation, monitoring and evaluation. A family may include biological, adoptive and foster parents, siblings, grandparents and other relatives, and other adults who are committed to the child. The development of mental health policy at state and local levels should include family representation.

(3) Community-based - Whenever possible, services should be delivered in the child's home community, drawing on formal and informal resources to promote the child's successful participation in the community. Community resources include not only mental health professionals and provider agencies, but also social, religious and cultural organizations and other natural community support networks.

(4) Multi-system - Services should be planned in collaboration with all the child- serving systems involved in the child's life. Representatives from all these systems and the family should collaborate to define the goals for the child, develop a service plan, develop the necessary resources to implement the plan, and provide appropriate support to the child and family.

(5) Culturally competent - Culture determines our world view and provides a general design for living and patterns for interpreting reality that are reflected in our behavior. Therefore, services that are culturally competent are provided by individuals who have the skills to recognize and respect the behavior, ideas, attitudes, values, beliefs, customs, language, rituals, ceremonies and practices characteristic of a particular group of people.

Note: Pennsylvania's cultural competence initiative has focused specifically on African Americans, Latinos, Asian Americans and Native Americans who have historically not received culturally appropriate services.

(6) Least restrictive/least intrusive - Services should take place in settings that are the most appropriate and natural for the child and family and are the least restrictive and intrusive available to meet the needs of the child.

These principles encompass not only the psychological, but the physical, cognitive, and socio-cultural development of children, which include the child's dependency on family, community, and environmental influences in general. From these principles, the home/ community delivered services for which "Admission Guidelines" are provided below, can be understood as components within a wider network of service options.

CLASSIFICATION SYSTEM:

Because the collective of home/community behavioral health services is appropriate to treat

the full range of symptom severity, an organizational system for associating intensity of service with severity of need is essential. This is different from the current clinic and hospital based services which associate the individual service with the severity of need, such that inpatient hospitalization is associated with higher severity of symptoms than that of partial or outpatient. By dividing the community delivered services into four levels of intensity from least to most, these services roughly parallel the four traditional categories of clinic and hospital based services: Outpatient; Partial Hospitalization; Residential Treatment; and Inpatient Hospitalization. Services are further divided into two types: treatment and therapeutic support. With intensity of service defined by the amount of time the service is provided, as related to the type of service provided, the four levels of home/community delivered services may be identified as contiguous segments along a continuum of intensity.

The first of the four levels describes the criteria for the children with the least severe need who are eligible for the service. Each of the successive levels represents an increase in the severity level for which it is designed. Criteria for children with intellectual disabilities are identified in the first two levels only with the recognition that if these children display greater severity in their symptomatology they may receive an axis I diagnosis. Because all of the home/community delivered services are available for each of the levels, the variation in intensity must be ranked by how much service is delivered. Time is selected as a general measure of quantity for each of the levels, because it is already used in this way to determine payment when a rate is assigned to the service. At this writing, the range of hours for each of the levels is not identified, however the levels represent a proportional relationship between both, the identified levels of severity and the range of services within each.

There are a maximum of four components to each of the levels. In order of presentation in the guidelines and the table: the first part identifies the type and extent of the emotional and behavioral disturbance, including the degree of endangerment; the second requires assurance that the child or adolescent and the family is amenable to treatment in community settings; while the third assures that there is the professional opinion that the service necessary is at this level of intensity. The fourth level applies only to the two least intensive levels and tends to serve the purpose of observation based on an initial assessment of need which needs greater clarity. As the two highest levels involve a higher severity of symptoms, "observation" for the purpose of determining the problem does not apply. Differentiation between the levels rests primarily with the severity of the problem, and the ability to treat in the community but it also includes the risk of endangerment allowed. More care is required of the assessment of endangerment, but the other categories solicit the psychiatrist or psychologist to elaborate their justification. The usual process for determining improvement or relapse and identifying service and therapeutic support needs, should guide the use of the services.

Using a continuum of severity expresses schematically the importance of allowing children to flow from one category to another as indicated by the child's needs (see Table 2, below). However, suggesting discrete categories with fixed ranges may be interpreted in a manner contradictory to the value of a continuum in providing fluidity. The association of fixed ranges

of time with each level is complicated by the potential mix in the available array of services such as clinic based services, services from other child serving systems, or the inclusion of informal family and community supports. These issues beg the question of whether the severity levels may be so firmly attached to the hours of service that a child associated with one level must "officially" be reduced to another level, in order to reduce the hours of home/community based services; though the "true" severity level is higher, and the child, in truth continues to receive a high number of hours of service, but from other sources. Ideally, each severity level would have a range of hours for serving a child in each of three categories: clinic/hospital services; home/community services; and the service inherent in the personal support network. However, the usual application of admission guidelines is to structure the use of a specific service or service category, and that is the exercise here. The establishment of a recommended range of hours for the delivery of home/community services is not addressed, except to suggest an adjustable range of times depending on the other services used or functions served by family members, and that there is a proportional increase in the expectation of the maximum amount of service within each category.

For the purpose of establishing a reasonable framework, it will be assumed that the hours assigned do not consider the complicating factors of other services and other therapeutic supports, or temporary reductions of service to assess progress. The next task will be to set up a system of values for any additional services and therapeutic supports which can be used as weights to identify a child with the appropriate level.

GUIDELINE FORMATION:

Working toward furthering consistency between children's treatment needs and the broader philosophy of individualized service delivery in the most appropriate manner, is a complex task. Generalizing work such as, the principles of the Child and Adolescent Service System Program (CASSP), the values presented in a variety of CASSP publications, and the wraparound philosophy of care, provide a theoretical basis, and though this body of work has much room to grow, it is time to develop the tools of implementation. The work of admission guidelines for home/community based services is an important beginning to provide a unified basis for decision-making. It is one of the essential instruments needed for behavioral health providers, case managers, interagency teams, and third party payers (including Managed Care Organizations and their sub-contractors), to coordinate service determinations among themselves and with families (including friends and community services as appropriate). Such coordination is vital to foster confidence in the appropriateness of admissions to any of the recommended treatment modalities, as well as continued stay, and appropriate discharge planning.

Inherent in these guidelines is a framework for implementing the wraparound concept in service delivery and developing discrete individualized service programs. Individualized treatment plans may coordinate a number of services but importantly, the functions of the services must be identified so that they build upon actual strengths, actual needs are addressed by the services. It is also important to help develop family and community resources to meet these

needs. Traditional outpatient and partial hospitalization services are examples of other services which may be coordinated with home/community delivered services when medically necessary. Home/community treatment is for children who: may be effectively treated at home; who require comprehensive wraparound planning for transition from a more restrictive setting back to the home and community; who may require a treatment support system while in the community until an effective family and community support network can be activated. These services provide a full range of intensity to the child in his/her natural setting, depending on the evaluated need of the child. In considering the intensity of home/community service, delivery involves three basic elements of consideration: severity of presenting problem, appropriate intensity of service, and the least restrictive and/or intrusive service necessary. These elements are considered separately below.

Severity of Symptoms

Symptom severity is often more apparent to the clinician than it is easy to describe. Levels with identifiable indicators can make the process of assessing severity easier. Additional descriptive information remains important to provide clarifying documentation in the child or adolescent's record. Each of the four levels represented in these guidelines requires an assessment of the child's expression of emotional and behavioral disturbance in any of the following categories for consideration in the design of the individual's treatment: judgement, thought, mood, affect, impulse control, psychosocial, psychomotor retardation/ excitation, physiological functioning and/or cognitive/perceptual abilities. Also important is an assessment of the impact of any disturbance on social skill development and the relationship between them. Gaging the severity of any of these presenting symptoms is ultimately left to the judgement of the clinician in his or her review. If severity is otherwise linked to endangerment or imminent risk of out-of-home or out-of-school placement, descriptors may be crafted to indicate relative severity. Challenging behaviors closely associated with social contexts such as family, school, or other community activities must be considered when determining an appropriate treatment design involving home/community services, or any combination of home/community and the more conventional services. The severity of presentation determines the extent of service need. The severity of expression for a child with intellectual disabilities must be evaluated in relation to the individual child's behavioral norm or "baseline." The design of the treatment plan must also consider the concomitant discharge planning.

Intensity of Treatment

The intensity and range of treatment varies for each of the home/community services available for children (see Table 1). But because different treatment plans call for different combinations of services to treat a variety of children or adolescents who could be assessed at the same level of severity, intensity is associated with a multiplicity of service options and gauged by the amount of total service time needed. However, one division has been made, establishing two tiers of service based on the professional level of the service. The first is "home/community professional behavioral health services," such as Mobile Therapy and Behavioral Specialist

Consultant, and the second is "home/community behavioral health implementation-therapeutic support services," such as Therapeutic Staff Support (TSS) and Therapeutic Staff Support Aid (TSSA). The professional services are those performed by highly credentialed individuals who also play a critical role in the development of the treatment plan. Therapeutic support services require personnel who have specific training and a Bachelor's degree or, for TSSAs, a High School diploma. Their role is to assist the child or adolescent, and the family, in the follow-through of the treatment plan.

Of the four severity levels, the last two listed are intended to divert the child or adolescent from out-of-home services, or serve as a step down following the child's discharge from any in-patient or out-of-home placement. Highly intensive community delivered treatment is often needed to prevent out-of-home placement, and/or to help children to return to their natural home, school, and community from an out-of-home placement. This works by directly associating the therapeutic process of treatment with effective adaptation to the social environment. The first two severity levels allow a lower range of service intensity to assist the child and family. All the levels provide treatment, but they also encourage the family's developmental process in unassisted interaction. The therapeutic function and emphasis of each of the four service levels depends strongly on the cohesiveness of the interagency and treatment teams and the interaction between the behavioral health staff, the parents/custodians, and the child, for the effectiveness of the treatment plan developed.

Least Restrictive/Least Intrusive

Structural differences between the two kinds of services allow each to be scaled differently along the CASSP principle of providing the least restrictive and least intrusive services necessary. The site-based services, clinics and hospitals, may be scaled on a continuum of restrictiveness from more to less. Restrictiveness essentially refers to the degree the child or person is separated from the general community and integrated into a treatment community. For off-site delivery of services, or those delivered to individuals in their homes, schools, or other community settings, scaling restrictiveness does not apply. However, these services may be scaled on a continuum of intrusiveness, if intrusiveness is to be understood as the degree to which service is integrated into the natural setting and the lifestyle of the individual(s) served. It is through this understanding that it may be asserted that mental and behavioral health services in the lives of clients are not "natural," but an intervention intended to be time-limited. Of course, depending on the severity of the problem, the network of inclusion/ support and the other environmental/ecological factors, the time required for individuals' successful treatment will vary. It is these last three elements which are used to formulate the classification system in the guideline.

Home/community services are generally regarded as the least restrictive service options for children who need intensive behavioral health services. However, by delivering services to children in their homes and communities these services may potentially be the most intrusive. Traditionally, intensive behavioral health services were designed to provide treatment in settings

separate from the community, such as inpatient and partial hospitalization settings, residential treatment facilities, and outpatient clinics. This segregation of children from greater community involvement for the period of treatment has become the defining characteristic of restrictiveness and allows consideration of these services on a continuum from least restrictive to more restrictive. Home/community services parallel the intensity available in the traditional services, but because these services engage the child in family and community activities home/community services are not easily characterized as restrictive. However, they may be identified with intrusiveness due to their close involvement with, and presence in the daily activities of the child receiving treatment, and the family.

The four levels for the delivery of the home and community addressed in this bulletin, are presented in ascending order of service intensity and professional intervention. The need for greater or lesser intensity of service must be adjusted to the individual's need for active treatment as reflected in the evaluation and the treatment plan. Increased intensity of service may improve the effectiveness of treatment by providing convenience and opportunity for more responsive intervention. Reducing levels of intervention is a necessary element of therapy directed toward fostering and developing independence in the relationship formations of children with their families, peers, and functioning in normalized settings in the community. Also, care must be taken to avoid the development of a dependency relationship between any family members and behavioral health professionals which result in a non-therapeutic alliance. Each service level provides treatment with the object of helping children with acute behavioral problems or serious emotional disturbance to increase their ability to integrate into the community and culture of their respective families by increasing his or her capacity for self control.

ADMISSION GUIDELINES:

Criteria for each level of Home/community service is based on the individual severity indicators. In the admission guidelines described below is a process for deciding when to treat, continue, or discontinue treatment and refer elsewhere for other services. However, the concept of tapering, or systematically reducing the intensity of the services delivered has been added here. The guideline is divided into five (5) sections: I- Diagnostic Evaluation and Documentation; II- Severity Levels and Service Correlates; III- Therapeutic Support Criteria; IV- Continued Care; and V- Discharge and Service Transition. The first three include the evaluation and documentation criteria for Admission, the fourth and fifth are for determining the appropriateness of continuing, tapering, and discontinuing care.

As these guidelines are written, it is assumed that any child or adolescent receiving services has a case manager, that children with intellectual disabilities have a county MH/MR/ID case manager, and that all children with multiple systems involvement have incorporated into the planning process an interagency team. Concerning the structure of Section II which associates the severity of the presenting problem with four contiguous levels, each level proposes corresponding ranges of hours for both professional behavioral health services and behavioral

health therapeutic support services. For the purpose of clarity in the structure, the hours proposed assume there are no other services provided to the individual in treatment. Nor do they carry any presumption of the richness of the home/community therapeutic supports available to the child or adolescent in treatment. However, both the system and community therapeutic supports are critical to the appropriate determination of service hours to be delivered. It is for this reason that Table 2 has been included. This table provides two matrices, one for reviewing the problems of the child and the other for the strengths of the child, family and community. Each lists the possible domains and settings affected. The matrices are designed to help in the decision-making process when determining the appropriate mix of services, and the appropriate adjustment for the amount of the services in each severity level in Section II below. Such determinations should be used and documented as an adjustment of time within the severity level selected, and it is expected that this is a natural part of any interagency or treatment team process.

Home/Community Services
Admission Guidelines
(Must meet I, II, and III)

Admission of a child for Home/Community Behavioral Health Treatment is most appropriately based on a face-to-face assessment and diagnosis by the prescribing Board Certified or Board eligible child and adolescent psychiatrist, developmental pediatrician, or licensed psychologist specializing in children or adolescents. In the absence of these prescribers, a diagnosis may be appropriately provided by any Board Certified or Board eligible psychiatrist or a licensed psychologist. Any time a child or adolescent specialist is unavailable to perform the necessary diagnostic services, this should be documented and explained. As part of the assessment process and the development of treatment recommendations, the prescriber addresses the concerns and recommendations of the case manager and the interagency team.

Diagnostic references for the purpose of the documentation below must be from the most current edition of the Diagnostic and Statistical Manual (DSM). The most current edition in use at this writing is the DSM IV; for ease of reading, the text following will reflect this edition. For further convenience in reading, "child and adolescent" will follow the form of "child", unless otherwise indicated.

I. DIAGNOSTIC EVALUATION AND DOCUMENTATION

A. Mental Health

1. Diagnosis on DSM IV Axis I or Axis II, as part of a complete multi-axial, face-to-face evaluation (MR or D&A cannot stand alone);

AND

2. Evaluation indicates:
   a. child has, or is at serious risk of developing, an emotional or behavioral disturbance, or mental illness; ***and***
   b. clinic based treatment is not sufficient or appropriate to effectively serve the child/family; ***and***
   c. behaviors indicate manageable risk for safety to self/others while in the community, and child must not require inpatient treatment or a psychiatric residential treatment facility; ***and/or***
   d. the child needs home/community mental health treatment as a result of documented emotional and behavioral disturbance of functioning:
      1) within the family or other community-based residential setting, ***or***
      2) in the school setting, ***or***
      3) resulting in limitations in social and community interactions;
      or
   e. a combination of mental health needs that cannot be met without treatment delivered to the child in the community by mental/behavioral health professionals.

OR

B. Intellectual Disabilities

1. Diagnosis on DSM IV Axis II and Axis IV, as part of a complete multi-axial, face-to-face evaluation (ID cannot stand alone), without a diagnosis on Axis I;

AND

2. Evaluation indicates:
   a. an onset of remarkable or crisis behavior(s) in a child or adolescent with intellectual disabilities; ***and/or***
   b. a notable adverse change in the baseline behavior of a child or adolescent with intellectual disabilities; ***and***
   c. a medical condition has been ruled out; ***and***
   d. existing intellectual disability services are no longer sufficient or appropriate to effectively serve the child/family; ***and***
   e. behaviors indicate manageable risk for safety to self/others while in the community, and child must not require inpatient treatment or a residential treatment facility; ***and/or***
   f. the child needs home/community behavioral health treatment as a result of a documented behavioral disturbance functioning:

1) within the family, foster care, family living or other community-based setting, ***or***
2) due to behavior which results in limitations in social and community interactions; ***or***

g. a combination of behavioral health needs that cannot be met by existing intellectual disability services without treatment delivered to the child in the community by additional behavioral health professionals.

AND

C. Parent(s)/guardian(s), and/or care giver as appropriate, a lead case manager and the child to his/her fullest ability must be involved in the planning process. Where a parent (or legal guardian) or the child are not or cannot be involved, the attempts to involve either or both and the reasons for non-involvement must be documented. The interagency team should otherwise recommend the most appropriate alternatives should home/community service alone be insufficient to serve the child's needs;

AND

D. There is:

1. serious and/or persistent impairment of developmental progression not attributable to intellectual disabilities and/or psychosocial functioning due to a serious emotional disturbance or psychiatric disorder;

OR

2. an onset of remarkable or crisis behavior(s) in a child or adolescent with intellectual disabilities;

AND/OR

3. a notable adverse change in the baseline behavior a child or adolescent with intellectual disabilities resulting in significant measurable reduction in psychosocial functioning with respect to the existing developmental disorder, requiring treatment to alleviate acute existing symptoms and/or behaviors; or to prevent relapse in the child with symptoms and/or behaviors which are in partial or complete remission;

OR

E. Significant psychosocial stressors and/or medical condition increasing the risk that the child's functioning will decrease for his/her developmental level when developmental level is unrelated to intellectual disabilities;

OR

F. Behaviors or symptoms improve in response to comprehensive treatment at a higher level of care, but child needs home/community treatment to sustain and reinforce stability;

OR

G. Requires medication, and time limited monitoring of the medications is needed to mitigate the effects of the child's symptoms until the child and/or family can assume this role.

II. SEVERITY LEVELS and SERVICE CORRELATES

(See also Table 1)

Service volume and intensity must be recommended as the most clinically appropriate and least intrusive necessary for the child, by the prescriber, as informed by the interagency team.

(Must meet A or B or C or D)

A. MH - Level 1 (Least) - DSM IV Axis I/ II diagnosis

(MR or D&A cannot stand alone)

Home/Community Professional Mental Health Services

Home/Community Mental Health Therapeutic Support Services

(Must meet 1, 2, and 3; **OR** 4)

1. Service must be recommended as the most clinically appropriate service available for the child, by the prescriber as informed by the case manager and interagency team, ***and***

   a. There is serious and/or persistent impairment of developmental progression and/or psychosocial functioning due to a psychiatric disorder other than intellectual disabilities, requiring treatment to alleviate acute existing symptoms and/or behaviors; or to prevent relapse in the child for the prescribed period of time to allow the therapeutic process to hold its effectiveness with symptoms and/or behaviors which are in partial or complete remission; ***or***
   b. Significant psychosocial stressors and/or medical condition increasing the risk that the child's functioning will decrease for his/her developmental level, require home/community based intervention to develop resources within the child and/or family to provide the balance to these stressors needed to continue the child in remission and/or to promote effective adaptation; ***or***
   c. Symptoms improve in response to comprehensive treatment at a higher level of care, but child is still in need of direct home/community based treatment to reenforce stability; ***or***
   d. Requires medication and home/community based monitoring of medications to help the child (and family) understand the importance of adhering to the therapy recommended to mitigate the effects of the child's symptoms, and establish a pattern of following the prescription;

AND

2. Child's behavior is assessed to be manageable in the home/community setting, child is assessed to be responsive to the implementation of a community-based treatment plan in the professional judgment of the appropriate behavioral health professional , as a result of:

   a. the delivery of the professional care required to serve the child's specific treatment occurring on site; ***and***
   b. documented commitment by the primary care givers(usually parent/guardian) to the treatment plan;

AND

3. The severity and expression of the child's symptoms are such that:

   a. continuation with a less intense level of care cannot offer either an expectation of improvement, or prevention of deterioration, as identified above; ***and***
   b. on-site intervention in the home or community offers a more effective preventive to longer term consequences.

OR

4. OBSERVATION

   The child's problematic behavior and/or severe functional impairment discussed in the presenting history *and* psychiatric examination requires further observation for clarification under Section II. Allowable for up to fifteen (15) days within which time the examining psychiatrist must clarify the child's eligibility for admission under Section II *AND/OR* recommend development of a transition plan. Should it be found that the child does not fit the guidelines for admission, an appropriate transition plan is to be developed with the interagency team, and the child discharged under the provisions of that plan.

   a. Troubling symptoms of the child which have been described by members of the family, persist (and/or representatives of the community or school) but,
      - they are not observed on a psychiatric inpatient unit, or they are denied by the child in outpatient or partial hospitalization treatment, such that observation of the child in natural settings provides an ideal opportunity to observe and treat the child; ***or***
   b. Child's symptoms have not sufficiently improved despite well-planned comprehensive treatment in site-based levels of care, which has involved the participation of an interagency team.

A. MR- Level 1 - DSM IV Axis II/IV diagnosis

(MR cannot stand alone)

Home/Community Professional Behavioral Health Services

Home/Community Behavioral Health Therapeutic Support Services

(Must meet 1, 2, and 3)

1. Service must be recommended as the most clinically appropriate service available for the child, by the prescriber as informed by the lead case manager and interagency team, ***and***

   a. There is significant change or amplification in exhibited behaviors as indicated by an increase in frequency (average number of events per day), duration (after first day, the increase in number of consecutive days), and/or locations; ***and***
   b. Behavior presents serious risk of self injury, or injury to others, or destruction of environment; ***and***
   c. Significant psychosocial stressors are present affecting a decrease in the child's functioning; ***and/or***
   d. Requires medication and home/community based monitoring of medications to help the child (and family) understand the importance of adhering to the therapy recommended to mitigate the effects of the child's symptoms, and establish a pattern of following the prescription;

AND

2. Child's behavior is assessed to be manageable in the home/community setting, child is assessed to be responsive to the implementation of a community-based treatment plan in the professional judgment of the appropriate behavioral health professional, as a result of:

   a. the delivery of the professional care required to serve the child's specific treatment occurring on site; ***and***
   b. there is documented commitment by the primary care givers(usually parent/guardian) to the treatment plan;

AND

3. The severity and expression of the child's behaviors are such that:
   a. continuation with a less intense level of care cannot offer either an expectation of improvement, or prevention of deterioration, as identified above; ***and***
   b. on-site intervention in the home or community offers a more effective preventive approach to longer term consequences.

B. MH - Level 2 - DSM IV Axis I/ II diagnosis

(MR or D&A cannot stand alone)

Home/Community Professional Mental Health Services

Home/Community Mental Health Therapeutic Support Services

(Must meet 1, 2, and 3; or 4)

1. Risk of child harming him/herself or others, or causing destruction to property, is assessed low in the child's current problematic behavioral or functional impairment; presenting history and psychiatric examination, ***and***

   a. Must include at least one (1) of the criterion below:
      1) Suicidal/homicidal ideation
      2) Impulsivity and/or aggression
      3) Psycho-physiological condition (i.e.- bulimia, anorexia nervosa)
      4) Psychomotor retardation or excitation
      5) Affect/Function impairment (i.e.- withdrawn, reclusive, labile, reactivity)
      6) Psychosocial functional impairment
      7) Thought Impairment (i.e.- psychosis)
      8) Cognitive Impairment; ***and/or***
   b. Presence of very impaired judgement or functional capacity and capability, for the child's developmental level which is not attributable to intellectual disabilities such that interpersonal skills, and/or self-maintenance in home/school/community is/are highly compromised;

AND

2. Behavior is assessed to be manageable in the home/community setting, and degree of risk is assessed to be responsive to, and effectively reduced by the implementation of a treatment plan in the professional judgment of the advising physician or mental health professional , as a result of:

   a. the delivery of the professional care required to serve the child's specific treatment occurring on site; ***and***
   b. documented commitment by the primary care givers usually parent/guardian to the therapeutic plan;

AND

3. The severity and expression of the child's symptoms are such that:
   a. continuation with a less intense level of care cannot offer either an expectation of improvement, or prevention of deterioration, as identified above; ***and***
   b. on-site intervention in the home or community offers a more effective preventive to longer term consequences.

OR

4. OBSERVATION:

The child's problematic behavior ***and/or*** severe functional impairment discussed in the presenting history and psychiatric examination requires further observation for clarification under Section II. Allowable for up to fifteen (15) days within which time the examining psychiatrist must clarify the child's eligibility for admission under Section II *AND/OR* recommend development of a transition plan. Should it be found that the child does not meet the guidelines for admission, an appropriate transition plan is to be developed with the interagency team, and the child discharged under the provisions of that plan.

a. Troubling symptoms of the child which have been described by members of the family, persist (and/or representatives of the community or school) but,
- they are not observed on a psychiatric inpatient unit, or they are denied by the child in outpatient or partial hospitalization treatment, such that observation of the child in natural settings provides an ideal opportunity to observe and treat the child; ***or***
b. Child's symptoms have not sufficiently improved despite well planned comprehensive treatment in site-based levels of care, which has involved the participation of an interagency team.

MR - Level 2 - DSM IV Axis II/IV diagnosis
(MR cannot stand alone)
Home/Community Professional Behavioral Health Services
Home/Community Behavioral Health Therapeutic Support Services
(Must meet 1, 2, and 3)

1. Service must be recommended as the most clinically appropriate service available for the child, by the prescriber as informed by the lead case manager and interagency team, ***and***

a. There is significant change or amplification in exhibited behaviors as indicated by an increase in frequency (average number of events per day), duration (after first day, the increase in number of consecutive days), and/or locations; ***and***
b. Behavior has resulted in self-injury, or injury to others, or destruction to environment; ***and***
c. Significant psychosocial stressors are present affecting a decrease in the child's

functioning or an escalation of the child's symptoms; ***and/or***

d. Requires medication and home/community based monitoring of medications to help the child (and family) understand the importance of adhering to the therapy recommended to mitigate the effects of the child's symptoms, and establish a pattern of following the prescription;

AND

2. Child's behavior is assessed to be manageable in the home/community setting, child is assessed to be responsive to the implementation of a community-based treatment plan in the professional judgment of the appropriate behavioral health professional, as a result of:

a. the delivery of the professional care required to serve the child's specific treatment needs occurs on site; ***and***

b. there is documented commitment by the primary care givers(usually parent/guardian) to the treatment plan;

AND

3. The severity and expression of the child's behaviors are such that:

a. continuation with a less intense level of care cannot offer either an expectation of improvement, or prevention of deterioration, as identified above; ***and***

b. on-site intervention in the home or community offers a more effective preventive approach to longer term consequences.

C. MH - Level 3 (Intensive)

Home/Community Professional Mental Health Services
Home/Community Mental Health Therapeutic Support Services
(Must meet 1, 2, and 3)

1. Severe functional impairment discussed in the presenting history and psychiatric examination, is assessed in the child's problematic behavior in home, school or community, and there is risk of an out-of-home or out-of-school placement. In addition, there may be risk of danger in child harming him/herself, harming others, and/or demonstrated destruction to property; *and*

a. Must include at least one (1) of the criterion below:

1) Suicidal/homicidal threats or intensive ideation
2) Impulsivity and/or aggression
3) Psycho-physiological condition (i.e.- bulimia, anorexia nervosa)
4) Psychomotor retardation or excitation.

5) Affect/Function impairment (i.e.- withdrawn, reclusive, labile, reactivity)
6) Psychosocial functional impairment
7) Thought Impairment (i.e.- psychosis)
8) Cognitive Impairment; ***and/or,***

b. There is an exacerbation of severely impaired judgement or functional capacity and capability for the child's developmental level, which is not attributable to intellectual disabilities, such that interpersonal skills, and/or self-maintenance in home/school/community is/are severely compromised;

AND

2. Behavior is assessed to be manageable in the home/community setting, and degree of risk is assessed to be responsive to, and effectively reduced by the implementation of a treatment plan in the professional judgment of the advising physician or mental health professional, as a result of:

a. the delivery of the professional care required to serve the child's specific treatment occurring on site; ***and***
b. documented commitment by the primary care givers (usually parent/guardian) to the treatment plan; ***and***
c. if endangerment/destruction is a relevant feature of the presenting problem, both adolescent and primary care giver develop a safety plan which at least the care giver signs;

AND

3. The severity and expression of the child's symptoms are such that:

a. continuation with a less intense level of care cannot offer either an expectation of improvement, or prevention of deterioration, as identified above; ***and***
b. on-site intervention in the home or community offers a more effective preventive to longer term consequences.

D. MH - Level 4 (Highly Intensive)

Home/Community Professional Mental Health Services
Home/Community Mental Health Therapeutic Support Services
(Must meet 1, 2, & 3)

1) The severe functional impairment discussed in the presenting history and psychiatric examination is assessed in the child's problematic behavior in home, school or community and there is a high risk of an out-of-home or out-of-school placement, or a resumption of out-of-home/school placement for a child transitioning back to

home or school. In addition, there may be demonstrated risk of endangerment involving child harming self or others, or destruction to property, due to emotional or behavioral problems, or mental illness;

a. Must include at least one (1) of the criterion below:

1) Suicidal/homicidal threatening behavior or intensive ideation
2) Impulsivity and/or aggression
3) Psycho-physiological condition (i.e.- bulimia, anorexia nervosa)
4) Psychomotor retardation or excitation.
5) Affect/Function impairment (i.e.- withdrawn, reclusive, labile, reactivity)
6) Psychosocial functional impairment
7) Thought Impairment (i.e.- psychosis)
8) Cognitive Impairment; ***and***

b. There is an exacerbation of severely impaired judgement or functional capacity and capability for the child's developmental level, which is not attributable to intellectual disabilities, such that interpersonal skills, and/or self-maintenance in home/school/community is/are severely compromised;

AND

2. Behavior is assessed to be manageable in the home/community setting, and degree of risk is assessed to be responsive to, and effectively reduced by the implementation of a treatment plan in the professional judgment of the advising physician or mental health professional , as a result of:

a. the delivery of the professional care required to serve the child's specific treatment needs occurs on site; ***and***
b. there is documented commitment by the primary care givers (usually parent/guardian) to the therapeutic plan; ***and***
c. if endangerment/destruction is a relevant feature of the presenting problem, both adolescent and primary care giver develop a safety plan which, at least the care giver signs;

AND

3. The severity and expression of the child's symptoms are such that:
a. continuation with a less intense level of care cannot offer either an expectation of improvement, or prevention of deterioration, as identified above; ***and***
b. on-site intervention in the home or community offers a more effective

preventive to longer term consequences.

III. SUPPORT CRITERIA

The on-site clinical expertise necessary must be available as appropriate to the SEVERITY OF SYMPTOMS or BEHAVIORS. There must be family commitment to the treatment process of the child or adolescent. The treatment must support community integrative objectives including development of the child/adolescent's network of personal, family, and community support.

IV. CONTINUED CARE

A. Child must be reevaluated *and* continue to meet criteria for admission (Section I);

AND

B. Child shows:
   1. measured improvement *and/or* begins to demonstrate alternative/replacement behaviors (show indicators in the evaluation);

   or

   2. increased *or* continued behavioral disturbance with continued expectation for improvement (show rationale in the treatment plan);

AND

C. Treatment plan is addressing the behavior within the context of the psychosocial stressor(s)/event(s);

AND

D. Interagency service plan recommends continuation of care.

The child/adolescent must meet Admission Criteria for Section II, Level 3 or lesser levels of severity. Whenever service is provided for a term greater than three (3) months, there must be a quarterly review of the child being served which clarifies the child's progress, progress toward developing community linkages, and the necessity for continuing Home/community service rather than another service appropriate to the child's needs or discharge from behavioral health services altogether. The Interagency Service Plan must be updated and attached to the Treatment

Plan.

V. DISCHARGE AND SERVICE TRANSITION GUIDELINES

A. Mental Health

Prescriber, with the participation of the interagency team, determines that home/community service:

1. results in an expected level of stability and treatment goal attainment such that no additional home/community services are necessary and discharge occurs;

   OR

2. should be maintained as follows:
   a. continued at the current level; *or*
   b. continued with a reduced number of hours as a result of the child's improvement, and/or the child's network of family and friends, and/or the activity of community members and services; *or*
   c. increased due to changes in the context and/or adjustments in the treatment plan;

   OR

3. ceases to be effective, requiring reassessment of services and alternative planning prior to authorization of any further home/community mental health services;

   OR

4. interferes with the development of a service-independent lifestyle, requiring reassessment of the treatment plan and careful analysis of the benefits derived in light of the potential for problems created;

   OR

5. A child admitted under Section IIB only, of the ADMISSION Guidelines must be discharged within fifteen (15) days of admission, unless a subsequent face-to-face psychiatric evaluation clarifies child's eligibility under Section IIA;

   OR

B. Intellectual Disabilities

Prescriber, with the participation of the interagency team, determines that home/community service:

1. results in an expected level of stability and treatment goal attainment for the intervention such that the child meets:
   a. baseline behavior, *or*
   b. expected positive behavioral response, *and/or*
   c. that no additional home/community services are necessary;

   OR

2. should be:
   a. discontinued because it ceases to be effective, requiring reassessment of services and alternative planning prior to authorization of any further home/community behavioral health services; *or*

b. continued with a reduced number of hours as a result of the child's improvement, and/or the child's network of family and friends, and/or the activity of community members and services; *or*
c. increased due to changes in the context and/or adjustments in the treatment plan;

OR

3. the services provided create a service dependency interfering with the development of the child's progress toward his/her highest functional level, requiring reassessment of the treatment plan and careful analysis of the benefits derived in light of the potential for problems created;

OR

C. The parent/guardian (or other legally responsible care giver if applicable) or adolescent, 14 years old or older, requests reduction in service or termination of the service.

TABLE 1

BEHAVIORAL HEALTH REHABILITATION SERVICES UNDER EPSDT:
Home/Community Services

TABLE OF *SECTION II* SEVERITY LEVELS AND SERVICE CORRELATES WITH CORRESPONDING PROPORTIONAL ORDERING OF TREATMENT HOURS

(All Services Are to Be Determined On an Individual Basis for the Child or Adolescent)

(Table does not represent EPSDT psychosocial rehabilitative services provided on provider sites,such as After-school and Summer Therapeutic Activities Programs)

Level 1 (Least)	Level 2 (Moderate)	Level 3 (Intensive)	Level 4 (Highly Intensive)
(Must meet A, B, & C; ***OR*** D)	(Must meet A, B, & C; ***OR*** D)	(Must meet A, B, and C)	(Must meet A, B, and C)
I. & II. [Combined] DIAGNOSTIC INDICATORS BY LEVEL			
A. Service must be recommended as the most clinically appropriate for the child, by the *prescriber*, as informed by the *interagency team*, ***and***	**A.** Risk of harming [self, others, or property] is assessed low in the child's current problematic behavior or functional impairment and presenting history; ***and*** psychiatric or psychological examination must include:	**A.** Severe functional impairment is assessed in the child's problematic behavior in the home, school, or community; there is risk of an out-of-home or out-of-school placement; may be risk of danger of child harming him/herself, others, and/or demonstrated destruction to property; ***and***	**A.** High risk of out of home placement, or demonstrated risk of endangerment, involving child harming self or others, or destruction to property, due to emotional or behavioral problems, or mental illness; ***and/or*** the severe functional impairment in the home, school, or community, *and*
1. Children with a Diagnostic Indicator on AXIS I			
a. There is serious and/or persistent impairment of developmental progression and/or psychosocial functioning due to a serious emotional disturbance or	**a.** Assessment of at least one (1) of the following: 1. Suicidal/homicidal ideation 2. Impulsivity and/or aggression	**a.** Assessment of at least one (1) of the following: 1. Suicidal/homicidal threats or intensive ideation 2. Impulsivity and/or aggression	**a.** Assessment of at least one (1) of the following: 1. Suicidal/homicidal threatening behavior or intensive ideation 2. Impulsivity and/or aggression

TABLE 1

Level 1 (Least)	Level 2 (Moderate)	Level 3 (Intensive)	Level 4 (Highly Intensive)
psychiatric disorder, requiring treatment to alleviate acute existing symptoms and/or behaviors;	3. Psycho-physiological condition (i.e.- bulimia, anorexia nervosa) 4. Psychomotor retardation or excitation	3. Psycho-physiological condition (i.e.- bulimia, anorexia nervosa) 4. Psychomotor retardation or excitation.	3. Psycho-physiological condition (i.e.- bulimia, anorexia nervosa) 4. Psychomotor retardation or excitation.
or to prevent relapse in the child for the prescribed period of time to allow the therapeutic process to hold its effectiveness with symptoms and/or behaviors which are in partial or complete remission;	5. Affect/Function impairment (i.e.- withdrawn, reclusive, labile, reactivity) 6. Psychosocial functional impairment 7. Thought Impairment 8. Cognitive Impairment	5. Affect/Function impairment (i.e.- withdrawn, reclusive, labile, reactivity) 6. Psychosocial functional impairment 7. Thought Impairment 8. Cognitive Impairment	5. Affect/Function impairment (i.e.- withdrawn, reclusive, labile, reactivity) 6. Psychosocial functional impairment 7. Thought Impairment 8. Cognitive Impairment
or	***and/or***	***and/or***	***and***
b. Significant psychosocial stressors and/or medical condition increasing the risk that the child's functioning will decrease for his/her developmental level require home/community based intervention to develop resources within the child and/or family to provide the balance to these stressors needed to continue the child in remission; ***or***	**b.** Presence of very impaired judgement or functional capacity and capability, for the child's developmental level, such that interpersonal skills, and/or self-maintenance in home/school/community is/are highly compromised, are not attributable to intellectual disabilities;	**b.** There is an exacerbation of severely impaired judgement or functional capacity and capability, for the child's developmental level, such that interpersonal skills, and/or self-maintenance in home/school /community is/are severely compromised, are not attributable to intellectual disabilities;	**b.** There is an exacerbation of severely impaired judgement or functional capacity and capability, for the child's developmental level, such that interpersonal skills, and/or self-maintenance in home/school /community is/are severely compromised, are not attributable to intellectual disabilities;
c. Symptoms improve in response to comprehensive treatment at a higher level of care, but child is still in need of direct home/community based treatment to reenforce stability; ***or***			

TABLE 1

Level 1 (Least)	Level 2 (Moderate)	Level 3 (Intensive)	Level 4 (Highly Intensive)
d. Requires medication and home/ community based monitoring of medications to help the child (and family) understand the importance of adhering to the therapy recommended to mitigate the effects of the child's symptoms, and establish a pattern of following the prescription;			
AND/OR	**AND/OR**		
2.Children with a Diagnostic Indicator on AXIS II (without a diagnosis on Axis I)			
a. There is an onset of remarkable behaviors which could escalate to a crisis	**a.** There is an onset of remarkable or crisis behaviors.		
b. Behavior presents serious risk of self injury, or in jury to others, or destruction of environment; *and*	**b.** Behavior has resulted in self-injury, or injury to others, or destruction to environment; *and*		
c. There is significant change from baseline behavior, or amplification in exhibited behaviors, as indicated by the frequency, intensity, duration, of the behavior(s), and/or locations where the behavior(s) occur(s); ***and/or***			
d. Requires medication and home/community based monitoring of medications to help the family, and the child, consistent with the child's age and cognitive abilities, to understand the importance of adhering to the therapy recommended to mitigate the effects of the child's symptoms, and establish a			

TABLE 1

Level 1 (Least)	Level 2 (Moderate)	Level 3 (Intensive)	Level 4 (Highly Intensive)
pattern of following the prescription;			
B. Behavior is assessed to be manageable in the home/community setting, and degree of risk is assessed to be responsive to, and effectively reduced by the implementation of a behavior management plan in the professional judgment of the advising physician or mental health professional, as a result of:			
1. the delivery of the professional care required to serve the child's specific treatment needs occurs on site; *and*			
2. there is documented commitment by the primary care givers (usually parent/guardian) to the therapeutic plan.			
		and	
		3. if endangerment/destruction is a relevant feature of the presenting problem, both adolescent and primary care giver develop a safety plan which, at least the care giver signs.	**3.** if endangerment/destruction is a relevant feature of the presenting problem, both child or adolescent and primary care giver develop a safety plan which, at least the care giver signs.
AND			
C. The severity and expression of the child's symptoms are such that:: 1. continuation with a less intense level of care cannot offer either an expectation of improvement, or prevention of deterioration, as identified above; ***and*** 2. on-site intervention in the home or community offers a more effective preventive to longer term consequences.			
D. OBSERVATION- 15 days **1.** Troubling symptoms of the child (described by family/ school/ others) persist though - not observed on a psychiatric inpatient unit, ***or*** - *they are denied by the child in outpatient or partial hospitalization treatment,* *such that* observation of the child in natural settings provides the opportunity to assess and treat the child; ***OR***			

TABLE 1

Level 1 (Least)	Level 2 (Moderate)	Level 3 (Intensive)	Level 4 (Highly Intensive)
2. Child's symptoms have not sufficiently improved despite responsible comprehensive treatment in other levels of care, involving the interagency team.			

III. SUPPORT CRITERIA

The on-site clinical expertise necessary must be available as appropriate to the SEVERITY OF BEHAVIORS. There must be family commitment to the treatment process of the child or adolescent. The treatment must support community integration objectives including development of the child/adolescent's network of personal, family, and community support.

IV. CONTINUED CARE

Whenever service is provided for a term greater than three (3) months, there must be at least a quarterly review of the child being served which clarifies the child's progress, progress toward developing community linkages, and the necessity for continuing home/community service.

1. Child must be reevaluated *and* continue to meet criteria for admission (I); *and*

2. Child shows:

a) measured improvement *and/or* begins to demonstrate alternative/replacement behaviors (show indicators in the evaluation); *or*

b) increased *or* continued behavioral or emotional disturbance with continued expectation for improvement (show rationale in the treatment plan); *and*

3. Review includes consideration/evaluation of alternative Levels of Care, therapeutic approaches, informal approaches, and resources.

4. Treatment plan must be updated addressing the presenting problem within the context of the psychosocial stressor(s)/event(s); indicating that service should be:

a) continued with a reduced number of hours as a result of the amelioration of original indication for service, *and/or* activity of community members and services, and/or the child's network of family and friends; *or*

b) increased due to changes in the context and/or adjustments in the treatment plan; *and*

5. Interagency service plan must be updated to reflect the recommendation to continue care and be attached to the treatment plan

TABLE 1

V. DISCHARGE CRITERIA

A. Prescriber, with the participation of the interagency team, determines that home/community service:

1. results in an expected level of stability and treatment goal attainment for the intervention such that the child meets:
   a. baseline behavior, *or*
   b. expected positive behavioral response, *and/or*
   c. that no additional home/community services are necessary;

OR

2. should be discontinued because it *ceases to be effective*, requiring reassessment of services and alternative planning prior to authorization of any further home/community behavioral health services;

OR

3. the services provided *create a service dependency interfering with the development of the child's progress toward his/her highest functional level*, requiring reassessment of the treatment plan and careful analysis of the benefits derived in light of the potential for problems created;

OR

B. The parent/guardian (or other legally responsible care giver if applicable) or adolescent, 14 years old or older, requests reduction in service or termination of the service.

MATRICES OF

CURRENT PROBLEMS AND CURRENT STRENGTHS

BY DOMAIN AND SETTING

Matrix of Current Problems

Domain	Setting		
	Home	School	Community
Medical			
Behavioral			
Emotional			
Cognitive/Learning			
Interpersonal			
Leisure			
Unique/Other			

Matrix of Current Strengths

Domain	Setting		
	Home	School	Community
Medical			
Behavioral			
Emotional			
Cognitive/Learning			
Interpersonal			
Leisure			
Unique/Other			

REFERENCE FORM A

Expectations for All Individualized Community Based Enhanced Mental Health Services:

Individualized community based enhanced mental health services can be used in the home, community, or school, separately or in combination, as medically necessary. The child's emotional or behavioral disturbance should be carefully evaluated along the following parameters: thought, mood, affect, judgement, insight, impulse control, psychomotor retardation /excitation, physiological functioning, cognitive/perceptual abilities, psychosocial functioning as manifested in interpersonal and social skills, and motivation. Social contexts, such as home, school, and neighborhood/community must be understood in order to determine the appropriate sites of services as well as the resources within each context. Service planning determines the unique combination of individualized community based enhanced mental health services, other child serving systems and/or traditional mental health services.

The following represent specific expectations regarding the utilization of all individualized, community based enhanced mental health services subject to this document. Treatment and its documentation should be consistent with the following:

- Nature of emotional or behavioral disturbance, mental illness, or serious at-risk status is clear and is clearly demonstrated.

- Each proposed or utilized mental health service has a clearly documented rationale, with a specific role in addressing the child's medically necessary needs. Services, separably and in combination, constitute the least restrictive and least intrusive services which are medically necessary.

- Service decisions are substantially determined by an interagency process based on child-driven needs.

- Proposed treatment is demonstrated to meet identified, individualized needs and strengths, addressing child's development in multiple life domains.

- Ongoing efforts are being made to utilize community resources, whenever possible.

- Parents and guardians have requested or otherwise support the use of proposed services.

- Proposed treatment involves a plan, and subsequent demonstrated efforts to implement plan with active participation by parents, guardians, and other responsible adults.

- Treatment involves teaching and support of efforts by parents, guardians, and other responsible adults, and those activities specifically identified within the treatment plan as appropriate for involved mental health staff, rather than substitute care.

- Treatment involves ongoing integrated and supervised efforts by all service providers, which includes a lead case manager.

- Potential medication needs are being addressed or considered.

- Lack of improvement within a level of care is subject to careful clinical and systemic analysis by the team prior to either an increase or decrease of services or change in level of services.

- Exceptions to any of the above are clearly identified with explanation or rationale, and discussed with the interagency team.

REFERENCE FORM B

Function of Home/Community Services

- Provision of services which are less restrictive, more flexible yet effectively provides therapeutic supports for patients discharged from in-patient, residential treatment facilities, or partial hospitalization. In this way home/community services provide for the delivery of transitional care from a more restrictive setting.

- Prevent the need for more restrictive or higher level of services. To help the child develop the necessary self-control, *and/or* capacity for constructive expression, including cultivating more adaptive interpersonal skills for effective participation in the child's natural setting.

- Provision of service for children with mental and/or psychosocial disorders who require treatment directly in the setting where symptoms typically manifest, to remain stable and ensure the effectiveness of a treatment plan.

- Provision of after-school service for children with mental and/or psychosocial disorders, so that :
  - parents/guardians can develop the behavioral patterns necessary to provide the additional support necessary to maintain a therapeutic environment for the child;
  - parents/guardians can receive family therapy consistent with the treatment of their child.

Should service involve a child removed from school during regular school hours, this service, and any subsequent plan to continue service during this time, must be documented with an explanation of the child's condition which necessitates such intervention.

- Treatment components include: major diagnostic evaluations, medical and psychiatric treatment, and psychosocial rehabilitation. Recognizing the responsibility of the Department of Education to provide an educational program for all children, the therapist must collaborate with the school or school district, but only when appropriate and as necessary to assist in the child's Individualized Education Plan when one has been or should be developed. Where such collaboration is desired but not possible the reasons must be clearly documented.

Treatment Range- Home/community treatment varies in intensity, duration and purpose. Intensity may be reflected in the number and length of visits as well as the professional level of the service. The duration and types of service offered will vary according to the severity of the child's symptomatology and the complexity of the intervention required as described in the treatment plan. The range of service includes therapeutic support identified in four levels corresponding with the levels of severity established for Severe (but Inpatient Treatment not required), Residential Treatment Facility, Partial Hospitalization, and Outpatient Treatment, where clinical judgement suggests that outpatient treatment is therapeutically necessary to return the child to, or maintain the child in a stable condition. Home/community treatment may serve as a step-down from inpatient treatment, a residential treatment facility, and partial hospitalization, and to prevent the need for a more restrictive treatment setting. It also serves children, and their families, experiencing distress who may need the therapeutic support of short term services to ameliorate the presiding condition or stress.

REFERENCE FORM C

Continued Stay Service Documentation
For Mental Health Services

The following list of information should be documented for the four service levels.

1. Routine evaluations and treatment updates chart child's progress.

2. The establishment and documentation of active treatment must include, the implementation of the treatment plan, the therapy provided, documentation of the family's participation and interagency collaboration, cultural competency, and active discharge planning.

3. Current active treatment is focused upon stabilizing or reversing symptoms necessitating admission.

4. Current active treatment is focused on ameliorating symptoms and increasing the child's level of functioning.

5. The level of professional expertise and intervention are appropriate to address the child's current condition(s).

6. The initial discharge guidelines formulated for the child have been reviewed and revised, as necessary in the course of developing the discharge plan.

7. The treatment plan and strengths-based evaluation has been updated to reflect the child's progress, medication status, continuing needs and the provider's efforts to meet the identified needs. The treatment plan addresses any necessary therapeutic supports for the child's successful transition into the community, including mental health, substance abuse, intellectual disabilities and other community-based services, and the natural resources of the family. It incorporates a plan to form appropriate transitional linkages in preparation for discharge to less intrusive and non-restrictive services.

8. The treatment team programmatically reduces intensity of treatment as the child progresses toward the expected date of discharge, and through working with an interagency team forms linkages with community and family supports.

9. Type, duration and frequency of services provided to the child, and the outcome of each service must be well documented, i.e.- individual, group and family therapy; education, training and community involvement; family participation in treatment; any special activities; and medication administration and monitoring.

10. As the child improves clinically, active treatment facilitates and increases contact of the child with the community (including home and school) to which the child will return.

11. The provision of services supports the child's involvement in age appropriate activities and interests as outlined in the treatment plan.

12. In special programs where the child does not attend the local school, there must be a current Individualized Education Plan *and/or* plan to provide the child an educational program in collaboration with the local school or school district on record at the PRTF.

13. Family (parent, guardian or custodian) is actively involved in the treatment planning and/or process. Should conditions prevent the possibility of such involvement, attempts to involve parents and/or reasons explaining their non-involvement must be fully documented and presented to an interagency team.

14. Continued inpatient hospitalization **must** be recommended by the treatment team (to also include child, parent/guardian, case manager [when one is assigned], current treating or evaluating therapist).

15. All appropriate documentation follows the child as the child makes the transition to other therapeutic services, be they more *or* less intense.

REFERENCE FORM D

Community Integration Questionnaire

1. Are the **child's interest areas?** and **strengths?** documented, with a plan to **explore new interests and strength's** for the child?

2. Have the **child's community and family support network, and cultural resources** been explored for the purpose of involving the child in his/her own community, and recorded?

3. Has there been **recruitment of family members, or other significant individuals,** to participate as designated support persons

4. Do you have a list of the **available services, events and activities** in the community? [Both the child's home community and the community surrounding the therapeutic center, if different].

5. What activities has the child been **involved in** over the past two months? Is there a plan to **continue** this involvement?

6. Does the **treatment plan** include community integrative activities, such as:
   - planned parental supervised activities?
   - age appropriate, child independent participation in planned community activities [such as: Traditional events/celebrations; school sponsored clubs and gatherings; extra-curricular classes (i.e. dance, music, martial arts, etc); church/community center/playground activities, etc.]?
   - opportunity for child-peer interaction in the community [such as: visits to neighborhood friends (including overnight visits); participation in peer group activities (such as: neighborhood "hoops", stick ball, parties and informal gatherings].
   - [other activities- specify in treatment plan].

OR, for children who may be more severely impaired:
   - staff oversight of planned parental supervised activities?
   - staff supervised activities for parent/child interaction?
     for child/community peer interaction?
   - staff supervised activities in the community?
   - planned reentry into the regular classroom (independently, or with a therapeutic staff support

7. Do you have a **plan of reenforcement** for a child's successful participation outside of the treatment setting? and a **crisis intervention plan** for the child while outside of the treatment setting?

8. Do the **progress notes** detail the outcome of the home/community integrative activity?

9. Do you have a data gathering form or instrument to **measure the outcome** of a child's participation in a home/community activity?

10. Do you have a **plan to expand** the child's home/community/cultural participation?

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1985 "Description of Services and Service Areas." Title 55 PA Code, Chapter 4210, Harrisburg, Commonwealth of Pennsylvania, Office of Medical Assistance Programs. Title 55 PA Code, Chapters 1151 and 1153. Commonwealth of Pennsylvania.

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APPENDIX T
Part B (3)

HEALTHCHOICES BEHAVIORAL HEALTH SERVICES
GUIDELINES for BEHAVIORAL HEALTH MEDICAL NECESSITY CRITERIA

CHILDREN AND ADOLESCENTS

The Family Based Mental Health Services Program (1st Edition)

INTRODUCTION:

The Family Based Mental Health Services Program (FBMHS) represents an important option within the array of services for children and adolescents up to age 21, and their families. Utilization of the FBMHS program occurs following referral for this service and the subsequent determination by the FBMHS treatment team that the service is clinically appropriate. FBMHS is available to children who are at risk for out-of-home placement due to a severe emotional or behavioral disorder, or due to a severe mental illness. FBMHS is also used as a step-down for children returning to their family, which may include natural or substitute care families, following out-of-home placement.

These Family Based Mental Health Services Program guidelines for medical necessity (and its subsequent revisions) provide a basis for the referral of children and their families for this service. [See FBMHS program standards in State Plan Under Title XIX of the Social Security Act, Amendment, Effective Date July 1, 1990 Attachment 3.1A, Section 13.(d)(I), available in the HealthChoices Proposers' Library].

PROGRAM PHILOSOPHY & ORGANIZATION:

Consistent with the CASSP principles and philosophy, the guiding tenets of FBMHS are that children grow-up best in their own home, that the family is a resource and partner in the treatment process, that treatment utilizes strengths in addressing areas of need and concern, and

that coordination among other human service systems and with the community is essential. In addition, while the child receives treatment, services also work to enhance the family role as a resource and partner in the treatment process.

The Family Based Mental Health Services Program is a discrete service provided by a team composed of either two child mental health professionals or one child mental health professional and a child mental health worker, which is comprehensive in scope, incorporating intensive home therapy, casework services, family support services and 24 hour, 7 day availability for crisis stabilization. Each team maintains a caseload of up to eight (8) families to ensure the intensity of service and team availability to the families they serve. Team members receive supervision together as an integral part of an ongoing program for the families served. In addition, there is an ongoing training curriculum that extends over a three year period designed specifically for Family Based Mental Health Service Team members.

The service is broadly conceived for flexible use in the home and community. The specific frequency and schedule of face-to-face contacts are developed collaboratively with the family, based on needs at that time. This allows the team to provide for individual family needs when they are closely associated with the child's treatment, such as time for family education/training regarding therapeutic components and skill building for the child and family. The team also works with the family to identify resources available to them. Teams are available to provide 24 hour service, and they also work with other systems when they are involved with the child and family, such as Drug and Alcohol Services, Children and Youth, Juvenile Justice, special education, etc. Clinical treatment within FBMHS is guided by the recognition of the normal growth and development of children at different ages, and supports family caretaking and functioning through collaborative, conjoint family meetings, which can include different combinations of family members and community members as indicated. Due to its commitment to support both the development of children and the integrity of the family, FBMHS, while primarily treatment, also serves a preventive function. The needs of all the children within a family, not just the child in response to whom services were initiated, are actively considered and included as part of the treatment process.

Services offered by the FBMHS program include formal individual and family therapy sessions with the child and/or family. In addition, program service requirements include the following:

- Crisis intervention and stabilization;

- Emergency availability;

- Ongoing information-gathering in support of active treatment;

- Collaborative development and modification of the treatment plan;

- Clinical intervention by each team member with the child in attaining identified treatment goals and objectives within the treatment plan, including: remediation of child's symptoms (i.e. behavioral, affective, cognitive, thought impairments, etc.), improvement of family relationships, community integration, and other aspects of psychosocial competence and skill development in the home, school, or community;

- Support for the parents in implementing effective behavior management and parenting approaches specific to the presenting problems of their child;

- School-based consultation and intervention as needed;

- Referral, coordination, and linkage to other agencies, social services, and community services, as appropriate;

- Assistance in obtaining relief services such as babysitters, homemakers, respite care and supportive services such as transportation and recreation, and developing a network in order to receive these services.

The Family Support Service (FSS) is a requirement in the Family Based Mental Health Services Program under Health Choices. Family-Based Family Support Services (FBMHS) are formal and informal services or tangible goods which are needed to enable a family to care for and live with a child who has a serious emotional disturbance. FBMHS/FSS include supportive services and tangible goods, which facilitate achievement of the child's treatment goals. If a child is in temporary out-of-home placement, FBMHS/FSS should be used to facilitate the return of the child to the natural family and in this instance should be available to both the natural family as well as the foster family.

A cost component for FBMH/FSS is built into the HealthChoices capitation rate. As such, it is recommended that the provider and the BH-MCO agree to a method for setting aside an appropriate percentage of the FBMHS provider fee for the purchase of services or goods needed to further the child's treatment goals.

The FBMHS budget identifies administrative and program costs which include family support services.

- The FBMHS unit of service is billed for activities or direct services which are provided by the Family-Based team members using existing procedure codes. Only such FBMHS units are reported as encounter data.

- There is no separate reporting requirement for FBMH Family Support Services.

- The provider must have an accounting system that identifies revenue sources and expenditures.

ADMISSION CRITERIA

(Must meet I and II)

I. DIAGNOSTIC EVALUATION AND DOCUMENTATION

A. Diagnosis on DSM IV Axis I or Axis II, as part of a complete multiaxial, face-to-face assessment (MR or D&A cannot stand alone), by a Mental Health Professional (see Title 55. Public Welfare § 5200.3). A psychiatrist, physician or licensed psychologist determines that the child is eligible and recommends the FBMHS program (State Plan Under Title XIX of the Social Security Act, Amendment, Effective Date July 1, 1990 Attachment 3.1A, Section 13.(d)(I));

AND

B. Other less restrictive, less intrusive services have been provided and continuation in this less intensive level of care cannot offer either an expectation of improvement or prevention of deterioration of the child's and the family's condition;

OR

Child has been discharged from an Inpatient Hospitalization or a Residential Treatment Facility, and other less restrictive, less intrusive services cannot offer either an expectation of improvement or prevention of deterioration of the child's and the family's condition;

AND

C. Behaviors indicate manageable risk for safety to self/others and child must not require treatment in an inpatient setting or a psychiatric residential treatment facility.

II. SEVERITY OF SYMPTOMS

A. Treatment is determined by the treatment team to be necessary in the context of the family in order to effectively treat the child,

AND

1. the family recognizes the child's risk of out of home placement and the problem of maintaining their child at home without intensive therapeutic interventions in the context of the family;

AND/OR

2. the child is returning home and FBMHS is needed as a step down from an out-of-home placement;

AND

B. The child's problematic behavior and/or severe functional impairment discussed in the presenting history and psychiatric/psychological examination must include at least one (1) of the following:

1. Suicidal/homicidal ideation
2. Impulsivity and/or aggression
3. Psycho-physiological condition (i.e.- bulimia, anorexia nervosa)
4. Psychomotor retardation or excitation.
5. Affect/Function impairment (i.e.- withdrawn, reclusive, labile, reactivity)
6. Psychosocial functional impairment
7. Thought Impairment
8. Cognitive Impairment

AND

C. Following referral, service must be recommended as the most clinically appropriate and least restrictive service available for the child, by the FBMHS treatment team. Parent(s)/guardian(s), and/or caretaker, as appropriate, case manager (when assigned) and the child must be involved in the planning process;

AND

D. There is serious and/or persistent impairment of developmental progression and/or psychosocial functioning due to a psychiatric disorder or serious emotional disturbance, requiring treatment in the home and family involvement to alleviate acute existing symptoms and/or behaviors; or to prevent relapse in the child with symptoms and/or behaviors which are in partial or tentative remission;

OR

E. There is an exacerbation of severely impaired judgement or functional capacity and capability, for the child's developmental level, such that interpersonal skills, and/or self-maintenance in the home is severely compromised, and intervention involving the child and family is necessary;

OR

F. Significant psychosocial stressors are affecting the child and the family as a whole, increase the risk that the child's functioning will decrease for his/her developmental level;

OR

G. Symptoms improve in response to comprehensive treatment at a higher level of care, but child needs FBMHS to sustain and reinforce stability while completing the transition back to home and community.

REQUIREMENTS FOR CONTINUED CARE

(Must meet I and II)

I. DIAGNOSTIC EVALUATION AND RECOMMENDATION

A. Recommendation to continue FBMHS must occur:

1. by the treatment team every 30 days through an updated and revised treatment plan, and

2. by a psychiatrist, licensed psychologist, or physician at the end of 32 weeks, with an updated diagnosis;

AND

B. There is significant family (including the child) cooperation and involvement in the treatment process.

AND

C. An updated treatment plan by the treatment team indicates child's progress toward goals, the progress of the child and family as a unit, and revision of goals to reflect documented changes, and the child and family involvement in the treatment planning process.

II. SEVERITY OF SYMPTOMS

A. Child and the family are making progress toward goals, and the treatment team review recommends continued stay;

OR

B. The presenting conditions, symptoms or behaviors continue, such that family and natural community supports alone are insufficient to stabilize the child's condition;

OR

C. The appearance of new conditions, symptoms or behaviors meeting the admission criteria.

III. SUPPORT CRITERIA

The on-site clinical expertise necessary must be available as appropriate to the SEVERITY OF BEHAVIORS. There must be family commitment to the treatment process of the child or adolescent. The treatment must support community integrative objectives including development of the child/adolescent's network of personal, family, and community support.

IV. CONTINUED CARE DOCUMENTATION

A. Child must be reevaluated every 30 days for the purpose of updating the treatment plan and continue to meet Requirements for Continued Care.

1. The review of the child being served must:
   a) clarify the child's progress within the family context and progress toward developing community linkages; and
      1) clarify the goals in continuing FBMHS; and
      2) the need for continuing FBMHS if continuation beyond 32 weeks is recommended; and
   b) whenever FBMHS service is considered for a term greater than 32 weeks:

1) a psychiatrist, licensed psychologist, or physician must update the diagnosis; and
2) review includes consideration/evaluation of alternative Levels of Care, therapeutic approaches, informal approaches, and resources; and

B. Child demonstrates:

1. measured improvement *and/or* begins to demonstrate alternative/replacement behaviors (document indicators in the evaluation); *or*
2. increased *or* continued behavioral disturbance with continued expectation for improvement (indicate rationale in the treatment plan);

and

C. Treatment plan is addressing the behavior within the context of the child's problem and/or contributing psychosocial stressor(s)/event(s);

and

D. Treatment plan is updated to reflect recommendation to continue care.

V. DISCHARGE AND SERVICE TRANSITION GUIDELINES

A. The treatment team, determines that FBMHS:

1. up to 32 weeks of FBMHS services has been completed; and/or
2. the service results in an expected level of stability and treatment goal attainment for the intervention such the child meets:
   a) expected behavioral response, and/or
   b) the FBMHS program is no longer necessary in favor of a reduced level of support provided by other services, or
3. FBMHS should be discontinued because it ceases to be effective, requiring reassessment of services and alternative planning prior to offering further FBMHS; or
4. creates a service dependency interfering with the family-child development and the development of the child's progress toward his/her highest functional level; requiring reassessment of the treatment plan and careful analysis of the benefits derived in light of the potential for problems created;

OR

B. The parent/guardian (or other legally responsible care giver if applicable) or adolescent (14 years old or older) requests a reduction in service or complete termination of the service.

TABLE OF FAMILY BASED MENTAL HEALTH SERVICES PROGRAM ADMISSION CRITERIA

Family Based Mental Health Services (Must meet I/II and III)
I. & II. [Combined] DIAGNOSTIC INDICATORS [Axis I or Axis II; D&A on Axis I, and MR on Axis II do not stand alone] (Must meet A, B, C & D)
A. Service must be recommended as the most clinically appropriate for the child, by the prescriber, as informed by the treatment team as an alternative to out-of-home placement or as a step down from inpatient hospitalization or Residential Treatment, **or** as a result of little or no progress in a less restrictive/intrusive service,
AND
B. Severe functional impairment is assessed in the child's presenting behavior. The intensity of service is determined on an individualized basis according to the following parameters: severity of functional impairments, risk of out-of-home placement, and risk of endangerment to self, others or property.
1. There is serious and/or persistent impairment of developmental progression and/or psychosocial functioning due to a psychiatric disorder or serious emotional disturbance, requiring treatment to alleviate acute existing symptoms and/or behaviors; or to prevent relapse in the child for the prescribed period of time to allow the therapeutic process to hold its effectiveness with symptoms and/or behaviors which are in partial or complete remission; and
2. Treatment is determined by the treatment team to be necessary in the context of the family in order to effectively treat the child, and a. the family recognizes the child's risk of out-of-home placement and the problem of maintaining their child at home without intensive therapeutic interventions in the context of the family; and/or

Family Based Mental Health Services (Must meet I/II and III)
b. the child is returning home and FBMHS is needed as a step down from an out-of-home placement; and
3. Presence of at least one (1) of the following: a. Suicidal/homicidal threatening behavior or intensive ideation b. Impulsivity and/or aggression c. Psycho-physiological condition (i.e.- bulimia, anorexia nervosa) d. Psychomotor retardation or excitation. e. Affect/Function impairment (i.e.- withdrawn, reclusive, labile, reactivity) f. Psychosocial functional impairment g. Thought Impairment h. Cognitive Impairment and
4. There is an exacerbation of severely impaired judgement or functional capacity and capability, for the child's developmental level, such that interpersonal skills, and/or self-maintenance in home/school /community is/are severely compromised; and
5. Following referral, service must be recommended as the most clinically appropriate and least restrictive service available for the child, by the FBMHS treatment team. Parent(s)/guardian(s), and/or caretaker, as appropriate, case manager (when assigned) and the child must be involved in the planning process; and
6. Significant psychosocial stressors are affecting the child and the family as a whole, increase the risk that the child's functioning will decrease for his/her developmental level;

Family Based Mental Health Services (Must meet I/II and III)
or
7. Symptoms improve in response to comprehensive treatment at a higher level of care, but child needs FBMHS to sustain and reinforce stability while completing the transition back to home and community.
AND
C. Behavior is assessed to be manageable in the home setting, and degree of risk is assessed to be responsive to, and effectively reduced by the implementation of the treatment plan, as a result of:
1. the delivery of the therapy and casework services in the home, required to serve the child's specific treatment needs; and
2. there is documented commitment by the family to the treatment plan and
3. if endangerment/destruction is a relevant feature of the presenting problem, both child or adolescent (age 14+) and family member develop a **safety plan** which, the family member signs.
AND
D. The severity and expression of the child's symptoms are such that:
1. continuation with a less intense level of care cannot offer either an expectation of improvement, or prevention of deterioration, as identified above; and 2. on-site intervention in the home or community offers a more effective preventive to longer term consequences.

Family Based Mental Health Services

(Must meet I/II and III)

III. SUPPORT CRITERIA

The on-site clinical expertise necessary must be available as appropriate to the SEVERITY OF BEHAVIORS. There must be family commitment to the treatment process of the child or adolescent. The treatment must support community integrative objectives including development of the child/adolescent's network of personal, family, and community support.

IV.CONTINUED CARE

Child must be reevaluated every 30 days for the purpose of updating the child's progress, progress toward developing community linkages, and the necessity for continuing Family Based Mental Health Services in the treatment plan.

A. The review of the child being served must:

1. clarify the child's progress in treatment, within the family context, and toward developing community linkages; and
   a. clarify the goals in continuing FBMHS; and
   b. the need for continuing FBMHS, if continuation beyond 32 weeks is recommended; *and*
2. whenever FBMHS service is considered for a term greater than 32 weeks:
   a. a psychiatrist, licensed psychologist, or physician must revise and/or update the diagnosis; *and*
   b. review includes consideration/evaluation of alternative Levels of Care, therapeutic approaches, informal approaches, and resources;

AND

B. Treatment plan is updated to reflect the recommendation to continue care.

AND

C. Treatment plan is addresses the presenting problem within the context of the family and/or contributing psychosocial stressor(s)/event(s); *and*

AND

D. Child demonstrates:

1. measured improvement *and/or* begins to demonstrate alternative/replacement behaviors (document indicators in the evaluation);

or

2. increased *or* continued behavioral or emotional disturbance with continued expectation for improvement (indicate rationale in the treatment plan);

V. DISCHARGE CRITERIA

A. Prescriber, with the participation of the interagency team, determines that:

1. Up to 32 weeks of FBMHS services has been completed;

and/or

2. The service results in an expected level of stability and treatment goal attainment for the intervention such that the child meets:
   a. expected positive behavioral response; *and/or*
   b. FBMHS are no longer necessary in favor of a reduced level of support provided by other services;

or

3. FBMHS should be discontinued because it *ceases to be effective*, requiring reassessment of services and alternative planning prior to authorization of any further Family Based Mental Health Services;

or

4. the services provided create a service dependency interfering with the family-child development and the development of the child's progress toward his/her highest functional level; requiring reassessment of the treatment plan and careful analysis of the benefits derived in light of the potential for problems created;

or

AND

B. The parent/guardian or adolescent, 14 years old or older, requests reduction in service or termination of the service.

HEALTHCHOICES BEHAVIORAL HEALTH SERVICES
GUIDELINES for MENTAL HEALTH SERVICE NECESSITY CRITERIA

CHILD/ADOLESCENT **TARGETED CASE MANAGEMENT SERVICES**

Admission Criteria

An individual who meets the minimum staff requirements for an Intensive Case Manager as defined by Chapter 5221, Mental Health Intensive Case Management; or a Resource Coordinator as defined by Mental Health Bulletin OMH-93-09 —Resource Coordination: Implementation; or a Blended Case Manager as defined by Office of Mental Health and Substance Abuse Bulletin OMHSAS-10-03 Blended Case Management (BCM) - Revised and has received training on the use of the environmental matrix has conducted an evaluation and has determined that:

I. The child/adolescent meets either the eligibility criteria for Resource Coordination Services as defined by Mental Health Bulletin OMH-93-09 —Resource Coordination: Implementation; or Intensive Case Management Services as defined by Chapter 5221, Mental Health Intensive Case Management; or Blended Case Management as defined by Office of Mental Health and Substance Abuse Bulletin OMHSAS-10-03 Blended Case Management (BCM) - Revised;

or

II. The child/adolescent meets the criteria for serious emotional disturbance (SED) as described in *Federal Register Volume 58 No. 96, May 20, 1993, pages 29422-29425*;

and

III. The child/adolescent is in need of Targeted Case Management Services as indicated by the evaluation of the functional level through utilization of the Targeted Case Management — Child/Adolescent Environmental Matrix and in conjunction with clinical information and the professional judgement of the reviewer.

Continued Stay and/or Change of Level of Need

The child/adolescent and his/her family and/or guardian, or caregiver/natural support must be reassessed at the point of concurrent review, but no less frequently than six month intervals, and when there are significant changes in the individual's situation that warrants a change in level of TCM services.

I. The child/adolescent continues to meet either I or II of Admission Criteria.

and

II. The child/adolescent is in need of Targeted Case Management Services as indicated by the evaluation of the functional level through utilization of the *Targeted Case Management — Child/Adolescent Environmental Matrix* and in conjunction with clinical information and the professional judgement of the reviewer

Discharge Indicators

Targeted Case Management may be terminated when one of the following criteria is met:

A. The child/adolescent or family receiving the service determines that targeted case management is no longer needed or wanted and the child/adolescent no longer meets the continued stay criteria; or

B. Determination by the targeted case manager in consultation with his/her supervisor or the director of targeted case management, and with written concurrence by the county administrator that targeted case management is no longer necessary or appropriate for the child/adolescent receiving the service and the child/adolescent no longer meets the continued stay criteria; or

C. The child/adolescent or family receiving the service determines that targeted case management is no longer wanted, even though, the child/adolescent does meet continued stay criteria; or

D. the child/adolescent and family has moved outside of the current geographical service area (e.g., county, state, country).

TCM ENVIRONMENTAL MATRIX —CHILDREN
INSTRUCTIONS

The Environmental Matrix — Children is a scale that evaluates the functional and need levels of children and adolescents who are under the age of 18 years old or who are over 18 years of age but who are still attending a school program. *Note: Adolescents age 16 – 22 may be assessed on either the child/adolescent environmental matrix or the adult environmental matrix, depending on the adolescent's current circumstances. The parent/guardian and adolescent, in discussion with the reviewer, should determine which Environmental Matrix will be used.* The child/adolescent and family and/or guardian or care giver/natural support must be assessed in a face to face interview assessment with the evaluator. Cultural competency will be recognized throughout the entire evaluation process and the entire document. Individuals should be reassessed as needed, but no less than every six months. There are ten (10) assessment areas identified in relationship to Targeted Case Management services:

1. Accessing Mental Health Services
2. Informal Support Network Building
3. Education/Vocation
4. Children and Youth System Involvement
5. Juvenile Justice/Criminal Justice System Involvement
6. Parent/Guardian and/or Other Family Members with Significant Family Needs.
7. Drug and Alcohol System Involvement
8. Mental Retardation System Involvement
9. Physical Health System Involvement

10a. At Risk of Out-of-Home Placement

Or

10b. Currently in RTF, Other Out of Home Placements or Inpatient

Please note: Although items 10a. and 10b. both deal with residential placement, scoring is done for ***only one of the items***, ***either*** item 10a. ***or*** item 10b., since only one of these items can be relevant to the child/adolescent's current residential status.

The scale has a range from 0 to 5 with the following values for each activity:

0	1	2	3	4	5
No assistance needed	Minimum of assistance needed		Needs moderate assistance in this area		Needs significant assistance in this area

All ten assessment areas are ranked on the above scale. The evaluator must complete the environmental matrix in a face-to-face, strengths-based assessment interview with the child/adolescent and his/her family and/or guardian, or care giver/natural support. Evaluators should incorporate in their assessment a recognition/determination of cultural strengths (i.e., extended family, resourcefulness and responsibility). The evaluator should consider the child's/adolescent's and parent's/guardian's (family) strengths and needs in the following life domains for each assessment area in order to produce a score that reflects the full dimension of need:

- Housing/living situation
- Income/benefits/financial management
- Socialization/support
- Activities of daily living
- Medical treatment

Each assessment area is defined at the " 1", " 3 ", and " 5 " levels (See attached Environmental Matrix) and the subtotal score is divided by 10 to obtain the EM Score (when scoring the individual, refer to the Environmental Matrix TCM Scoring Grid which identifies the expected frequency of TCM contact needed for the individual for that particular assessment area). Scoring levels may be gradated to the 0.5 level only; this allows for minor differentiation of the child's/adolescent's needs without compromising the integrity of the scale.

Looking at the behavior, inclusive of the lowest level of functioning, and situation of the child/adolescent during the last ninety (90) days, rate the child's/adolescent's need for TCM in each of the ten areas. Please note that the rating for each area should be made in whole numbers; in cases where there are extraordinary factors that make the assignment of whole numbers extremely difficult, if not impossible, 0.5 points may be added to or subtracted from the base scores. The sum of the ten (10) scores should then be taken and divided by 10 and the resulting subtotal score should be reviewed and compared to other known factors that may affect the consumer's need for service. Note: If a particular assessment area does not apply to the individual being assessed, a score should not be given for that assessment area and the total score should be divided by the number of assessment areas scored. This should be noted on the scoring sheet. If after averaging the scores, the average is lower by at least 2 points than any one value given in any one assessment area (e.g., if a person's average is 2 and he/she received a score of 4 in any one area), the evaluator must provide written justification for assignment to the level that corresponds to the average, rather than the higher value. The Environmental Matrix score, your *professional judgement* *, and other information (e.g., cultural factors, records of past treatment, etc.) that impacts on the child's/adolescent's level of need should then be considered and the recommended level of TCM service should be entered on the recommended level of TCM line of the scoring sheet. (These levels are consistent with minimum levels of contact as defined

in *Chapter 5221, Intensive Case Managemen*t regulations and bulletin *OMH-93-09, Resource Coordination: Implementation*.) If the recommended level of TCM services differs from the Environmental Matrix Score, the difference must be justified with professional judgement in the "Other Factors/Issues Affecting Score" section of the scoring sheet. **Note: The level of service indicated by the assessment represents the individuals needs at the time of the assessment. Service intensity could change as an individual's needs and/or desires for service change.**
Please note:

ENVIRONMENTAL MATRIX — CHILD/ADOLESCENT
TCM SERVICE SCORING GRID

MATRIX LEVEL	NEED LEVEL	INTENSITY OF CARE
4.0 –5.0	ICM	At least 1 contact every 14 days (Face to face contact strongly recommended).
1.5 –3.9	RC	At least 1 contact every 30 days (Face to Face)
0.0 - 1.4	NO TCM NEEDED	Alternative services may be needed and if necessary, referrals should be made.

* ***professional judgement:*** *opinion based on a thorough and ethical analysis of facts, data, history, and issues in accordance with one's training and experience.*

ACCESSING MENTAL HEALTH SERVICES

Child's/adolescent's mental health problems require mental health services and the family requires help to access them. The TCM should take into consideration that the behavioral health system may pose a number of barriers which serve as obstacles to assessing services (e.g., language, perceived/actual institutional racism/discrimination, the family may mistrust the behavioral health system, the family may lack the capability to access services, the family may lack information, be overwhelmed, poorly informed about the benefits of such services, or intimidated by the system). The TCM is instrumental in assuring that the child/adolescent receives the necessary services for therapy, medication monitoring, etc.

***The decision for level of TCM needed in this area must be determined in collaboration with family and/or guardian, or care giver/natural support and child/adolescent.**

0	1	2	3	4	5
	Needs minimal assistance in this area		Needs moderate assistance in this area		Needs significant assistance in this area

0= Parent/guardian and child/adolescent does not require/desire any assistance in this area.

1= Parent/guardian and child/adolescent requires/desires a minimal level of assistance, guidance and support to obtain mental health and other essential services to meet the child's/adolescent's multiple needs.

3= Parent/guardian and child/adolescent requires/desires a moderate level of assistance, guidance and support to obtain mental health and other essential services to meet the child's/adolescent's multiple needs.

5= Parent/guardian and child/adolescent requires/desires a significant level of assistance, guidance and support to obtain mental health and other essential services to meet the child's/adolescent's multiple needs.

INFORMAL SUPPORT NETWORK BUILDING

The child/adolescent and parent/guardian identifies, communicates, and interacts with family, friends, significant others, and community groups from whom the child/adolescent may gain informal support. Service system barriers and other factors, however, may impede the child/adolescent and parent/guardian from interacting with family, friends, significant others and community groups. The child/adolescent may need assistance to challenge and remove barriers so as to enhance the informal building of supports. The child/adolescent may need the assistance of the targeted case manager and/or others to identify, enhance and/or maintain existing relationships and the encouragement to develop new ones.

***The decision for level of TCM needed in this area must be determined in collaboration with family and/or guardian, or care giver/natural support and child/adolescent.**

0	1	2	3	4	5
	Needs minimal assistance in this area		Needs moderate assistance in this area		Needs significant assistance in this area

0= Parent/guardian and child/adolescent does not require/desire any assistance in this area.

1= Child/adolescent is able to identify and provide meaningful/accurate/relevant information about family, friends, significant others, and social/religious groups with whom he/she interacts and from whom the child/adolescent may gain informal support. The parent/guardian and child/adolescent requires and/or desires minimal assistance, to access and maintain positive relationships with these people and groups who provide personal social support and/or companionship.

3= Child/adolescent needs and/or requests moderate assistance in identifying and communicating with family, friends, significant others, and social/religious groups from whom the child/adolescent may gain informal support. The parent/guardian and child/adolescent requires and/or desires moderate assistance from others in order to enhance and/or maintain existing relationships and to develop new ones.

5= Child/adolescent is unable to identify nor interact with family, friends, significant others, and/or social/religious groups who may serve as personal supports. The child/adolescent has few, if any, personal or familial relationships and is unable/unwilling to interact positively, if at all, with these persons or groups. The parent/guardian and child/adolescent requires and/or desires significant assistance from others to elicit information and support on his/her behalf.

EDUCATION/VOCATION

The need for additional or more appropriate educational and/or vocational services, based on the needs of the child/adolescent, including a more appropriate educational and/or vocational placement, may require school meetings, IEP meetings, meetings with the Office of Vocational Rehabilitation or other vocational planning or service groups (e.g., vocational service providers), advocacy for the child's/adolescent's needs and providing information to the parent/guardian

regarding their rights in determining the appropriate education/vocational setting for their child/adolescent. The child/adolescent should have everything that is necessary to be successful in an educational and/or vocational environment, including access to the family's primary language for all meetings. TCM assists the parent/guardian in accessing educational and/or vocational advocacy and obtaining the appropriate education and/or vocational training for the child/adolescent and offers support in conflicts between the school and parent/guardian concerning the child/adolescent's needs and services to be provided.

***The decision for level of TCM needed in this area must be determined in collaboration with family and/or guardian, or care giver/natural support and child/adolescent.**

0	**1**	**2**	**3**	**4**	**5**
	Needs minimal assistance in this area		Needs moderate assistance in this area		Needs significant assistance in this area

0= Parent/guardian and child/adolescent does not require/desire any assistance in this area.

1= Parent/guardian and child/adolescent requires/desires a minimal level of assistance, guidance and advocacy to obtain support for and to maintain appropriate educational services.

3= Parent/guardian and child/adolescent requires/desires a moderate level of assistance, guidance and advocacy to obtain support for and to maintain appropriate educational services.

5= Parent/guardian and child/adolescent requires/desires a significant level of assistance, guidance and advocacy to obtain support for and to maintain appropriate educational services.

CHILDREN AND YOUTH SYSTEM INVOLVEMENT

TCM may assist family in working with CYS and meeting CYS requirements for the parent/guardian or care giver/natural support and their child/adolescent with serious emotional disturbances. TCM assists the family in responding to the

CYS family services plan. TCM may be needed to assure collaboration between the Children and Youth and Mental Health systems and a need for collaboration among multiple providers from these two systems. TCM may also participate in court processes for the family and the child/adolescent.

***The decision for level of TCM needed in this area must be determined in collaboration with family and/or guardian, or care giver/natural support and child/adolescent.**

0	**1**	**2**	**3**	**4**	**5**
	Needs minimal assistance in this area		Needs moderate assistance in this area		Needs significant assistance in this area

N/A= Parent/Guardian and child/adolescent does not need/have involvement with the Children and Youth System.

0= Parent/guardian and child/adolescent does not require/desire any assistance in this area.

1= Parent/guardian and child/adolescent requires/desires a minimal level of assistance, guidance and support from TCM to carry out the goals of CYS plan, maintain a safe and healthy environment and assure child's/adolescent's participation in mental health services.

3= Parent/guardian and child/adolescent requires/desires a moderate level of assistance, guidance and support from TCM to carry out the goals of CYS plan, maintain a safe and healthy environment and assure child's/adolescent's participation in mental health services.

5= Parent/guardian and child/adolescent requires/desires a significant level of assistance, guidance and support from TCM to carry out the goals of CYS plan, maintain a safe and healthy environment and assure child's/adolescent's participation in mental health services.

JUVENILE JUSTICE/CRIMINAL JUSTICE SYSTEM INVOLVEMENT

A child or adolescent with a serious emotional disturbance who demonstrates delinquent behavior and/or is not compliant with probation and mental health service needs may require TCM support in addition to probation services. TCM uses his/her ongoing relationship with the child/adolescent and family to encourage compliance with the probation plan and participation in mental health services. TCM may be needed to assure collaboration between the Juvenile Justice/Criminal Justice and Mental Health systems. The TCM may also participate in court processes with family/juvenile.

***The decision for level of TCM needed in this area must be determined in collaboration with family and/or guardian, or care giver/natural support and child/adolescent.**

0	1	2	3	4	5
	Needs minimal assistance in this area		Needs moderate assistance in this area		Needs significant assistance in this area

N/A= Parent/Guardian and child/adolescent does not need/have involvement with the Juvenile Justice/Criminal Justice System.

0= Parent/guardian and child/adolescent does not require/desire any assistance in this area.

1= Parent/guardian and child/adolescent requires/desires minimal level of assistance, guidance, advocacy, support and TCM involvement to assure child's/adolescent's cooperation with the probation plan.

3= Parent/guardian and child/adolescent requires/desires moderate level of assistance, guidance, advocacy, support and TCM involvement to assure child's/adolescent's cooperation with the probation plan.

5= Parent/guardian and child/adolescent requires/desires a significant level of assistance, guidance, advocacy, support and TCM involvement to assure child's/adolescent's cooperation with the probation plan.

PARENT/GUARDIAN AND/OR OTHER FAMILY MEMBERS WITH SIGNIFICANT FAMILY NEEDS

Other members of the family may have individual needs that have a serious impact on the child/adolescent's ability to function at home and in the community. Other family members may have chronic mental illness, serious emotional disturbances, substance abuse problems, and/or physical illness that combine to compromise caretaker availability to the child. TCM provides culturally consistent and language appropriate service to the child/adolescent and family, assuring access and participation in services, including mental health services.

***The decision for level of TCM needed in this area must be determined in collaboration with family and/or guardian, or care giver/natural support and child/adolescent.**

0	**1**	**2**	**3**	**4**	**5**
	Needs minimal assistance in this area		Needs moderate assistance in this area		Needs significant assistance in this area

0= Parent/guardian and child/adolescent does not require/desire any assistance in this area.

1= Other family members may have mental illness, serious emotional disturbance, physical illness, or substance abuse problems and/or there are significant family needs which may require or the family may desire a minimal level of TCM services to support the family in meeting the child's/adolescent's basic living needs and emotional well-being.

3= Other family members may have mental illness, serious emotional disturbance, physical illness, or substance abuse problems and/or there are significant family needs which may require or the family may desire a moderate level of TCM services to support the family in meeting the child's/adolescent's basic living needs and emotional well-being.

5= Other family members may have a mental illness, serious emotional disturbance, physical illness, or substance abuse problems and/or there are significant family needs which may require or the family may desire a significant level of TCM services to support the family in meeting the child's/adolescent's basic living needs and emotional well-being.

DRUG AND ALCOHOL SYSTEM INVOLVEMENT

TCM assists family in obtaining drug and alcohol treatment for a child/adolescent with serious emotional disturbances and co-occurring drug and alcohol problems and encouraging child/adolescent to accept and comply with these services. The TCM supports the child's/adolescent's participation in all phases of treatment, including aftercare. TCM assists the family in obtaining culturally competent, language appropriate services for the child/adolescent.

***The decision for level of TCM needed in this area must be determined in collaboration with family and/or guardian, or care giver/natural support and child/adolescent.**

0	**1**	**2**	**3**	**4**	**5**
	Needs minimal assistance in this area		Needs moderate assistance in this area		Needs significant assistance in this area

N/A= Parent/Guardian and child/adolescent does not need/have involvement with the Drug and Alcohol System.

0= Parent/guardian and child/adolescent does not require/desire any assistance in this area.

1= Parent/guardian and child/adolescent requires/desires minimal level of assistance, guidance, advocacy, and support to obtain and maintain the child's/adolescent's participation in drug and alcohol services.

3= Parent/guardian and child/adolescent requires/desires moderate level of assistance, guidance, advocacy, and support to maintain the child's/adolescent's participation in drug and alcohol services.

5= Parent/guardian and child/adolescent requires/desires a significant level of assistance, guidance, advocacy, and support to obtain and maintain the child's/adolescent's participation in drug and alcohol services.

MENTAL RETARDATION SYSTEM INVOLVEMENT

TCM assists the family in obtaining and maintaining participation in mental retardation services for a child/adolescent with a serious emotional disturbance and a co-occurring diagnosis of mental retardation. The TCM supports the child's/adolescent's and parent's/guardian's participation in all phases of mental retardation services. TCM assists the family in obtaining culturally competent, language appropriate services for the child/adolescent.

***The decision for level of TCM needed in this area must be determined in collaboration with family and/or guardian, or care giver/natural support and child/adolescent.**

0	**1**	**2**	**3**	**4**	**5**
	Needs minimal assistance in this area		Needs moderate assistance in this area		Needs significant assistance in this area

N/A= Parent/Guardian and child/adolescent does not need/have involvement with the Mental Retardation System.

0= Parent/guardian and child/adolescent does not require/desire any assistance in this area.

1= Parent/guardian and child/adolescent requires/desires minimal level of assistance, guidance, advocacy, and support to obtain and maintain the child's/adolescent's participation in mental retardation services.

3= Parent/guardian and child/adolescent requires/desires moderate level of assistance, guidance, advocacy, and support to maintain the child's/adolescent's participation in mental retardation services.

5= Parent/guardian and child/adolescent requires/desires a significant level of assistance, guidance, advocacy, and support to obtain and maintain the child's/adolescent's participation in mental retardation services.

PHYSICAL HEALTH SYSTEM INVOLVEMENT

TCM assists family and child/adolescent with a serious emotional disturbance in attending to significant physical/medical needs by helping parent/guardian to access medical care, and to develop confidence in working with physical health care providers. TCM assists the family in obtaining culturally competent, language appropriate services for the child/adolescent.

***The decision for level of TCM needed in this area must be determined in collaboration with family and/or guardian, or care giver/natural support and child/adolescent.**

0	**1**	**2**	**3**	**4**	**5**
	Needs minimal assistance in this area		Needs moderate assistance in this area		Needs significant assistance in this area

0= Parent/guardian and child/adolescent does not require/desire any assistance in this area.

1= Parent/guardian and child/adolescent requires/desires minimal level of assistance, guidance, advocacy, and support to obtain medical services and to assure coordination between physical and behavioral health care services.

3= Parent/guardian and child/adolescent requires/desires moderate level of assistance, guidance, advocacy, and support to obtain medical services and to assure coordination between physical and behavioral health care services.

5= Parent/guardian and child/adolescent requires/desires a significant level of assistance, guidance, advocacy, and support to obtain medical services and to assure coordination between physical and behavioral health care services.

CHILD/ADOLESCENT AT RISK OF OUT-OF-HOME PLACEMENT

The risk that a child/adolescent with a serious emotional disturbance will require an out-of-home placement may be reduced significantly through TCM services which assist parent/guardian in accessing needed child serving systems. TCM assistance may include information sharing with parent/guardian, advocacy with mental health service providers and other systems and support in working with multiple service providers. Every effort should be made to consider the child's ethnicity, culture and religious background in any out-of-home placement. TCMs may need to provide assistance in the provision of cultural competence supports for children (e.g., grooming, leisure activities, etc.).

***The decision for level of TCM needed in this area must be determined in collaboration with family and/or guardian, or care giver/natural support and child/adolescent.**

0	**1**	**2**	**3**	**4**	**5**
	Needs minimal assistance in this area		Needs moderate assistance in this area		Needs significant assistance in this area

0= Parent/guardian and child/adolescent does not require/desire any assistance in this area.

1= Child's/adolescent's ongoing emotional/behavioral issues place the child/adolescent at low risk of out-of- home placement.

3= Child's/adolescent's ongoing emotional/behavioral issues place the child/adolescent at moderate risk of out-of-home placement.

5= Child's/adolescent's ongoing emotional/behavioral issues place the child/adolescent at high risk of out-of-home placement.

CURRENTLY IN RTF, OTHER OUT-OF-HOME PLACEMENTS OR INPATIENT

Child/adolescent with a serious emotional disturbance is currently or has been receiving services in an RTF, other out-of-home placement or inpatient setting. The child/adolescent has been discharged within the past 30 days or discharge is anticipated within thirty 30 days. The child/adolescent may have been discharged for more than 30 days, however, TCM services are needed to assist with the discharge plan.

***The decision for level of TCM needed in this area must be determined in collaboration with family and/or guardian, or care giver/natural support and child/adolescent.**

0	1	2	3	4	5
	Needs minimal assistance in this area		Needs moderate assistance in this area		Needs significant assistance in this area

0= Parent/guardian and child/adolescent does not require/desire any assistance in this area.

1= Development and implementation of a multi-service-system plan for a child/adolescent discharged or anticipated to be discharged from RTF, other out-of-home placement or inpatient requires a minimal level of TCM service.

3= Development and implementation of a multi-service-system plan for a child/adolescent discharged or anticipated to be discharged from RTF, other out-of-home placement or inpatient requires a moderate level of TCM service.

5= Development and implementation of a multi-service-system plan for a child/adolescent discharged or anticipated to be discharged from RTF, other out-of-home placement or inpatient requires a significant level of TCM service.

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TARGETED CASE MANAGEMENT
ENVIRONMENTAL MATRIX - CHILD/ADOLESCENT

Agency **County**

CHILD/ADOLESCENT INFORMATION:

Name :
(Last) **(First)** **(MI)**

Parent/Guardian Name:

Identifying Number(s):

Date of Birth: / /
(MM)/(DD)/(YYYY)

Social Security Number: - -

CIS/BSU/MCO Number:

PHMCO:

BHMCO:

Form Completed by:

Date Completed:

The purpose of this form is to assess what environmental and cultural factors help to determine an individual's need for the various levels of case management services. Please complete this form utilizing the individual's behavior and situation during the last ninety days as a basis for scoring each indicator. Please note that the decision for level of need in each of the areas must be determined in collaboration with family and/or guardian, or care giver/natural supports and child/adolescent. Please see the *Scoring Sheet* for additional information on determining the Environmental Matrix Score and its meaning for level of care assignments.

ENVIRONMENTAL MATRIX CHILD/ADOLESCENT SCORING SHEET

CHILD/ADOLESCENT NAME:_____

ID#(SOCIAL SECURITY/CIS/BSU):_____

SCORES:

1.	Accessing Mental Health Services	_____
2.	Informal Support Network Building	_____
3.	Education	_____
4.	Children and Youth System Involvement	_____
5.	Juvenile Justice System Involvement	_____
6.	Parent/Guardian and/or Other Family Members With Significant Needs	_____
7.	Drug and Alcohol System Involvement	_____
8.	Mental Retardation System Involvement	_____
9.	Physical Health System Involvement	_____
10a.	At Risk of Out-of-Home Placement	_____
	Or	
10b.	Currently in RTF, Other Out-of-Home Placements or Inpatient	_____
	SUBTOTAL	_____

ENVIRONMENTAL MATRIX SCORE = SUBTOTAL ÷ BY ALL APPLICABLE ASSESSMENT AREAS (*AREAS SCORED "N/A" ARE NOT USED IN DETERMINING OVERALL SCORE)* _____

OTHER FACTORS/ISSUES AFFECTING SCORE: _____

ENVIRONMENTAL MATRIX — CHILD/ADOLESCENT
TCM SERVICE SCORING GRID

MATRIX LEVEL	NEED LEVEL	INTENSITY OF CARE
4.0 –5.0	ICM	At least 1 contact every 14 days (Face to face contact strongly recommended)
1.5 –3.9	RC	At least 1 contact every 30 days (Face to Face)
0.0 - 1.4	NO TCM NEEDED	Alternative services may be needed and if necessary, referrals should be made.

* ***professional judgement:*** *opinion based on a thorough and ethical analysis of facts, data, history, and issues in accordance with one's training and experience.*

RECOMMENDED LEVEL OF TARGETED CASE MANAGEMENT SERVICE:_____

CONSUMER (if age appropriate): _____ **DATE:**_____

PARENT/GUARDIAN **DATE:**_____

PERSON COMPLETING THE FORM:_____ **DATE:**_____

APPROVED LEVEL OF TARGETED CASE MANAGEMENT SERVICE:

REVIEWER **DATE:**_____

HEALTHCHOICES BEHAVIORAL HEALTH RECIPIENT COVERAGE DOCUMENT

Background

This document includes descriptions of policies supported by the Department of Human Services (Department) data systems and processes. In cases where the policy expressed in this document conflicts with another provision of the contract (i.e., the Department Agreement) between the Primary Contractor and the Department, the Agreement will take precedence.

The Department will provide sufficient information to the Primary Contractor in order for it to reconcile Behavioral Health Managed Care Organization (BH-MCO) membership data and amounts paid to/ recovered from the Primary Contractor.

Instances of Medical Assistance (MA) coverage for a recipient do not imply corresponding HealthChoices coverage on the same dates by a Behavioral Health Managed Care Organization (BH-MCO). Because not all persons eligible for Medical Assistance (MA) benefits are also eligible for BH-MCO membership on the same date, MA eligibility does not equate to BH-MCO coverage.

Instances of simultaneous MA eligibility and BH-MCO coverage for a recipient do not imply corresponding HealthChoices coverage on the same dates by a Physical Health Managed Care Organization (PH-MCO). Please refer to the *PH-MCO Recipient Coverage Document* (Exhibit BB of the HealthChoices Physical Health Agreement) for physical health coverage guidelines.

In situations where a Departmental error may have inadvertently resulted in loss of BH-MCO coverage, the Department will accept exception requests for reinstatement of BH-MCO coverage. The Department's Division of Systems Management will process each request, and as appropriate, will coordinate with the BH-MCO and County Assistance Office. The Department reserves the right to approve/disapprove any requests for expedited enrollments/disenrollments. The Department's determination for the expedited requests will be final. Exception request disapprovals may occur for a variety of reasons.

Coverage Rules

A BH-MCO is responsible for a member if coverage is determined by applying the general rules found in any of paragraphs A, B, or C below, subject to exceptions and clarifications found in paragraphs D, E, F, and G.

A. Unless otherwise specified, the BH-MCO is responsible to provide MA behavioral health benefits to BH-MCO Members in accordance with eligibility information included on the Monthly Membership File and/or the Daily Membership File, which is provided by DHS to each BH-MCO.

B. Monthly Membership Files containing information on Members are created on the next to the last Saturday of each month and are normally provided to the BH-MCO no later than the following Monday. Information on the file includes retroactive, current or prospective eligibility periods, PH-MCO coverage and BH-MCO coverage, and demographic data. For each BH-MCO member identified on the Monthly Membership File, the BH-MCO is responsible to provide behavioral health benefits from the beginning of the month or from

the BH-MCO coverage start date, whichever is later. BH-MCO coverage will continue from the start date through the last day of the calendar month, unless the Department subsequently sends the BH-MCO updated information on a Daily Membership File. BH-MCO coverage beyond the last date of the month in which a Monthly Membership File is created is preliminary information that is subject to change.

Daily Membership Files are provided to each BH-MCO with changes that have been applied to their enrolled population. In the example that follows, assume that the only information provided by DHS is on the November Monthly Membership File (created in late October). If an eligibility period of October 11 through November 18 is provided, the BH-MCO is responsible from October 11 through November 30, assuming no subsequent daily file changes occur prior to November 1 to end the coverage in October. If two eligibility periods are provided (e.g., one from October 11 through October 25 and one from October 29 on with no end date), the BH-MCO is responsible from October 11 through at least November 30, subject to a daily file change prior to November 1. Coverage after October 31 is preliminary based on daily file changes.

If a Recipient is shown on the Department's Client Information System (CIS) as covered by a BH-MCO (coverage by a BH-MCO is indicated by an open MA eligibility record and a corresponding open BH-MCO record), the BH-MCO is responsible for the person from the first day of BH-MCO coverage through the last day of the month of the BH-MCO end date (if any). The Department will pay the Primary Contractor from the first day of coverage in a month through the last calendar day of the month. Because a recipient may lose MA eligibility (and potentially regain MA eligibility), information on CIS for any future date should be viewed as preliminary. If a Recipient has eligibility in more than one county during the month, the BH-MCO with the earliest period of responsibility is responsible for providing services for the month.

A recipient who becomes ineligible for Medical Assistance (MA) will lose BH-MCO coverage. If a recipient subsequently regains MA eligibility, and the recipient's category of assistance and geographic location remain valid, the recipient will be auto-assigned back into BH-MCO coverage. Upon regaining MA eligibility, the recipient's BH-MCO effective date will be their MA eligibility begin date ***or*** the date CIS is updated (i.e., the systems date), ***whichever is later***. The change in MA eligibility will normally result in a period of MA Fee-For-Service coverage for the MA recipient's behavioral health coverage. This is so because even in the case of retroactive MA eligibility, there is no assignment of retroactive BH-MCO coverage. MA eligibility does not equate to BH-MCO coverage. Periods of time where a person is MA eligible yet where there is no corresponding BH-MCO coverage on the same date is normal, so providers and BH-MCOs must plan accordingly in the authorization, delivery and payment of services. This will include coverage for children placed in a Residential Treatment Facility (RTF), who lose BH-MCO coverage and become covered under the MA FFS Program. In these and other scenarios, barring those cases identified in Section D below, the BH-MCO is not responsible for MA recipients for whom the Department has informed the BH-MCO on Monthly and/or Daily Eligibility Files that it has no responsibility.

C. DHS has established benefit packages based on category of assistance, program status code, age, and for some packages, the existence of Medicare coverage or a Deprivation Qualifying Code. In cases where the Recipient benefits are determined by the benefit package, the most comprehensive package is to be honored. For example, if a Recipient has the most comprehensive package on the first of the month but changes to a lesser level package during the month, they should receive the higher level of benefits for the entire month. If a Recipient has a lesser level benefit package at the beginning of the month but changes to a higher level during the month, they should receive the higher level benefits effective the first day of coverage under the higher level. The daily and monthly files can be used for determining increased benefits during a month.

D. BH-MCO Coverage Exceptions and Clarifications:

1. The BH-MCO will not be responsible and will not be paid when DHS sends the BH-MCO correspondence specifying member months for which they are not responsible. The Department will recover capitation payments made for a Recipient for whom it had been determined the BH-MCO was not responsible to provide services.

2. In the unlikely case where CIS shows Fee-For-Service (FFS) coverage that coincides with BH-MCO coverage, the Recipient may use either coverage and there will be no monetary adjustment between the Department and the BH-MCO. (This is subordinate to #8 below.)

3. If the BH-MCO has actual knowledge that a Recipient is deceased, and if such Recipient is shown on either the Monthly Membership File or the Daily Membership File as active, the BH-MCO is required to notify the County Assistance Office (CAO) and the Department. The Department will recover capitation payments made for deceased Recipients after the service month in which the date of death occurred.

4. If it is determined that the member was not MA eligible on the begin date of coverage during a month, and the BH-MCO was paid, the Department will recover or adjust capitation payments.

5. If a member is placed in a setting that results in the termination of coverage by the BH-MCO (e.g., State Mental Hospital), the Department will recover capitation payments made for the member after the service month in which the termination of coverage occurred.

6. The BH-MCO retains responsibility for Members when placed outside the county, HealthChoices zone or state by the BH-MCO, juvenile court or county Children and Youth (C&Y) even if PH-MCO coverage information is not found on CIS, the daily or monthly eligibility files. The BH-MCO will continue to receive capitation payments.

If a member is placed in a facility by juvenile court or county Children and Youth authority for service(s) which the BH-MCO determines is not medically necessary, the cost of the service is the responsibility of the placing authority, not the BH-MCO. (See Section H for additional details).

7. Newborn babies are the responsibility of the BH-MCO that covered the mother on the date of birth. Where CIS does not reflect this, if the PH-MCO notifies the Department, the Department will coordinate adjustment of coverage. Limitations in Sections E-2 and E-3 applicable to the mother will apply to the newborn.

8. Placement out of a BH-MCO's service area, or lack of MA coverage or eligibility on a date of service for which the policies in this document otherwise hold a BH-MCO responsible for a Recipient do not negate a BH-MCO's responsibility to provide MA benefits. If a BH-MCO is aware that a Recipient is placed outside of its county, it is the BH-MCO's responsibility to notify the County Assistance Office, within ten (10) days of the date of learning of the Recipient's status. Gaps in the notification process may result in loss of BH-MCO coverage, and MA FFS coverage will apply.

9. If the rules to determine BH-MCO responsibility to provide benefits to MA Members that are outlined in this document indicate that a BH-MCO is responsible to provide benefits to a MA Recipient on a certain date, a lack of MA eligibility indicated on CIS for that date does not negate this responsibility.

10. Errors in coverage must be reported to the Department within 45 days of receipt of the monthly eligibility file in order for retroactive changes to be considered. The BH-MCO will be responsible to cover Members, even when coverage assignment resulted from errors, if not reported to the Department within 45 days unless the error results in duplicate payment or coverage.

11. If CIS shows an exemption or facility/placement code (e.g., facility/placement code 14 – State Mental Hospital) that precludes BH-MCO coverage, the Recipient may not be enrolled in a BH-MCO.

12. The Department's Office of Mental Health and Substance Abuse Services (OMHSAS) will maintain an exception review process to research and decide upon any unusual BH-MCO coverage cases that are brought to its attention in a timely manner. Loss of Medical Assistance eligibility by a recipient, in and of itself, is not considered to be cause for an exception. Loss of BH-MCO coverage by a recipient because of loss of the recipient's MA eligibility, in and of itself, is not cause for an exception.

E. When a Recipient has managed care coverage during part of an inpatient/residential stay, financial responsibility* is as follows: For purposes of this document, an inpatient/residential stay shall include those in the following facilities:

General Hospital
Rehabilitation Hospital
Acute Care Hospital (PT 01 – Spec 010)
Private Psychiatric Hospital (PT 01 – Spec 011)
Residential Treatment Facility – Accredited (PT 01 – Spec 013)
Extended Acute Care Psychiatric Hospital (PT 18 – Spec 018)
Drug & Alcohol Rehab Hospital (PT 01 – Spec 019)
Private Psychiatric Unit (PT 01 – Spec 022)
Drug & Alcohol Rehab Unit (PT 01 – Spec 441)
Residential Treatment Facility - Non-Accredited (PT 56 – Spec 560)

*The covering plan will only be responsible for inpatient/residential services for continuous stays when the service is included as a covered service under its contract with the Department.

1. Inpatient/residential Facilities Covered Under the Prospective Payment System for Diagnostic Related Groups.

If a Recipient is in a facility covered by a DRG and is FFS on the admission date (or determined eligible through a retroactive determination by the CAO) and the BH-MCO coverage begins while the Recipient is in the inpatient/residential facility, the FFS program is financially responsible for the entire initial stay. The BH-MCO will become financially responsible for the member upon discharge. Upon becoming aware of a new member currently in one of these facilities, the BH-MCO must coordinate with the Provider in determining an appropriate course of treatment as soon as possible, prior to discharge.

EXAMPLE: If a Recipient is determined to be covered by FFS on the admission date to an inpatient/residential facility, which is covered under the prospective payment system for Diagnostic Related Groups, on June 21, and the BH-MCO coverage begin date is July 1, and the individual is transferred/discharged on July 15, the FFS program will be financially responsible for the entire stay. The BH-MCO will be financially responsible for all covered services beginning July 15. Upon becoming aware of a new member currently in a facility on July 1, the BH-MCO must become involved in discharge planning for the individual.

2. Recipient Covered by FFS Becomes BH-MCO Covered While in Facility

If a Recipient is covered by FFS on the admission date and the BH-MCO coverage begins while the Recipient is in an inpatient/residential facility not covered under the DRG Prospective Payment System, the FFS program is financially responsible for the stay until the BH-MCO begin date. Starting with the BH-MCO begin date, the BH-MCO is financially responsible for the remainder of the stay, as well as physician or other covered services not included in the inpatient/residential facility bill that would be their responsibility as the Recipient's BH-MCO. Upon assuming financial responsibility of a Recipient age 21 and over, the BH-MCO has the ability to conduct a concurrent review of the FFS authorized inpatient/residential facility stay to determine continued medical necessity.

EXAMPLE: If a Recipient covered by FFS is admitted to an inpatient/residential facility on June 21 and the BH-MCO coverage begin date is July 1, the BH-MCO will assume payment responsibility for the inpatient/residential facility stay on July 1. The FFS program will remain financially responsible for the stay through June 30. Any time after June 30, the BH-MCO may conduct a concurrent review to determine medical necessity of the inpatient/residential facility stay if the member is an adult age 21and over.

3. Recipient Covered by BH-MCO Becomes FFS While in Facility

If a Recipient is covered by a BH-MCO when admitted to an inpatient/residential facility and the Recipient loses BH-MCO coverage and assumes FFS coverage while still in the inpatient/residential facility, the BH-MCO is responsible for the stay except as indicated below.

EXAMPLE #1: If the Recipient is still in the inpatient/residential facility on the FFS coverage begin date, and the Recipient's FFS coverage begin date is the first day of the month, the BH-MCO will be financially responsible for the stay through the last day of that month. The FFS program will be financially responsible for the stay beginning on the first day of the next month. For example, if a Recipient covered by the BH-MCO is admitted to an inpatient/residential facility on June 21 and the FFS program coverage begin date is July 1, the FFS program will assume payment responsibility for the inpatient/residential facility stay on August 1. The BH-MCO will remain financially responsible for the stay through July 31.

EXAMPLE #2: If the Recipient is still in the inpatient/residential facility on the FFS program coverage begin date, and the Recipient's FFS program coverage begin date is any day other than the first day of the month, the BH-MCO will be financially responsible for the stay through the last day of the FOLLOWING month. The FFS program will be financially responsible for the stay beginning on the first day of the NEXT month. For example, if a Recipient covered by a BH-MCO is admitted to an inpatient/residential facility on June 21 and the FFS program coverage begin date is July 15, the FFS program will assume payment responsibility for the inpatient/residential facility stay on September 1. The BH-MCO program will remain financially responsible for the stay through August 31.

4. Recipient Covered by BH-MCO Loses MA eligibility and BH-MCO coverage while in Facility

If a Recipient is covered by a BH-MCO when admitted to an inpatient/residential facility and the Recipient loses MA eligibility and BH-MCO coverage while in the inpatient/residential facility, the BH-MCO is responsible for the stay except as indicated below.

EXAMPLE: #1: If the recipient is still in the inpatient/residential facility on the date the clients loses MA eligibility, the BH-MCO will be financially responsible through the end of the month in which MA eligibility is lost. The CAO subsequently re-establishes MA eligibility retroactively to the last MA eligibility end-date resulting in consecutive MA eligibility spans and the BH-MCO coverage resumes on the system store date. For example, if a Recipient covered by a BH-MCO is admitted to an inpatient/residential facility on August 26 and loses MA eligibility on August 27, the BH–MCO is responsible through August 31. (Reference D. Exceptions and Clarifications #9). The BH-MCO coverage will then resume on the system store date of October 15. If requested, MA FFS may review the case to determine medical necessity for possible FFS coverage of the stay where the dates of service were September 1 through October 14.

5. Recipient Covered by one BH-MCO Becomes Covered by a Different BH-MCO While in a Facility

If a Recipient is covered by a BH-MCO when admitted to an inpatient/residential facility and transfers to another BH-MCO while still in the inpatient/residential facility, the first BH-MCO is responsible for that stay except as indicated below.

EXCEPTION #1: If the Recipient is still in the inpatient/residential facility on the gaining BH-MCO coverage begin date, and the Recipient's gaining BH-MCO coverage begin date is the first day of the month, the first BH-MCO will be financially responsible for the stay through the last day of that month. The second BH-MCO will be financially responsible for the stay beginning on the first day of the next month. For example, if a Recipient is admitted to an inpatient/residential facility on June 21 and the second BH-MCO coverage begin date is July 1, the second BH-MCO will assume payment responsibility for the inpatient/residential facility stay on August 1. The first BH-MCO will remain financially responsible for the stay through July 31.

EXCEPTION #2: If the Recipient is still in the inpatient/residential facility on the second BH-MCO coverage begin date, and the Recipient's second BH-MCO coverage begin date is any day other than the first day of the month, the first BH-MCO will be financially responsible for the stay beginning on the first day of the NEXT month. The second BH-MCO will be financially responsible for the stay beginning on the first day of the following month. For example, if a Recipient is admitted to an inpatient/residential facility on June 21 and the second BH-MCO coverage begin date is July 15, the second BH-MCO will assume payment responsibility for the inpatient/residential facility stay on September 01. The first BH-MCO will remain financially responsible for the stay through August 31.

F. Other Causes for Coverage Termination:

1. Nursing Facility - BH-MCO Members are disenrolled after 30 consecutive days of placement in a nursing facility. This includes cases where the CAO enters a facility code placement on a client's record with a retroactive begin date and the BH-MCO record remains opened, the Department will take into consideration the 30 days from the begin date of the placement prior to end-dating BH-MCO coverage. Example: A recipient is determined BH-MCO eligible beginning January 1 and is admitted to a nursing facility on February 17. On February 28 the CAO retrospectively enters a facility placement code of "36" onto the recipient's CIS record (CIS systems date = 02/28) with a placement begin date of February 17. The BH-MCO record will remain open for the period of January 1 through March 18 before end-dating; with the last 30 days of BH-MCO coverage corresponding to the first 30 consecutive days of nursing facility placement.

2. Pennsylvania Department of Aging (PDA) Waiver - BH-MCO Members are disenrolled 30 days after enrollment in the PDA Waiver.

3. Admission to a State Facility - BH-MCOs are not responsible for BH-MCO Members placed in a state facility. The Recipient will be disenrolled from the BH-MCO effective the day before placement in the facility. Medical Assistance eligibility will be determined by the County Assistance Office. The Department will recover MCO capitation payments made for any months after the month of placement.

4. Admission to a Correctional Facility – A member who becomes an inmate of a penal facility or correctional institution (including work release), or a member who is remanded to a Youth Development Center/Youth Forestry Camp will be disenrolled from the BH-MCO effective the day before placement in the facility. The Department will recover MCO capitation payments made for any months after the month of placement.

5. Placement in a Juvenile Detention Center (JDC) – A member who is placed in a juvenile detention center is disenrolled from the BH-MCO after 35 days and covered through Medical Assistance Fee-For-Service. During the first 35 days of this JDC placement, the BH-MCO is responsible for all covered services that are provided to the member outside the JDC site; services provided inside the JDC are the responsibility of the FFS program. This includes cases where the CAO enters a facility code placement on a client's record with a retroactive begin date and the BH-MCO record remains opened, the Department will take into consideration the 35 days from the begin date of the placement prior to end-dating BH-MCO coverage. Example: if a client is BH-MCO eligible beginning July 1 and the CAO retroactively enters a facility code "74" (store date 11/08) with a placement begin date of August 17; the BH-MCO record will remain open from July 1 through September 20.

6. Health Insurance Premium Payment Program (HIPP) - BH-MCO Members determined by the Department to be HIPP eligible (Employer Group Health Plan) will be disenrolled from the BH-MCO as of the date when the BH-MCO Member Record reflects such disenrollment. Additionally, HIPP eligible MA Members are prevented from enrolling in BH-MCOs.

7. A member enrolled in the LTCCAP (Long-Term Care Capitated Assistance Program, is disenrolled from the BH-MCO effective the day before the begin date of LTCCAP.

8. Residing in a PA Veterans Home – BH-MCO will not be responsible for a Member residing in a PA Veterans Home. The Member will be disenrolled from the BH-MCO the day before the admission date and covered by the MA FFS program.

G. Other Facility Placement Coverage:

1. Intermediate Care Facility-Mental Retardation (Intellectual Disability) or Other Related Conditions (ICF-MR or ICF-ORC - Members placed in a private ICF-MR or ICF-ORC facility will continue to be covered by their BH-MCO for all medically necessary behavioral health services that are included in the scope of benefits provided by the contract with DHS.

2. Residential Facilities - BH-MCO Members placed by the BH-MCO in mental health and drug and alcohol residential treatment facilities will continue to be covered by their BH-MCO for all behavioral health services. The residential/treatment costs of Members placed by the BH-MCO in residential treatment facilities will be the responsibility of the BH-MCO. (See section H. 2 for exceptions for children in substitute care)

3. Extended Acute Care Psychiatric Hospital - BH-MCO Members admitted to an extended acute care psychiatric hospital will continue to be covered by their selected BH-MCO for all behavioral health services. The residential/treatment costs will be the responsibility of the BH-MCO.

H. Children and Adolescents In Substitute Care Issues:

When children have been adjudicated dependent or delinquent and are placed in substitute care, behavioral healthcare coverage is the responsibility of the BH-MCO. For purposes of this Section, terms "child" and "children" shall include "adolescents". For a definition of Child in Substitute Care see "Definitions."

1. Behavioral Health Services (includes MH and D&A)

If a child is placed in a substitute care setting, either in the same or different zone, the child is enrolled in the BH-MCO county of origin. The child remains enrolled in that BH-MCO which retains authorization and payment responsibility for BH-MCO approved behavioral health services, including both residential and non-residential services**.** For a child placed in a substitute care setting out of zone, the child remains enrolled in the BH-MCO which retains authorization and payment responsibility for BH-MCO approved behavioral health services, including residential and non-residential services.

2. Placement in a Mental Health or Drug and Alcohol Residential Facility

a. Medically Necessary - Consistent with H.1 above, if a Child in Substitute Care is placed in a mental health or drug and alcohol residential treatment facility either in or out of state and the BH-MCO determines the placement is medically necessary, the behavioral health services are the responsibility of the BH-MCO.

b. Not Medically Necessary - If a Child in Substitute Care is placed in a mental health or drug and alcohol residential facility by a placement authority or juvenile court and the BH-MCO in which the child is enrolled determines the placement is not medically necessary; the BH-MCO is not responsible for payment for the placement. The child remains enrolled in the BH-MCO and the BH-MCO remains responsible for medically necessary Behavioral Health Services other than the mental health or drug and alcohol residential placement.

c. If a Child in Substitute Care is covered by the HealthChoices Behavioral Health program and is placed in a mental health or drug and alcohol residential facility without review by the BH-MCO, the BH-MCO is not responsible for payment for residential behavioral health services. The BH-MCO will be responsible for medically necessary Behavioral Health Services other than the residential placement. The facility or placing authority can request authorization of services from the BH-MCO which will determine the medical necessity of the placement.

The BH-MCO will not be responsible for any services delivered prior to the request for medical necessity determination unless, at the discretion of the placing authority and the BH-MCO, they can agree to begin BH-MCO coverage at the admission date or any mutually agreeable later date. The child is enrolled in a (Physical Health Service System) PHSS serving the zone in which the child is placed. Children placed out of state revert to FFS for physical health and for ancillary behavioral health services other than the placement. Ancillary services could include services such as assessments, psychotherapy, or medication management provided on an outpatient basis.

3. Placement in a C&Y or JPO non-Mental Health Placement

If a Child in Substitute Care is placed in a non-mental health or drug and alcohol placement such as:

a. Shelter programs
b. Diagnostic centers
c. Foster family home, including kinship care homes
d. Residential facilities

The child remains enrolled in the BH-MCO from the original placing county. The child is enrolled in PHSS serving the zone in which the child is placed. Children placed out of state revert to FFS for physical health.

4. The BH-MCO will be required to pay for Out-of-Network medically necessary behavioral health care services for up to ten days for a child enrolled in its plan who is placed in substitute care if the (County Children and Youth Agency) CCYA cannot identify the child nor verify MA coverage. However, this Out-of-Network coverage will only be required in certain circumstances, such as emergency placement as determined by county child welfare or juvenile probation, or where the CCYA has had no contact with the child prior to the placement. All efforts must be made by the CCYA to identify the child and to determine MA coverage responsibility in the most expedient manner possible.

5. For youth placed in a Juvenile Detention Center, the BH-MCO is responsible for medically necessary State Plan Services delivered in treatment settings outside (off site) the Juvenile Detention Center (JDC) during the first 35 consecutive days of detention. However, the BH-MCO is not responsible at any time for services delivered within the JDC.

6. Children whose adoptions have been finalized by the court and for whom there is an adoption assistance agreement in place, enrolls in the BH-MCO of the county where the adoptive family resides. If the family has moved to a permanent residence outside the Commonwealth of Pennsylvania and the family retains Pennsylvania Medicaid for the adopted child, the child will revert to Fee-For-Service for behavioral health services.

I. Private Coverage Organization continuity of care impacts on BH-MCO coverage

Prior Authorizations

Any PCO beneficiary who is transferred from PCO to BH-MCO coverage will continue (at the recipient's option) to receive any PCO-prior authorized behavioral health service the individual was to receive or is receiving. The service must be provided by the BH-MCO, as long as it is a BH-MCO compensable service, and must continue for up to sixty (60) days from the effective date of the transfer/enrollment; ***or*** until the BH-MCO conducts a concurrent clinical review to determine if continuation of the prior authorized service is medically necessary.

Any BH-MCO member who is transferred from BH-MCO to PCO coverage will continue (at the recipient's option) to receive any BH-MCO-prior authorized behavioral health service the individual was to receive or is receiving. The service must be provided, as long as it is a PCO compensable service, and must continue for up to sixty (60) days from the effective date of the transfer/enrollment; ***or*** until the PCO conducts a concurrent clinical review to determine if continuation of the prior authorized service is medically necessary.

Any MA FFS recipient who is transferred from FFS to BH-MCO coverage will continue (at the recipient's option) to receive any MA FFS-prior authorized behavioral health service the individual was to receive or is receiving. The service must be provided, as long as it is a BH-MCO compensable service, and must continue for up to sixty (60) days from the effective date of the transfer/enrollment; ***or*** until the BH-MCO conducts a concurrent clinical review to determine if continuation of the prior authorized services is medically necessary.

Any BH-MCO member who is transferred from BH-MCO to MA FFS coverage will continue (at the recipient's option) to receive any BH-MCO-prior authorized behavioral health service the individual was to receive or is receiving. The service must be provided, as long as it is a MA FFS compensable service, and must continue for up to sixty (60) days from the effective date of the transfer/enrollment; ***or*** until the MA FFS Program conducts a concurrent clinical review to determine if continuation of the prior authorized service is medically necessary.

Newborns

Each normal newborn baby born to a beneficiary of a PCO will be enrolled into a BH-MCO effective the newborn's date of birth. This may result in limited retroactive BH-MCO coverage.

Dual Eligibles
Existing dual eligibles who are covered by the BH-MCO (i.e., individuals with dual Medicare and Medicaid coverage) who are ages 21 – 64 will be exempted from initial enrollment into PCO, and remain covered by the BH-MCO. Individuals enrolled in a PCO at the time they become newly dual eligible will be disenrolled from PCO the end of the month in which the PCO category is end dated. (Depending on when the Medicare Part A, B and/or D is/are posted to the recipient's eligibility record, the PCO will be end dated either the end of the current month or the end of the next month. The PCO remains responsible for those beneficiaries through the disenrollment date.) Following PCO disenrollment, the recipient may be enrolled into BH-MCO coverage for behavioral health care.

Definitions:

Beneficiary – A member of (recipient covered by) a Private Coverage Organization (PCO).

BH-MCO Coverage Period - A period of time during which a Recipient is eligible for Medical Assistance (MA) coverage ***and*** a BH-MCO coverage period exists on the Department's Client Information System (CIS). Exceptions and Clarifications are identified in Sections D, E, F, G and H of this document.

BH-MCO Member **-** An MA Recipient who is enrolled with the BH-MCO under the HealthChoices Behavioral Health Program and for whom the BH-MCO is responsible to provide behavioral health services under the provisions of the HealthChoices Behavioral Health Program. Not all persons who are MA eligible are simultaneously BH-MCO members.

BH-MCO Member Record - A record contained on the Daily Membership File or the Monthly Membership File that contains information on MA eligibility, managed care coverage, and the category of assistance, which identifies the Recipient as a BH-MCO member.

Child in Substitute Care – A Child in Substitute Care is one who has been adjudicated dependent or delinquent and residing outside their own home. *Dependent* children and adolescents are living in the legal custody of a public child welfare agency, in any of the following settings:

- Shelter programs
- Foster family homes
- Group homes
- Supervised independent living
- Residential treatment facilities (RTF)
- Drug and alcohol treatment facilities
- Transitional living residence
- Mobile and outdoor programs
- Residential facilities
- Kinship homes

Children in Substitute Care classified as *delinquent* are adjudicated as such by the juvenile court and placed in temporary secure juvenile detention center (JDC), secure care or any of the settings listed above. They are under the supervision of the juvenile court and there is no transfer of legal custody to a public agency.

Client Information System (CIS) - The Department's automated file of previous, current and future MA Recipients and BH-MCO members.

Daily Membership File – A HIPAA-compliant 834 electronic file generated by the Department's contractor on a daily basis (exclusive of weekends and Department holidays), which is transmitted to the Primary Contractor (or its subcontractor). The Daily Membership File contains information on changes made to MA Recipient records on CIS, and may include: retroactive, current or prospective MA eligibility, and current or retrospective BH-MCO coverage information.

Drug and Alcohol Residential Facility – Includes inpatient or non-hospital residential drug and alcohol services. Non-hospital residential includes residential detox, rehab and half-way house.

Eligibility Verification System (EVS) - An automated system available to MA Providers and other specified organizations for on-line verification of MA eligibility, prepaid capitation, PH-MCO or BH-MCO enrollment, third party resources, and the benefit package under the MA Fee-For-Service (FFS) and PCO Programs.

MA Eligibility Period - A period of time during which a Recipient is eligible to receive MA benefits. An eligibility period is indicated by the eligibility start and end dates on CIS. A blank eligibility end date on CIS signifies an open-ended eligibility period. MA eligibility on a date does not equate to BH-MCO membership on the same date.

Monthly Membership File - A HIPAA-compliant 834 electronic file, generated by the Department's contractor on the next to the last Saturday of the month, that is transmitted to the Primary Contractor (or its subcontractor). The Monthly Membership File lists retroactive, current and prospective BH-MCO Members, specifying for each BH-MCO Member the corresponding eligibility period, PH-MCO coverage and BH-MCO coverage. Recipients not included on this file with an indication of prospective coverage will not be the responsibility of the BH-MCO unless a subsequent Daily Membership File indicates otherwise. Those with an indication of future month coverage will not be the responsibility of the BH-MCO if a Daily Membership File received by the BH-MCO prior to the beginning of the future month indicates otherwise.

Negation BH-MCO Member Record - A BH-MCO Member Record used by the Department to advise the Primary Contractor that a certain related BH-MCO Member Record previously submitted by the Department to the Primary Contractor should be negated. A Negation BH-MCO Member Record can be recognized by its sequence of BH-MCO membership start and end dates with the end date preceding the start date.

Open-ended - A period of time that has a start date and does not have a definitive end date.

PCO – Private Coverage Option (the Healthy PA program), or Private Coverage Organization (the Department-approved managed care entity).

PH-MCO Coverage Period - A period of time during which a Recipient is eligible for MA coverage and a PH-MCO coverage period exists on CIS. Exceptions and clarifications are identified in the *PH-MCO Recipient Coverage Document* (Exhibit BB of the HealthChoices Physical Health Agreement).

PH-MCO Member - An MA Recipient who is enrolled with a specific PH-MCO and to whom the PH-MCO is responsible to provide physical health MA benefits under the provisions of the HealthChoices Physical Health Program. BH-MCO coverage for a recipient does not suggest the recipient also has PH-MCO coverage on the same date.

Physical Health Managed Care Organization (PH-MCO) - A Commonwealth licensed risk-bearing entity, which has contracted with the Department to manage the purchase and provision of physical health services under the HealthChoices Physical Health Program.

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

System Date – The System Date is the date a change in coverage or eligibility is entered into the Client Information System (CIS). The effective date of the change may be different than the System Date, as evidenced by the fact that the BH-MCO coverage effective begin date is the MA eligibility begin date or the System Date – whichever is greater.

BEHAVIORAL HEALTH AUDIT CLAUSE

AUDITS

Annual Contract Audits

The Primary Contractor shall cause, and bear the costs of, an annual contract audit to be performed by an independent, licensed Certified Public Accountant. The contract audit shall be completed using guidelines provided by the Commonwealth. Such audit shall be made in accordance with generally accepted government auditing standards. The contract audit shall be submitted to the Commonwealth no later than the 15th day of the fifth month after the contract period is ended.

If circumstances arise in which the Commonwealth or the Primary Contractor invoke the contractual termination clause or determine the contract will cease, the contract audit for the period ending with the termination date or the last date the contractor is responsible to provide medical assistance benefits to HealthChoices recipients shall be submitted to the Commonwealth no later than the end of the fifth (5th) month after the contract termination date or the last date the contractor is responsible to provide medical assistance benefits.

The Primary Contractor shall ensure that audit working papers and audit reports are retained by the Primary Contractor's auditor for a minimum of five (5) years from the date of final payment under the contract, unless the Primary Contractor's auditor is notified in writing by the Commonwealth to extend the retention period. Audit working papers shall be made available, upon request, to authorized representatives of the Commonwealth or Federal agencies. Copies of working papers deemed necessary shall be provided by the Primary Contractor's auditor.

Distribution shall be as follows:

Three (3) copies to: Pennsylvania Office of the Budget
Public Health and Human Services Comptroller Office
1010 North 7th Street
Eastgate Building, Suite 316
Harrisburg, PA 17102-1410

Two (2) copies to:

Regular Mail:

Department of Human Services
Office of Mental Health and Substance Abuse Services
Bureau of Financial Management and Administration
Division of Medicaid and Financial Review
P.O. Box 2675
Harrisburg, PA 17105-2675

Overnight Courier:

Department of Human Services
Office of Mental Health and Substance Abuse Services
Bureau of Financial Management and Administration
Division of Medicaid and Financial Review
Commonwealth Towers, 12th Floor
303 Walnut Street
Harrisburg, PA 17101

Annual Entity-Wide Financial Audits

The Primary Contractor and its Prime Subcontractor shall provide to the Commonwealth a copy of its annual entity-wide financial audit, performed by an independent, licensed Certified Public Accountant. Such audit shall be made in accordance with generally accepted auditing standards. If the Primary Contractor is a county government, the report on such audit shall be submitted within nine months after the end of the county's fiscal year. If the Primary Contractor or Prime Subcontractor is not a county government, such audit shall be submitted to the Commonwealth within 180 days after the entity's fiscal year end. If the Primary Contractor or Prime Subcontractor is a Commonwealth-licensed, risk-bearing entity, the annual audit prepared and submitted to the Pennsylvania Insurance Department, is acceptable for submission to the Department of Human Services. Distribution shall be as follows:

One (1) copy to: Pennsylvania Office of the Budget
Public Health and Human Services Comptroller Office
Assistant Comptroller for Medical Assistance
P.O. Box 2675
Harrisburg, PA 17105-2675

One (1) copy to: Department of Human Services
Office of Mental Health and Substance Abuse Services
Bureau of Financial Management and Administration
Division of Medicaid and Financial Review
P.O. Box 2675
Harrisburg, PA 17105-2675

Other Financial and Performance Audits

The Commonwealth reserves the right for federal and state agencies or their authorized representatives to perform additional financial or performance audits of the Primary Contractor, its Prime Subcontractors or providers. Any such additional audit work will rely on work already performed by the Contractor's auditor to the extent possible. The costs incurred by the federal or state agencies for such additional work will be borne by those agencies.

Audits of the Primary Contractor, its Prime Subcontractors or providers may be performed by the Commonwealth or its designated representatives and include, but are not limited to:

- Financial and compliance audits of operations and activities for the purpose of determining the compliance with financial and programmatic record keeping and reporting requirements of this contract;

- Audits of automated data processing operations to verify that systems are in place to ensure that financial and programmatic data being submitted to the Commonwealth is properly safeguarded, accurate, timely, complete, reliable, and in accordance with contract terms and conditions; and

- Program audits and reviews to measure the economy, efficiency and effectiveness of program operations under this contract.

Audits performed by the Commonwealth shall be in addition to any federally-required audits or any monitoring or review efforts. Commonwealth audits of the Primary Contractor's or its Prime Subcontractor's operations will generally be performed on an annual basis. However, the Commonwealth reserves the right to audit more frequently, to vary the audit period, and to determine the type and duration of these audits. Audits of Prime Subcontractors or providers will be performed at the Commonwealth's discretion.

The following provisions apply to the Primary Contractor, its Prime Subcontractors and providers:

- Except in cases where advance notice is not possible or advance notice may render the audit less useful, the Commonwealth will give the Primary Contractor, its Prime Subcontractors or providers (Entity) at least three weeks advance written notice of the start date, expected staffing, and estimated duration of the audit. While the audit team is on-site, the Entity shall provide the team with adequate workspace; access to a telephone, photocopier and facsimile machine; electrical outlets; and privacy for conferences. The Primary Contractor shall also provide, at its own expense, necessary systems and staff support to timely extract and/or download information stored in electronic format, gather requested documents or information, complete forms or questionnaires, and respond to auditor inquiries. The Entity shall cooperate fully with the audit team in furnishing, either in advance or during the course of the audit, any policies, procedures, job descriptions, contracts or other documents or information requested by the audit team.

- Upon issuance of the final report to the Entity, the Entity shall prepare and submit, within 30 calendar days after issuance of the report, a Corrective Action Plan for each observation or finding contained therein. The Corrective Action Plan shall include a brief description of the finding, the specific steps to be taken to correct the situation or specific reasons why corrective action is not necessary, a timetable for performance of the corrective action steps, and a description of the monitoring to be performed to ensure that the steps are taken.

Record Availability, Retention and Access

The Primary Contractor shall, at its own expense, make all records available for audit, review or evaluation by the Commonwealth, its designated representatives or federal agencies. Effective for rating periods on or after July 1, 2017, records required for this purpose include, but are not limited to: books, contracts, computer or other electronic systems of the Primary Contractor, its BH-MCO, BH-MCO Services Providers and Subcontractors. Access shall be provided either on-site, during normal business hours, or through the mail. During the contract and record retention period, these records shall be available at the Primary Contractor's chosen location, subject to approval of the Commonwealth. All records to be sent by mail shall be sent to the requesting entity within 15 calendar days of such request and at no expense to the requesting entity. Such requests made by the Commonwealth shall not be unreasonable.

The Primary Contractor shall maintain books, records, documents, and other evidence pertaining to all revenues, expenditures and other financial activity pursuant to this agreement as well as to all required programmatic activity and data pursuant to this agreement. Records other than medical records may be kept in an original paper state or preserved on micro media or electronic format. Medical records shall be maintained in a format acceptable by the Department. These books, records, documents and other evidence shall be available for review, audit or evaluation by authorized Commonwealth personnel or their representatives during the contract period, and effective for rating periods starting on or after July 1, 2017, for ten (10) years from the final date of the Agreement period or from the date of completion of any audit, whichever is later, except if an audit is in progress or audit findings are yet unresolved, in which case records shall be kept until all tasks are completed.

Audits of Subcontractors

The Primary Contractor shall include in Prime subcontract agreements clauses, which reflect the above provisions relative to "Annual Contract Audits", "Annual Entity-Wide Financial Audits", "Other Financial and Performance Audits" and "Record Availability, Retention, and Access".

The Primary Contractor shall include in all contract agreements with other subcontractors or providers clauses, which reflect the above provisions relative to "Other Financial and Performance Audits" and "Record Availability, Retention, and Access".

HEALTHCHOICES BEHAVIORAL HEALTH PROGRAM

Program Standards and Requirements

Appendix X

HealthChoices Category/Program
Status Coverage Chart

Updated Coverage Chart at:
https://dpwintra.dpw.state.pa.us/HealthChoices/custom/program/recipelig/recipelig.asp

Attachment: *PROMISe Managed Care Payment System Table for HealthChoices. Access at:*
https://dpwintra.dpw.state.pa.us/HEALTHCHOICES/custom/program/cappay/cappay.asp
(Overviews/General Information)

HEALTHCHOICES BEHAVIORAL HEALTH PROGRAM

Program Standards and Requirements

Appendix Y

HealthChoices Behavioral Health Services Reporting Classification Chart (BHSRCC)

"To access the current version of the HealthChoices BHSRCC, visit Intranet site:
http://mydhs/omhsas/whatsnew/systemsnews/index.htm

COMMONWEALTH OF PENNSYLVANIA
DEPARTMENT OF HUMAN SERVICES
OFFICE OF MENTAL HEALTH AND SUBSTANCE ABUSE SERVICES

HealthChoices Supplemental Services and Out-of Network Provider Enrollment for Providers, Counties and Behavioral Health Managed Care Organizations

1. The HealthChoices enrollment process for supplemental service providers begins when a county or Behavioral Health Managed Care Organization (BH-MCO) identifies a service need and credentials and contracts with a provider. The following steps are included in this process:

   A. The county/BH-MCO identifies the need for a supplemental service(s) and an appropriate provider (or providers) to deliver the supplemental service(s).

   B. The county/BH-MCO works directly with the Provider(s) to make application for supplemental services or for an out-of-network Provider.

   C. The Provider(s), with assistance from the county/BH-MCO, completes an enrollment application. The enrollment application includes:

      - HealthChoices Supplemental Services Provider Enrollment Application;
      - Provider Agreement for Outpatient Providers;
      - Ownership or Control Interest Form;
      - Document Generated by the Federal IRS listing name and FEIN or SSN;
      - Supplemental Service Description (where applicable);
      - BH-MCO Attestation Form;
      - OMHSAS Field Office Attestation Form (where applicable);

   D. There are two categories of Supplemental Services which require a supplemental service description (SSD) tailored to describe the provider-specific information. They are “standard” and “newly proposed.”

      The “standard” HealthChoices Supplemental Services which require the submission of a Supplemental Service Description (SSD) with the provider enrollment application include:

      - BSU Diagnostic Assessment
      - Drug and Alcohol Intervention
      - Drug and Alcohol Intensive Case Management
      - Drug and Alcohol Resource Coordination
      - Drug and Alcohol Level of Care Assessment

      A “newly proposed” HealthChoices Supplemental Service should fall into one of the 3 categories listed below:

- Community Treatment Team
- Community Mental Health Services, Other
- Drug and Alcohol Services, Other

OMHSAS reviewers will ensure the SSD is consistent with the service requirements, and completed to describe the service as it is proposed to be delivered by the provider. Service descriptions that are incomplete or do not reflect provider-specific information will be returned to the County/BH-MCO.

A Service Description must be completed for each requested supplemental service. The Enrollment Form identifies standard (i.e., existing Supplemental Services). Whether the county/BH-MCO is requesting one of these standard services or a brand new service not included on the form, a Service Description Form must be completed. The county/BH-MCO needs to review the Office of Mental Health and Substance Abuse Services' (OMHSAS) list of Supplemental Services service descriptions, which have standard descriptions, staff qualifications, expected outcomes, and other information to determine if the particular service being considered is included.

If the supplemental service is not on the standard supplemental services list, the county/BH-MCO assists the provider to develop a new supplemental service description.

- **Date of Submission** - list the date the County Contractor/BH-MCO submitted the service description for review and approval;
- **Provider's Name** - Enter the name of the provider who will be providing this service;
- **Service Name** – Enter the name of the proposed service;
- **County/BH-MCO Name** – enter the name of the County Contractor/BH-MCO who is requesting this new service;
- **Description of Service** - complete this section;
- **Coding for Billing and/or Reporting of Services Rendered** – complete this section;
- **Anticipated Units of Services per Person** - complete this section;
- **Targeted Length of Service** - complete this section;
- **Information About Populations to be Served** - complete the table indicating the population, age ranges, projected numbers, and characteristics;
- **Program Philosophy, Goals, and Objectives** - complete this section;
- **Expected Outcomes** - complete this section;
- **Clinical Staffing Patterns** – complete this section;
- **Cost-Benefit Analysis** - complete this section.

E. The county/BH-MCO reviews the enrollment application for accuracy and completeness and completes the actions to credential the provider.

F. If the original or modified enrollment application is accepted and is complete, the Appropriate entity signs the Attestation Form and forwards the enrollment application to the OMHSAS Field Office – when applicable.

G. OMHSAS Field Office (when applicable) - will review the enrollment application for completeness and for determination of the desire to include the supplemental services provider and submit the new service description for review and approval through the Service System Review Committee (SSRC). After approval is received, the Field Office representative signs the Field Office Attestation Form and secures it to the front of the enrolment application.

H. OMHSAS has delegated the approval of OON providers to the County/BH-MCO. It is the BH-MCO's responsibility to enter into a written agreement with an OON provider, and to report person level encounters for the usage of OON providers. Out-of-network providers are not entered into the PROMISe™ system. Consideration should be given to bringing frequently-used OON providers into the BH-MCO's network to ensure inclusion in the BH-MCO's quality management review.

OFFICE OF MENTAL HEALTH AND SUBSTANCE ABUSE SERVICES
DEPARTMENT OF HUMAN SERVICES
PRIOR AUTHORIZATION REQUIREMENTS FOR PARTICIPATING BEHAVIORAL HEALTH MANAGED CARE ORGANIZATIONS IN THE BEHAVIORAL HEALTH HEALTHCHOICES PROGRAM

A. GENERAL REQUIREMENT

The HealthChoices Behavioral Health Managed Care Organizations (BH-MCO) must submit to the Department of Human Services (Department) a written description of their policies and procedures for the prior authorization of services. The BH-MCO may require prior authorization for any services which require prior authorization in the Medical Assistance Fee-for-Service (FFS) Program. The BH-MCO must notify the Department of the FFS authorized services they will continue to prior authorize and the basis for their determinations of medical necessity. The BH-MCO must request the Department's approval to require the prior authorization of any services not currently required to be prior authorized under the FFS Program. For each service to be prior authorized, the BH-MCO must submit for the Department's review and approval the written policies and procedures in accordance with the guidelines described below.
The policies and procedures must:

- be approved by the Department in writing prior to implementation;
- adhere to specifications of the HealthChoices Behavioral Health (HC BH) Agreement, including the Program Standards and Requirements (PSR), applicable policy in Medical Assistance General Regulations, Chapter 1101, and DHS regulations;
- ensure that behavioral health care is medically necessary and provided in an appropriate, effective, timely, and cost efficient manner;
- adhere to the applicable requirements of The Centers for Medicaid and Medicare Services (CMS) Guidelines for Internal Quality Assurance Programs of Health Maintenance Organizations (HMOs), Health Insuring Organizations (HIOs), and Prepaid Health Plans (PHPs), contracting with Medicaid/Quality Assurance Reform Initiative (QARI);
- include an expedited review process to address those situations when an item or service must be provided on an urgent basis.

Future changes in state and federal law, state and federal regulations, and court actions may require review of any previously approved prior authorization proposal. Any deviation from the Department's approved policies and procedures, including time frames for decisions, is considered to be a change and requires a new request for approval. Failure of the BH-MCO to comply may result in an actions by the Department up or including sanctions/or penalties by the Department.

The Department defines prior authorization as any review of a service or request for a service, which must be conducted as a condition of the service being delivered. The term prior authorization is understood to include but is not limited to:

- pre-certification;
- concurrent;
- predetermination;
- any other review for the purpose of authorizing services.

Prior authorizations proposals from the BH-MCO must be reviewed and approved by OMHSAS.

B. GUIDELINES FOR REVIEW

1. Basic Requirements:

a. If the prior authorization is limited to specific populations, the BH-MCO must identify all populations who will be affected by the proposal for prior authorization.

2. Medical Necessity Requirements:

a. The BH-MCO must describe the process to validate medical necessity for:

- covered care and services
- procedures and level of care
- medical or therapeutic items

b. The BH-MCO must identify the source of the criteria used to review the request for prior authorization of services. The criteria must be consistent with the HC BH PSR definition of medical necessity.

c. Medical necessity criteria used by BH-MCOs must be approved by the Department and conform to Appendix T of the HC BH PSR.

For BH-MCOs, if the criteria being used are:

- purchased and licensed, the BH-MCO must identify the vendor;
- developed/recommended/endorsed by a national or state health care provider association or society, the BH-MCO must identify the association or society;
- based on national best practice guidelines, the BH-MCO must identify the source of those guidelines;
- based on the medical training, qualifications, and experience of the BH-MCO's Medical Director or other qualified and trained practitioners, the BH-MCO must identify the individuals who will make the medical necessity determinations.

d. The BH-MCO must identify the qualifications of staff who will determine medical necessity. Medical necessity determinations must be made by qualified and trained practitioners with appropriate clinical experience or expertise in treating the member's condition or disease in accordance with CMS Guidelines, the HC BH PSR, and applicable legal settlements.

Requests for service will not be denied for lack of medical necessity unless a physician or other health care professional with appropriate clinical experience or expertise in treating the member's condition or disease determines:

- that the prescriber did not make a good faith effort to submit a complete request, or
- that the service or item is not medically necessary.

3. Administrative Requirements

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

b. The BH-MCO's written policies and procedures must explain how prior authorization data will be incorporated into the BH-MCO's overall Quality Management Plan.

4. Notification, Grievance, and Appeal Requirements

The BH-MCO must demonstrate how written policies and procedures for requests for prior authorization comply and are integrated with the member notification requirements and member grievance and appeal requirements of the HC BH PSR.

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 BH-MCO may choose to establish a process or protocol requiring notification prior to service delivery. If this process does not involve any approvals/denials or delays in receiving the service, the BH-MCO must notify providers of this notification requirement. This process may not be administratively cumbersome to providers and members. These situations need not comply with the other prior authorization requirements contained in this Appendix

C. Prior Authorization Review and Decision Process:

1. Timeframes for Notice of Decisions

a. The BH-MCO is required to process each request for Prior Authorization (prospective utilization review) of a service and ensure that the member is notified of the decision as expeditiously as the member's health condition requires, at least verbally within two (2) business days of receiving the request, unless additional information is needed. If no additional information is needed, the BH-MCO must mail written notice of the decision to the Member and the prescribing Provider within two business days after the decision is made.

b. If additional information is needed to make the decision, the BH-MCO must request the additional information from the provider within 48 hours of receipt of the request and allow up to14 days for the provider to submit the additional information.

c. The BH-MCO must provide written notice to the member that additional information has been requested; on the date the additional information was requested, using the template supplied by the Department as **Attachment 1.**

d. If the requested information is provided within 14 days, the BH-MCO must make the determination to approve or deny the service and notify the member orally, within 2 business days of receipt of the additional information. The BH-MCO must mail written notice of the decision to the Member and the prescribing Provider within two business days after the decision is made. If the additional information is not received within 14 days, the decision to approve or deny the service must be made based upon the available information and the member notified orally within 2 business days after the additional information was to have been received. The BH-MCO must mail written notice of the decision to the Member, and the prescribing Provider within two business days after the decision is made.

In all cases, if the member does not receive written notification of the decision to approve or deny a covered service within twenty-one (21) days from the date the BH-MCO received the request, the service is automatically approved.

e. If the member is currently receiving a requested service, the written notice of denial must be mailed to the member at least ten (10) days prior to the effective date of the denial of authorization for continued services. If probable recipient fraud has been verified, the period of advance notice is shortened to five (5) days. For inpatient services, the effective date on a denial of a continuation of services must be at least one day after the date of the notice. If the member wishes to have services continued as previously approved, the member must file a grievance or request a DHS Fair Hearing before the effective date of the denial as indicated on the denial notice.

f. Advance notice is not required when the agency has factual information confirming the death of a recipient; the agency receives a clear written statement signed by a recipient that s/he no longer wishes to receive services or gives information that requires termination or reduction of services and indicates that s/he understands that termination or reduction must be the result of supplying that information; the recipient has been admitted to an institution where s/he is ineligible under the Contract for further services; the recipient's whereabouts are unknown and the post office returns agency mail directed to the recipient indicating no forwarding address; the recipient has been accepted for Medicaid services by another State; or a change in the level of medical care is prescribed by the recipient's physician.

2. Denial of Service:

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

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

NOTE: A denial of a request for service must be based upon one of the following four reasons, along with an explanation for the reason**,** which must be explicitly stated on the notice of action:

- The service requested is not a covered service.
- The service requested is a covered service but not for this particular recipient (due to age, etc.)
- The information provided is insufficient to determine that the service is medically necessary.
- The service requested is not medically necessary.

3. Authorization Decisions:

A behavioral health denial decision based on medical necessity may be made only by a licensed physician or by a licensed psychologist if the requested service is within the psychologist's scope of practice. A licensed psychologist may not determine the medical necessity of requested inpatient services or prescribed medication. For substance abuse services, a decision based on medical necessity must be made by a licensed physician. Any representative of the BH-MCO who determines the medical necessity of a requested service must, in addition to being appropriately licensed, be appropriately experienced to render such a decision.

4. Denial Notice:

A written denial notice must be issued to the member using the notice template provided by the Department as **Attachment 2** of this Appendix when a service is denied as defined in Section C.2. of this Appendix.

5. Denial Notice Reporting:

BH-MCOs must report denial occurrences to the Department via the denial log, as detailed in Appendix M.

6. Quality Review of Denial Notices

a. The Primary Contractor is responsible for ensuring the content and quality of denial notices is consistent with the Department's expectations by implementing a formal monitoring process with documented procedures that include (but may not be limited to):
    - Criteria used to review denial notices,
    - frequency of reviews,
    - percentage of denial notices to be reviewed,
    - denial notice selection process,
    - plan to ensure various levels of care are reviewed,
    - plan to communicate review results to the BH-MCO,
    - individuals responsible for the review and dissemination of results, and
    - process to ensure BH-MCO incorporates recommendations from reviews.
b. The Primary Contractor and BH-MCO are expected to comply with the Department's quality reviews of denial notices to ensure Primary Contractor oversight is adequate. The Department, for each quality review, will specify a specific sample of denial notices that will be reviewed for compliance with Federal and State regulations, policies, standards and best practices.

Final 3/29/04

APPENDIX AA
ATTACHMENT 1
Notice of Request for Additional Information

[Date additional information was requested from Provider]

Member Name
Address
City, State Zip

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

Subject: Request for Additional Information from your Provider

Dear **[Member Name]**:

[BH-MCO Name] received a request for **[describe specific services]** from **[provider name]** on **[date received].**

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

[list specific information requested]

[BH-MCO Name] will make a decision on the requested services within 2 business days after receiving the additional information from your provider. **[BH-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. **[BH-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 **[phone #]**.

Sincerely,

[BH-MCO Name]

cc: Prescribing Provider

[BH-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 [Plan's Member Service's phone #].

Final 3/29/04

APPENDIX AA
ATTACHMENT 2a

STANDARD DENIAL NOTICE FOR REQUESTS THAT ARE DENIED COMPLETEY

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

[Member or Parent/Guardian Name]
[Address]
[County]

RE: [*Member's name, DOB, and Member or Denial Identifier*]

Dear **[*Member or Parent/Guardian Name*]**:

[BH-*MCO Name*] physician/peer-advisor, ***[name and credentials]***, has reviewed the ***[initial, continued, OR amended] current*** request for **[*identify SPECIFIC service with amount, frequency, and dates of service (if applicable)*]** submitted by **[*prescriber's name and credentials*]** on behalf of **[*patient name*]** on **[*date*]**. ***[Note if additional information was requested from the provider and when information was received (if applicable)]*** After review, the request for service 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*]**.

To continue getting services
If you have been receiving the service 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 will continue until a decision is made.

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

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:

MCO address

2)**File a Complaint or Grievance**

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

To file a complaint or grievance:

- Call **[*MCO Name*]** at **[*phone #*]**; or
- Send your complaint or grievance to **[*MCO Name*]** at the following address:

MCO address for filing complaint or grievance

To ask for an early decision

If your doctor or psychologist believes that waiting **[#]** days **[*MCO: Insert 30 unless plan 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 **[*MCO Name*]** at **[*phone #*]**
- Your doctor or psychologist must fax a letter to **[*MCO fax #*]** explaining why taking **[#]** days **[*MCO: Insert 30 unless plan will be using a shorter timeframe*]** to decide your complaint or grievance could harm your health.

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

3)**Request a Fair Hearing**

You may ask for a fair hearing from the Department of Human Services. 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 Human Services
Office of Mental Health and Substance Services
Division of Quality Management
Commonwealth Towers, 12th Floor
P. O. Box 2675
Harrisburg, PA 17105

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 psychologist 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 1-877-356-5355, or fax your request to 1-717-772-7827;
- Your doctor or psychologist must fax a letter to [1-717-772-7827] explaining why taking the usual amount of time to decide your request for a fair hearing could harm your health. If your doctor or psychologist does not send a letter, your doctor or psychologist 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:

Address for records information

4)**Get a second opinion**

You may get a second opinion from a provider in the **[*MCO Name*]** network. Call your **[*MCO Name*]** at **[*phone #*]** 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 that you have been receiving.

If you have any questions or need help filing a complaint, grievance or request for a fair hearing, you may call us at **[*MCO phone #*]**, the legal aid office at 1-800-322-7572 (www.palegalservices.org), or the Pennsylvania Health Law project at 1-800-274-3258 (www.phlp.org)**.**

cc: Prescribing Provider

[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 [*MCO Name*] at [*phone #*].

APPENDIX AA
ATTACHMENT 2b

STANDARD DENIAL NOTICE FOR REQUESTS THAT ARE APPROVED OTHER THAN REQUESTED

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

[Member or Parent/Guardian Name]
[Address]
[County]

RE: [*Member's name, DOB, and Member or Denial Identifier*]

Dear **[*Member or Parent/Guardian Name*]**:

[BH-*MCO Name*] physician/peer-advisor, ***[name and credentials]***, has reviewed the ***[initial, continued, OR amended] current*** request for **[*identify SPECIFIC service with amount, frequency, and dates of service (if applicable)]*]** submitted by **[*prescriber's name and credentials*]** on behalf of **[*patient name*]** on **[*date*]**. ***[Note if additional information was requested from the provider and when information was received (if applicable)]*** After review, the request for service 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 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 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 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:

MCO address

2)**File a Complaint or Grievance**

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

To file a complaint or grievance:

- Call **[*MCO Name*]** at **[*phone #*]**; or
- Send your complaint or grievance to **[*MCO Name*]** at the following address:

MCO address for filing complaint or grievance

To ask for an early decision

If your doctor or psychologist believes that waiting **[#]** days **[*MCO: Insert 30 unless plan 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 **[*MCO Name*]** at **[*phone #*]**
- Your doctor or psychologist must fax a letter to **[*MCO fax #*]** explaining why taking **[#]** days **[*MCO: Insert 30 unless plan will be using a shorter timeframe*]** to decide your complaint or grievance could harm your health.

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

3)**Request a Fair Hearing**

You may ask for a fair hearing from the Department of Human Services. 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 Human Services
Office of Mental Health and Substance Abuse Services
Division of Quality Management
Commonwealth Towers, 12th Floor
P. O. Box 2675
Harrisburg, PA 17105

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 psychologist 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 1-877-356-5355, or fax your request to 1-717-772-7827
- Your doctor or psychologist must fax a letter to [1-717-772-7827] explaining why taking the usual amount of time to decide your request for a fair hearing could harm your health. If your doctor or psychologist does not send a letter, your doctor or psychologist 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:

Address for records information

4)**Get a second opinion**

You may get a second opinion from a provider in the **[*MCO Name*]** network. Call your **[*MCO Name*]** at **[*phone #*]** 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.

If you have questions or need help filing a complaint, grievance or request for a fair hearing, you may call us at **[*MCO Phone #*]**, the legal aid office at 1-800-322-7572 (www.palegalservices.org), or the Pennsylvania Health Law project at 1-800-274-3258 (www.phlp.org)**.**

cc: Prescribing Provider

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

The information contained in this notice is available in other languages and formats by calling [*MCO Name*] at [*phone #*].

ATTACHMENT 2c

STANDARD DENIAL NOTICE FOR REQUESTS THAT ARE DENIED AS REQUESTED BUT HAVE APPROVED DIFFERENT SERVICES

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

[Member or Parent/Guardian Name]
[Address]
[County]

RE: [*Member's name, DOB, and Member or Denial Identifier*]

Dear **[*Member or Parent/Guardian Name*]**:

[BH-*MCO Name*] physician/peer-advisor, ***[name and credentials]***, has reviewed the ***[initial, continued, OR amended] current*** request for **[*identify SPECIFIC service with amount, frequency, and dates of service (if applicable)*]** submitted by **[*prescriber's name and credentials*]** on behalf of **[*patient name*]** on **[*date*]**. ***[Note if additional information was requested from the provider and when information was received (if applicable)]*** After review, the request for service is:

> Denied as requested, but the following service is approved: **[*describe the specific service approved, including the level, frequency, and duration of service*].**
>
> A different service 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 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 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:

MCO address

2)**File a Complaint or Grievance**

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

To file a complaint or grievance:

- Call **[*MCO Name*]** at **[*phone #*]**; or
- Send your complaint or grievance to **[*MCO Name*]** at the following address:

MCO address for filing complaint or grievance

To ask for an early decision

If your doctor or psychologist believes that waiting **[#]** days **[*MCO: Insert 30 unless plan 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 **[*MCO Name*]** at **[*phone #*]**;
- Your doctor or psychologist must fax a letter to **[*MCO fax #*]** explaining why taking **[#]** days **[*MCO: Insert 30 unless plan will be using a shorter timeframe*]** to decide your complaint or grievance could harm your health.

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

3)**Request a Fair Hearing**

You may ask for a fair hearing from the Department of Human Services. 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 Human Services
Office of Mental Health and Substance Abuse Services
Division of Quality Management
Commonwealth Towers, 12th Floor
P. O. Box 2675
Harrisburg, PA 17105

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 psychologist 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 1-877-356-5355, or fax your request to 1-717-772-7827
- Your doctor or psychologist must fax a letter to 1-717-772-7827 explaining why taking the usual amount of time to decide your request for a fair hearing could harm your health. If your doctor or psychologist does not send a letter, your doctor or psychologist 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:

Address for records information

4)**Get a second opinion**

You may get a second opinion from a provider in the **[*MCO Name*]** network. Call your **[*MCO Name*]** at **[*phone #*]** 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 that you have been receiving.

If you have questions or need help filing a complaint, grievance or request for a fair hearing, you may call us at **[*MCO Phone #*]**, the legal aid office at 1-800-322-7572 (www.palegalservices.org), or the Pennsylvania Health Law project at 1-800-274-3258 (www.phlp.org)**.**

cc: Prescribing Provider

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

The information contained in this notice is available in other languages and formats by calling [*MCO Name*] at [*phone #*].

ATTACHMENT 2d

STANDARD DENIAL NOTICE FOR REQUESTS THAT ARE MULTIPLE SERVICE REQUESTS INVOLVING MULTIPLE ACTIONS

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

[Member or Parent/Guardian Name]
[Address]
[County]

RE: [*Member's name, DOB, and Member OR Denial Identifier*]

Dear **[*Member or Parent/Guardian Name*]**:

[BH-*MCO Name*] physician/peer-advisor, ***[name and credentials]***, has reviewed the following current request for behavioral health rehabilitation services (BHRS) submitted by **[*prescriber's name and credentials*]** on behalf of **[*patient name*]** on **[*date*]**:
[List all services individually and indicate initial/continued-increase/continued-decrease/amended request, amount, frequency, and dates of service of each service]

[Note if additional information was requested from the provider and when information was received (if applicable)]
After review, the above requested services are:

Approved as requested as follows (IF APPLICABLE):
[Type of service(s), amount, frequency, authorized dates]

Approved other than as requested as follows (IF APPLICABLE):
[Type of service(s), amount, frequency, authorized dates]

The following approved service(s) are different than what was originally requested (IF APPLICABLE):
[Type of service(s), amount, frequency, authorized dates]

This results in a denial of requested services as follows:
[Type of service(s), amount, frequency, denied dates]

The above services have been authorized and denied 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 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 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:

MCO address

2)**File a Complaint or Grievance**

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

To file a complaint or grievance:

- Call **[*MCO Name*]** at **[*phone #*]**; or
- Send your complaint or grievance to **[*MCO Name*]** at the following address:

MCO address for filing complaint or grievance

To ask for an early decision

If your doctor or psychologist believes that waiting **[#]** days **[*MCO: Insert 30 unless plan 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 **[*MCO Name*]** at **[*phone #*]**;
- Your doctor or psychologist must fax a letter to **[*MCO fax #*]** explaining why taking **[#]** days **[*MCO: Insert 30 unless plan will be using a shorter timeframe*]** to decide your complaint or grievance could harm your health.

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

3)**Request a Fair Hearing**

You may ask for a fair hearing from the Department of Human Services. 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 Human Services
Office of Mental Health and Substance Abuse Services
Division of Quality Management
Commonwealth Towers, 12th Floor
P. O. Box 2675
Harrisburg, PA 17105

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 psychologist 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 1-877-356-5355, or fax your request to 1-717-772-7827
- Your doctor or psychologist must fax a letter to 1-717-772-7827 explaining why taking the usual amount of time to decide your request for a fair hearing could harm your health. If your doctor or psychologist does not send a letter, your doctor or psychologist 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:

Address for records information

4)**Get a second opinion**

You may get a second opinion from a provider in the **[*MCO Name*]** network. Call your **[*MCO Name*]** at **[*phone #*]** 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 that you have been receiving.

If you have questions or need help filing a complaint, grievance or request for a fair hearing, you may call us at **[*MCO Phone #*]**, the legal aid office at 1-800-322-7572 (www.palegalservices.org), or the Pennsylvania Health Law project at 1-800-274-3258 (www.phlp.org)**.**

cc: Prescribing Provider

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

The information contained in this notice is available in other languages and formats by calling [*MCO Name*] at [*phone #*].

DEPARTMENT OF HUMAN SERVICES

OFFICE OF MENTAL HEALTH AND SUBSTANCE ABUSE SERVICES

REGULATIONS AND POLICIES NOT APPLICABLE TO HEALTHCHOICES BEHAVIORAL HEALTH PROGRAM

PREAMBLE

Appendix BB is a compendium of regulations, portions of regulations and Bulletins which were reviewed and identified as not applicable to the operation of the HealthChoices Medicaid mandatory managed care program approved through the Section 1915(b) waiver provisions of the Social Security Act. The creation of this list is the outcome of a formalized process to review all of the regulations and Bulletins guiding the provision of MA funded services including the rules for billing, fees and payment. Rules that limited service delivery or described processes specifically applicable to the Department's Fee-For-Service system of payment are entered onto this list. The intention is to recognize that payment under a capitation arrangement with Managed Care Organizations (MCO) is different for the Commonwealth, as a contractor, and a significant change from fee-for-service payments going directly to providers. Prescribed methods of billing, the application of specific fees and limitations on the delivery of services provided in the rules would no longer be necessary but elements that would need to remain would be those that ensured the integrity of the services to be provided, including those understood to prevent fraud, waste and abuse.

This marks a change in role for Medical Assistance from one that pays providers directly for services provided to paying a capitation payment to MCOs. Appendix BB serves to inform MCOs of the parts of the regulatory system that do not apply to the operation of the MCO and how the MCOs manage their provider networks. Appendix BB has no direct application to the operation of individual providers of services and has no application in the Medical Assistance fee-for-service context.

Regulations and policies not applied to HealthChoices Behavioral Health Managed Care Contractors:

REGULATIONS

CITATION/EXCLUSION	Relevant Portion if the Citation Does Not Apply in its Entirety
BH-MCOs are required to adhere to the provisions of all applicable Chapters of Title 55 of the Pennsylvania Code with the following exceptions:	
Chapter 1101 -- General Provisions	
1101.21 Definition of "Shared Health Facility" (iv) and (v)	(iv) at least one practitioner receives payment on a fee-for-service basis. (v) A provider receiving more than $30,000 in payment from the MA program during the 12-month period prior to the date of the initial or renewal application of the shared health facility for registration in the MA program.
Chapter 1151, Inpatient Psychiatric Services	
1151.21(b)	"for up to 60 days"
1151.34	
1151.41 (b)(c)(1-2)(d)(i)(j)	
1151.42 (a (c)(d)	
1151.43 (a)(b)	
1151.45(2)(3)	
1151.46	
1151.48 (a)(2-6)(9-16)(18-20)	
1151.50(b)(1-4)	
1151.52	
1151.53	
1151.54	
Chapter 1153 -- Outpatient Psychiatric Services	
1153.2 Definitions – Psychiatric Partial Hospitalizations	"….a minimum of 3 hours and a maximum of six hours in a 24 hour period"
1153.14(9)	
1153.52(a)(2)	"separate billings for these additional services are not compensable"
1153.53 Limitations on Payments	
1153.53 a. Requests for Waiver for Hour Limits	
Chapter 1163 – Inpatient Drug and Alcohol Services	
1163.59	
1163.455	

CITATION/EXCLUSION	Relevant Portion if the Citation Does Not Apply in its Entirety
Chapter 1223, Outpatient Drug and Alcohol Clinic Services	
1223.12 – Outpatient services	"fee for service"
1223.14 (8)(9)	
1223.52(2)(3)(c)	"Separate billing for these interviews are not compensable"
1223.53 Limitations on Payment	
Chapter 4300, County Mental Health and Mental Retardation Fiscal Manual	
4300.11	
4300.22	
4300.23	
4300.25 through 4300.28	
4300.41 through 4300.69	
4300.81 through 4300.108	
4300.111 through 4300.118	
4300.131 through 4300.160	
Chapter 5221 Mental Health Intensive Case Management	
5221.42(b)(c)(f) length of services only (g)	
5221.42(h)	….100% of the approved expenditure for…..
Chapter 5260 Family Based Mental Health Services for Children and Adolescents	
5260.12(b)(c)(d)	
5260.21(2)	….full-time director
5260.21(b)	….members of the treatment team and the program director may not be employed in another MH program…
5260.22(b)(1-7)	
5260.45(e)(f)(g)(i)(j)(k)	
5260.46	
Note: These exceptions also apply to the Family-Based Mental Health Services Contract Addendum	

Bulletins

CITATION/EXCLUSION	Relevant Portion if the Citation Does Not Apply in its Entirety
BH-MCOs are required to adhere to the provisions of all applicable Medical Assistance Bulletins with the following exceptions:	
Medical Assistance Bulletin 01-93-04,11-93-02, 13-93-02, 41-93-02, 1165-93-01, 53-93-02	
Payment for Mental Health Services Provided in a Residential Treatment Facility for Eligible Individuals Under 21 Years of Age (applies at accredited RTFs only)	
Page 1, 1st paragraph	
Page 3, #4	
Section C. Payment for Service	
Section D. Request for prior authorization	
Section E. How to Invoice	
Attachment 6, 1150 Waiver request	
Attachment 7, Plan of care summary	
Attachment 8	
Attachment 9	
Medical Assistance Bulletin 01-94-01 Outpatient Psychiatric Services for Children Under 21 Years of Age	
Page 1, Background – Last paragraph	"….by an 1150 Waiver Request (MA 325)
Page 2	"Exceptions" – entire section
Page 3	"Note" – entire section
Page 3	"Reminder"….and must be requested from the Office of Medical Assistance through the 1150 waiver process.
Pages 3	Requirements and Procedures – first two paragraphs and number 1
Page 4, #6 (a-c)	
Pages 3-9	The MA fee, type services and procedure code
Pages 6-9	The Limit, MA fee and "Limit of three per year of any combination of the procedure codes listed, type of service and procedure code."
Medical Assistance Bulletin 1153-95-01 Accessing Outpatient Wraparound Mental Health Services Not Currently Included in the Medical Assistance Program Fee Schedule for Eligible Children Under 21 Years of Age	
Page 5 - (c) (2) 3rd paragraph	"A Provider Type 50 may provide……"
Page 5 – D. 1 and 2	
Page 6 - A.1.(a)	"The Outpatient Services Authorization Request……"
Page 8 – 3 a, b, c and Note: "A facility or…."	
Page 8 – 4	"The request for prior approval and…….."
Page 9 – 5 a	Note: If a managed care plan…."
Page 9 – 5. b, c, d	
Page 10 – 5 (continued)	
Pages 10-11 - 6 (a - e)	

CITATION/EXCLUSION	Relevant Portion if the Citation Does Not Apply in its Entirety
Pages 11-12 – 7 (a - d)	
Pages 12-13 - 8 and 9	
Page 13 - B	"Invoicing for Outpatient Wraparound Mental Health Services"
Attachment D	Subcontract Agreement Form
Attachment E	Outpatient Service Authorization Request
Attachment H	Request for Expedited Outpatient Behavioral Health Services
Medical Assistance Bulletin 1157-95-01 Mental Health Services Provided in a Non-Accredited Residential Treatment Facility for Children Under 21 Years of Age	
Page 3 A(2)(c)	
Page 3, A(4)	
Page 4 B,C	"To receive MA reimbursement"
Page 5, D(1)(2)	"Payment will be made only for services prior approved by OMAP"
Page 9-14 (A), (B)	
Attachment 2, 3(e), 4(b), 4(e)	
Attachments 5,6,7,8,9,11	
Medical Assistance Bulletin 1165-95-01 Updated, Accredited Services	
Page 3, the two paragraphs following item C	
Page 4, 3. HIO and HMO	
Page 5, Invoicing for RTF Services	
Page 7 (b and c)	
Page 10, last sentence on the page	
Medical Assistance Bulletin 50-96-03 Summer Therapeutic Activities Program	
Page 2, 3rd paragraph	Reference to the maximum period of "five weeks per calendar year"
Page 2, 4th paragraph	The required supporting documentation for the provision of this service does not apply except as required by the MCO for their provider network.
Page 3, "Provider Requirements" - #1	
Page 4	"Payment for Services, including unit length"
Attachment - Service Description Format	
Medical Assistance Bulletin 01-97-08 Diagnostic and Psychological Evaluations	
Page 2	"The Department limits these procedure codes to three (3) per child, regardless of the combination of procedure codes….(to end of paragraph)"
Medical Assistance Bulletin 01-98-10 Change in Billing Procedure for Behavioral Health Rehabilitation Services	
Page 2	"Discussion"

CITATION/EXCLUSION	Relevant Portion if the Citation Does Not Apply in its Entirety
Medical Assistance Bulletin 01-98-19 Clozapine Support Services	
Page 3 "Non-covered services" #1, #3, #4 and #5	
Page 3, 2nd paragraph	The maximum time period for each order shall not exceed six (6) consecutive calendar months.
Page 5, entire chart	
Medical Assistance Bulletin 17-99-02 Procedures for Licensed, Enrolled Mental Retardation Providers to Access and Submit Claims for Outpatient Behavioral Health Services for Individuals Under 21 Years of Age	
Page 2, Procedures #2, #3 and #4	
Page 3, Procedure #5	
Page 3, Procedures	Procedure for Handling TSS, MT, and BSC Services Already Approved Through the 1150 Administrative Waiver Process - #s 1, 2 and 3
BH-MCOs are not required to adhere to the provisions of the following Medical Assistance Bulletins:	
Medical Assistance Bulletin 01-93-04 Payment for Mental Health Services Provided in a Residential Treatment Facility for Eligible Individuals Under 21 Years of Age	
Medical Assistance Bulletin 01-97-16 Changes in Procedure for Requesting and Billing Therapeutic Staff Support (TSS) Services	
Medical Assistance Bulletin 28-97-06 Change in Billing Procedures for Psychotherapy	
Medical Assistance Bulletin 50-97-03 Training for EPSDT Expanded Services Providers (Provider Type 50) on Completing Medical Assistance Invoices	
Medical Assistance Bulletin 99-98-12 Accurate Billing for Units of Service Based on Periods of Time	
Medical Assistance Bulletin 19-99-04 Prescriptions Not Received by the Medical Assistance Recipients	
Medical Assistance Bulletin 28-99-03 Increased Fees for Outpatient Psychiatric Clinics, Psychiatric Partial Hospitalization Programs and Outpatient Drug and Alcohol Clinics	

CITATION/EXCLUSION	Relevant Portion if the Citation Does Not Apply in its Entirety
BH-MCOs are to adhere to the provisions of the following Office of Mental Health and Substance Abuse Services Bulletins listed below with the following exceptions:	
OMH-91-19 Transmittal of General Family Based Mental Health Services Program Issues	
Page 2 - #7	
Page 8 - #40	
Page 9 - #46, #47	
Page 11 - #56, #57	
Page 12 - #62	
Page 13 - #67, #70	
Page 14 - #72 through #75	
Page 16, #1	
OMH-92-16 Mental Health Crisis Intervention Services: Implementation	
Attachment A, B	
Attachment C – Payment	
Subsections A - E – Payment Conditions	
OMH-93-09 Resource Coordination: Implementation	
Attachment A, B	
Attachment C - General Provisions – Service Description -	"The implementation of Resource Coordination services is optional at this time". (Resource Coordination (RC) is a required in-plan service under HealthChoices. However, if Blended Case Management (which provides both ICM and RC level of service) is available as an option, then the implementation of traditional RC is optional.)
Attachment C – Payment	
OMH-93-10 Mental Health Crisis Intervention Services Guidelines	
Issues (1)(2)(3)(4)(8)(9)	
OMH-94-09 180 Day Exception Requests of MA Invoices	
OMH-94-07 180 Day Exception Requests and Invoices Submission Timeframes	
OMH- 95-02 Maximum Allowable Rates of Reimbursement for Psychiatric Physicians	
OMH-96-04 Procedures for Claiming Federal Reimbursement on Administrative Costs for Medicaid Funded Mental Health Services	
OMHSAS-03-01 Mental Health Crisis Intervention (MHCI) Fee Schedule	
OMHSAS-99-02 Maximum Allowable Rates of Reimbursement for Psychiatric Physicians	

CITATION/EXCLUSION	Relevant Portion if the Citation Does Not Apply in its Entirety
OMHSAS-05-01 Cost Settlement Policy and Procedures for Community-Based Medicaid Initiatives	

CITATION/EXCLUSION	Relevant Portion if the Citation Does Not Apply in its Entirety
OMHSAS 10-03 Blended Case Management (BCM) Revised	
Attachment D, Section 1	Provider participation, requirement to be bound by Chapter 1101 (relating to General Provisions) and §1150.62 (Payment levels and notice of rate setting changes)
00-88-03 Appropriate Billing for Psychiatric Partial Hospitalization Services and Psychiatric Outpatient Clinic Providers	
00-88-14 Fee Schedule Revisions and Transportation Requirements	
4000-95-01 Room and Board Payments for Mental Health Only Children in Residential Facilities Which are Not JCAHO Accredited	
Administrative Bulletin 2015-01 Maximum Rate- of State Participation for Mileage – County Children and Youth Agencies and Mental Health/Intellectual Disabilities/Early Intervention Programs	

COMMONWEALTH OF PENNSYLVANIA

DEPARTMENT OF HUMAN SERVICES

OFFICE OF MENTAL HEALTH AND SUBSTANCE ABUSE SERVICES

Indicators of the Application of Cultural Competence Principles

Cultural Competence has long been an expectation of Pennsylvania's public mental health system. Included in the CASSP and CSP Principles from their inception, cultural competence has historically focused on the four traditionally under served populations of African Americans, Latinos, Asian Americans and Native Americans. More recently, the Office of Mental Health and Substance Abuse Services (OMHSAS) in collaboration with the OMHSAS Cultural Competence Advisory Committee, has taken a broader view of culture. Recognizing the diversity that makes up Pennsylvania's population, Cultural Competence is viewed as inclusive of rural and urban populations, deaf persons, the Amish, groups of recent refugees and clusters of various ethnic populations that are scattered across the Commonwealth, as well as the traditionally identified populations.

The Department of Human Services (Department) in its issuance of the Request for Proposals for the HealthChoices Behavioral Health Program recommends the implementation of Cultural Competence Principles by the Primary Contractor, managed care organization (MCO), its subcontractors and any associated provider networks.

It is the expectation that the implementation of Cultural Competence Principles will result in a system that understands the implications of racial genetics for medication prescription, the differences in help seeking behaviors among various groups and populations and the basis of internal and external stigma related to mental illness, as well as many other barriers to a successful and effective system of care.

PRINCIPLES OF CULTURAL COMPETENCE

1. Principle of the Universality of Ethnicity and Culture. Each person is aging therefore has an age and an age cohort. Each person has: a gender, therefore a gender orientation; abilities, therefore limitations; resources deriving from social constructs, therefore a socioeconomic status; a family history and a legacy that precedes by many generations, therefore an ethnicity and a culture. Identification with others by all these means helps provide a sense of security, belonging and identity. It is this power that drives "Honk if you own a Volkswagen", or "the wave" at ball parks to work so effectively. Each human encounter in so far as it crosses some boundary of age, belief or practice is, in a sense, a cross-cultural encounter, but we have many bridges to facilitate the crossing. Culture is more than just membership in one's racial/ethnic group. Culture is a dominant

force arising within us from our parental and community upbringing, serving to shape behavior, values, cognition and social institutions.

In the treatment setting, every consumer must be valued within his/her cultural context. Observed differences are to be appreciated as sources of strength and enrichment and resources of reconnection and reintegration. Within each individual's thinking, personal history and family culture lay the defining attributes of his or her problems and the solutions. The wholeness of the individual is important for a complete evaluation and effective intervention.

2. Principle of Cultural Competence. Treatment, recovery and rehabilitation are more effective when consumers and families fully engage in services that are compatible with their cultural values and world-views. Services that are culturally competent are provided by individuals who have the skills to recognize and respect the behavior, ideas, attitudes, values, beliefs, customs, language, rituals, ceremonies and practices characteristic of a particular group of people (Child and Adolescents Services Systems Program Principles). These skills are used to determine consumer wellness/illness, establish individualized and consumer-driven plans and goals, and to create unique services that are community-based and that integrate natural supports. Cultural competence entails knowledge of consumers' literacy level, native languages, levels of acculturation and assimilation, and cultural health care beliefs, customs and practices. This body of knowledge guides the service system to increase consumer access to services, and to better design, implement and evaluate services tailored to particular cultural groups. The principle entails vigorous integration of cultural competency principles and standards of practice throughout all levels of behavioral health and substance abuse planning, policy-making, research, evaluation, training and service delivery.

3. Principle of Social and Environmental Influences. Social conditions of poverty, unemployment, discrimination, class rank, immigration status, and isolation greatly impact all aspects of behavioral health care, and contribute deleterious effects and exacerbate symptomatology. Effective service outcomes and quality of life are achieved when the consequences of these social experiences are identified and incorporated into health care planning and service delivery. Services are designed and funded to assure these conditions are not barriers to health care. The service system assures that services do not merely reach the most motivated, educated and socially mobile consumer and family. Service evaluations entail assessing the prevalence of these social conditions in communities, and engaging consumers at the highest risk of illness. Planning processes recognize social conditions and their impact on health and interventions. Professionals avoid assigning fixed diagnoses and characteristics to consumers who are merely responding to stressful social conditions. Service systems adopt *no-reject/no-eject* standards of practice so that no consumer is rejected or ejected from services because of behavior that is necessary to survive and cope in their social conditions.

4. Principle of Consumer-Driven Services. Consumer-driven services include activities that individualize plans, assessments and services that focus on the priorities, values and goals of consumers and families. Whenever possible, self-help services are created and utilized. Consumer-driven services foster self-determination and choice. Cultural groups are fully engaged when they are actively involved in the design, implementation and evaluation of services that fit their unique worldview. For many cultural groups this entails services that heal the wounds of bias and discrimination. It entails the establishment of linguistically appropriate services, assuring the availability of culturally competent advocates, and educating consumers on the workings of the service system. Consumers, and their families and communities, fully participate in determining the kind of services that best achieve goals for achieving high quality and meaningful lives. Systems of care must have a goal of empowering consumers, during the course of treatment, to be self-determining in all domains of their lives.

5. Principle of a System of Care. Systems of care are consumer-driven, highly coordinated service responses to multiple needs of consumers and families. They require professional willingness to engage, interact and communicate in effective partnerships with culturally diverse populations, and to encourage and value consumers' active role in the service planning process. In a system of care services focus on all domains of consumers' lives (mental health, education, medical, housing, social rehabilitation, employment) and integrate health care needs into a single coordinated plan of services that is individualized and culturally relevant. Services are community-based, involve natural supports, strength-based, and are least restrictive. Cultural and non-traditional ways of healing are integrated in case management and treatment/rehabilitation plans. All planning processes are consumer-driven and family-focused. Family and community members are engaged and invited into the planning and service delivery processes. This entails planning meetings that are community-based and are convenient to consumer availability. These strength-based, comprehensive plans are designed to enhance consumers achieving high quality and meaningful lives.

6. Principle of Access. Access occurs when cultural groups perceive that services are relevant to their life experience and world-view, and use them. Linguistic, geographic and cultural barriers to services are identified and removed. Service systems use culturally relevant media to inform and educate cultural groups, and the general public, about services and supports. Full access to services is determined by evaluating both the use of services by cultural groups as compared to the general population, and by evaluating the prevalence of concerns and problems in specific cultural communities. Increasing access results in less use of crisis and emergency services. Problems and concerns are identified early, and prevention and support services reduce the severity and prevalence of chronic illnesses. This principle entails identifying and overcoming transportation, poverty and community safety barriers to services. Whenever possible, services are community-based.

7. Principle of Quality of Life Outcomes. Consumers and families evaluate outcomes of services, and the service system, by their ability to enhance and improve quality of life. Quality of life is achieved when consumers reach and accomplish self-defined meaningful life goals. It involves having meaningful social roles within family and community. It involves consumer empowerment and self-determination to make decisions in all domains of their life. Case management and treatment/rehabilitation plans encompass all domains of consumers' lives to foster growth and development of necessary personal, social, employment and interpersonal skills to achieve fulfillment and wellbeing. Holistic approaches to health care are essential to assure consumers have a high quality of life.

8. Principle of Managed and Integrated Health Care. Costs of public health care are best managed and contained by providing high quality, effective mental health and substance abuse services tailored to consumers and family culture that integrate and coordinate medical, mental health and substance abuse. In this way, consumer engagement may be maximized, and use of more costly emergency services reduced. Primary health care that engages consumers in preventative health care throughout life development reduces costs and improves the overall health of our communities. Integrating physical and emotional health in assessments, plans and services is essential. The service system emphasizes managing care, and not dollars, by assuring consumers are in least-restrictive treatment settings, and gain access to services early.

Prevention is a key goal for managed and integrated systems of care. Prevention includes community education about mental illness, substance abuse, family support services, early identification programs and services, and social marketing campaigns to de-stigmatize mental illness. Prevention and early intervention necessitate behavioral health providers to link with physical health care providers and other community-based services. Assuring a high quality of life for consumers is considered an important aspect of prevention. Subsequently, increasing community employment and job skill training are examples of prevention activities.

9. Principle of Data/Evaluated Driven Systems of Care. Traditional ways of collecting information, and planning and evaluating services, do not reach isolated and high-risk populations. Many existing information systems and planning processes do not attain information about communities, and only focus on those currently and traditionally served. Assuring services are culturally competent requires engaging communities to gather information about the prevalence of problems, stressful social conditions, substance abuse and mental illness. Data and findings are always interpreted in the context of each cultural community, and not merely compared to the general population as a normative standard. Individual, family and community outcomes are projected as an aspect of county planning processes. Storytelling, testimonials, and oral accounts of needs and satisfaction are considered data sources. In consumer-driven systems of care, feedback by consumers regarding service satisfaction and outcome are most important data for future planning and system re-design.

Outcomes and effectiveness of services are evaluated based on the prevalence of illness and problems in the cultural community, and not merely by comparing rates to the general population. This principle assures professionals and community members avoid using the dominant culture as a normative standard of health. Rates of illness are impacted by cultural, social and historic differences among social groups. Behavior that seems aberrant to the general population may be healthy responses to social conditions. Services target the unique patterns of illness and problems in cultural communities, and develop unique community-based health standards by which to evaluate services.

10. Principle of Least Restrictive/Least Intrusive Services. Services occur in settings that are the most appropriate and natural for the consumer and family, and are the least restrictive and intrusive in impacting the right of self-determination by consumers, families and communities. (CASSP) This means community-based, in-home and natural support services being first utilized, unless there are assessed indications that other services are necessary to assure outcomes and quality of life. Justification for more restrictive and intrusive services occurs at all levels of planning: initial assessment through discharge. Consumer, family and community members are included in determining the least restrictive/intrusive setting and service. As minorities are over-represented in restrictive settings, and as recipients of behavioral controlling treatments, service systems regularly collect data and monitor these services. Plans of action are created and implemented when evaluation finds cultural groups are over-represented in restrictive treatments.

GUIDELINES FOR THE APPLICATION OF CULTURAL COMPETENCE PRINCIPLES

ACCESS AND SERVICES AUTHORIZATION

Families and natural supports persons (self-defined family) have access to services in a respectful and welcoming manner. Services are provided in timely, convenient and easily accessible ways. Protocols exist to assure services are available to persons who are disinclined to accept treatment. Bilingual and bicultural providers, and trained interpreters, are available throughout the entire service system. Service availability and determination encompass a holistic rehabilitative approach that includes psychiatric, medical, social, vocational, behavioral, cultural, spiritual, familial and community supports.

Indicators of Guideline Application

1. Persons of diverse cultures and linguistic differences are served based on their preference and actual need.

2. Service systems utilize a variety of formats to disseminate culturally relevant information regarding mental health and addiction services, as well as non-traditional and self-help resources.

3. A written plan guides action that engages and encourages individuals in need of services but who are disinclined to accept treatment.

4. Service systems demonstrate timeliness in member access and authorization of services.

5. Service systems adopt flexible service hours to maximize the availability of services.

6. Service systems authorize cultural-based alternative and complementary treatment approaches that assure consumer engagement, retention and follow-up.

7. Service systems staff and Managed Care Organizations have culturally and linguistically competent staff available 24 hours a day, and 7 days a week.

8. Service agencies have a milieu and physical environment that reflects diversity and the surface cultures of consumers being served.

MEASURES OF GUIDELINE APPLICATION

1. Service utilization rates of traditionally under-served and over-represented persons are comparable to the prevalence of illness and problems that occur in the ethnic/cultural group. Cultural/ethnic community residents use behavioral healthcare providers as a community resource for all health concerns. In highly

2. restrictive services, utilization rates are comparable to all other groups in the general population.

3. Service providers have a list available in each facility of culturally and linguistically accessible services.

4. Descriptions of culturally sensitive services and programs are available for consumers in their community and other natural gathering places. Providers develop ethnically/culturally relevant ways of disseminating information that make services widely known in ethnic/cultural communities.

5. Educational and information materials reflect the languages and cultures of persons served.

6. Service systems track the utilization rates of persons who are traditionally disinclined to accept treatment. These systems develop studies on the prevalence of illness and problems in ethnic/cultural communities, and identify the barriers they experience to seeking help. Service systems create correction plans, implements actions, and measure improvements in help-seeking behavior. Indicators of positive impact include: decrease use of emergency rooms, decrease use of crisis services, increase number and use of advocacy groups, decrease arrest rates of persistently ill consumers, increase referral follow-through rates, and increase voluntary use of self-help and prevention services.

7. Service systems track the increase in availability of services. Availability is indicated by services occurring in settings that various ethnic/cultural groups define as comfortable, appropriate, consistent with their values and worldview, and complementary to their natural healing practices.

8. Service systems track the number and type of alternative and complimentary treatment approaches for various cultural groups. High performance is indicated by an integration of traditional healing practices and treatment approaches with professional models that capture the best of each.

9. Service systems determine consumer satisfaction and increase access because of flexible hours, and alternative and complimentary treatment.

10. Waiting area and offices display magazines, art, music, etc., reflective of the cultures and ethnic groups of consumers being served.

CASE MANAGEMENT

Case management shall be central to the operation of the multidisciplinary team. It reflects an understanding and appreciation of the values, norms and beliefs of consumers' cultures, and knowledge of resources in their communities. Case management recognizes the unique mental health/substance abuse issues associated with the consumer's economic conditions, social class, and experience of bias, discrimination and racism. Case management recognizes the impact of these issues on behavioral health, and takes these into account in considering the cultural appropriateness of all services that are coordinated and managed. Case management advocates for the consumer, assures consumers are knowledgeable of service options, and assists consumers in making best choices. These activities are individualized to the diverse culture, race, ethnicity and language differences. Case management services participate in ongoing assessments of their service system to determine and assure that they are responsive to diverse consumer needs and experiences.

INDICATORS OF GUIDELINE APPLICATION

1. Consumers have access to a comprehensive array of services that are compatible with their culture.

2. Consumers receive culturally competent services that are coordinated within multiple domains, i.e., vocational, social, educational and residential settings.

3. Culturally competent services are continually created and adapted to meet the needs of consumers.

MEASURES OF GUIDELINE APPLICATION

1. Service utilization data and information are utilized to increase enrollment of under-served populations. Ethnic cultural group enrollment in less restrictive services (outpatient, self-help, social rehabilitation) increases to levels comparable to the general population. Enrollment in restrictive services (inpatient, involuntary commitments, jail treatment settings, court-ordered outpatient) decreases to levels comparable to the general population.

2. Service systems document culturally competent services and resources received by consumers. Individual and family definitions of culture, ethnicity and need guide the development of indicators for high levels of performance. Merely providing culturally competent services to person of color, or persons who are perceived different than mainstream culture, is not an indicator of compliance.

3. Service systems document family and community contacts/visits, and visit locations. High levels of compliance are system-wide supports for family and community member advocacy and full participation in all aspects of case planning. Parent led support/advocacy groups naturally develop and influence decision-making throughout the delivery system. Merely having record of family member attendance at meetings is not an indicator of compliance.

4. Service systems document that consumers have improved relationships within family, and within social networks of their cultural group. High levels of compliance are indicated by fewer consumers estranged from their natural family, and high levels of family involvement in planning processes and support services.

5. Service systems document that consumers achieve the greatest degree of independence and self-determination. The use of restrictive services by ethnic/cultural groups is reviewed annually for use in comparison to the general population. Each provider implements a plan of correction until usage levels are comparable. Restrictive care includes the use of psychotropic treatment without complementary clinical/rehabilitative services.

6. Revised care plans and services demonstrate inclusion of ethnic, social and cultural factors.

7. Cultural competence training for all case managers is incorporated in reviews for regulation compliance. Training is designed for the ethnic/cultural groups that exist in the service community. Levels of training and competence are established.

8. Community resources and natural supports are included in all care plans.

TREATMENT/REHABILITATION PLAN

All persons served receive a treatment/rehabilitation plan that is holistic, and incorporates the consumer's choice of attainable goals, culturally compatible treatment modalities, and consumer driven alternative strategies of health care. These strategies include the use of family, community supports, spiritual leaders and folk healers. Plans are consumer driven, based on their individual strengths, and developed within the context of family and social networks so as to create a consumer-professional partnership. Plans are formulated and reviewed by culturally competent professionals and culturally competent consultants in full collaboration with consumers and families.

INDICATORS OF GUIDELINE APPLICATION

1. Identification and creation of culturally relevant goals.

2. Use of culturally compatible modalities and alternative strategies.

3. Consumers and families fully participate and share in the development of goals and wishes, and express satisfaction with their role and participation.

MEASURES OF GUIDELINE APPLICATION

1. Plans document consumer wishes and goals. These may be related to employment, education, training, personal appearance, health, family relationships, social activities and social relationships. Plans specify ethnically/culturally relevant wishes and goals.

2. Service systems document consumer and family satisfaction with their participation in the treatment/rehabilitation planning process. Low levels of satisfaction trigger plans of correction, implementation of these plans, and re-evaluation.

3. Plans outline cultural relevant treatment and rehabilitation modalities and strategies.

4. Service systems document that professionals are trained in the development of culturally competent treatment and rehabilitation plans. Training, staff skills, and cultural competence will be greatly impacted by the kinds of ethnic/cultural groups in the service area. A high level of performance is indicated by professional standards for competence for each ethnic/cultural group, and not a generalized declaration of professional competence due to completion of a generalized cultural competence training program.

5. Service systems create all written planning materials and documents in plain and simple text that is readily comprehended by consumers and families.

RECOVERY AND SELF-HELP

Recovery and self-help groups are readily available, and function as an integral part of a seamless continuum of care. Recovery and self-help groups are culturally diverse and culturally compatible, incorporating consumer-driven goals and objectives that are oriented toward rehabilitation and recovery outcomes. Culturally competent providers and consumers in recovery are enlisted as consultants and educators to assist in the creative development of alternative treatment services, models and supports that are compatible with the lifestyles, values and beliefs of various cultures.

INDICATORS OF GUIDELINE APPLICATION

1. Services are accessible and available in a variety of settings, including churches, neighborhood facilities, and consumer residences.

2. Service system creates more integrated, culturally and linguistically specific, recovery groups.

3. Services are readily accessible and available in a variety of settings.

4. Community groups, consumers in recovery and other natural supports groups are recruited in the development and design of recovery and self-help service models.

MEASURES OF GUIDELINE APPLICATION

1 Service systems document the increase use of recovery and self-help programs by consumers of various cultural groups. As families and communities are engaged in services, the number of ethnic/cultural self-help, advocacy and recovery groups increase. A high-level of self-determination which is emphasized while maintaining inclusion in the service system is a strong performance indicator.

2 Service systems document an increase in the variety of ethnically/culturally relevant recovery and self-help programs. The array of ethnic/cultural services increases as the service system better engages and empowers families and communities.

3. Providers make available to consumers a list of recovery and self-help services in locations that are readily accessible to consumers and their communities.

CULTURAL ASSESSMENT

A cultural assessment is conducted by competent staff for each consumer, and within the context of the consumer's culture, family and community. The assessment is individualized, multidimensional and strength-focused. The components of the assessment include functional, psychiatric, social status, cultural milieu, social and economic stresses, discrimination, and family supports.

INDICATORS OF GUIDELINE APPLICATION

1. A cultural assessment is the basis for a culturally relevant diagnosis, goals and rehabilitation/treatment plans.

2. A cultural assessment tool and guide exists to determine cultural factors that impact treatment/rehabilitation services.

3. On-going cultural assessment occurs at each phase of treatment and rehabilitation.

4. Cultural assessment includes consumer preferences, and differentiates pathology from cultural factors.

MEASURES OF GUIDELINE APPLICATION

1. Bilingual staff is available to assess consumers in their language of preference.

2. Qualified cultural interpreters are utilized when bilingual staff is not available.

3. Psychological assessment and measurement tools are culturally valid and reliable, and administered, scored and interpreted by culturally competent providers.

4. All consumers receive an ethnic/cultural assessment. The rates of chronic, anti-social and other serious diagnoses for all ethnic/cultural groups are comparable to the general population. The use of restrictive treatments for all ethnic/cultural groups is comparable to the general population.

5. Providers document the inclusion of family members and significant community support persons in the initial and on-going assessment process. An indicator of high level performance is community-based, including community/family/consumer driven assessments and service planning.

6. The assessment includes cultural factors that are important to the treatment process. These factors include, but are not limited to, the following:

   a) Preferred language.
   b) History of indigenous/immigration/migration/generation behavior patterns.
   c) Degree of acculturation and adaptation.
   d) Cultural, social, economic and discrimination stresses and traumas.
   e) Learning and cognitive styles.

   f) Family organization and relational roles.
   g) Extent of family support.
   h) Social network composition.

i) Ethnic identity
j) Consumer's perception/belief of presenting problems and explanations for symptoms.
k) Consumer's belief systems regarding mental illness/substance abuse.
l) Sexual identity and sex role orientation in cultural group.
m) Coping strategies utilized within the cultural group.
n) Help-seeking behavior.
o) Previous attempts at relieving, managing and treating symptoms. (Including healers, traditional medicine, etc.)

To protect the rights and confidentiality of consumers, family and friends are not to be used as language/communication interpreters. These persons are welcomed to participate in the treatment planning process.

COMMUNICATION STYLE AND LINGUISTIC SUPPORT

Consumers, families and other support persons receive cross-cultural and communication-support, such as assistive devices and qualified language interpreters and professionals interpreters. These supports are available at each entry point to services, and continue throughout the consumer's treatment and rehabilitation services. Staff is knowledgeable in the use of professional interpreters, and telephone interpreters are only utilized in emergencies. Orally presented information, and written materials and documents, are translated in the consumer's preferred language. Examples include consumer rights information, orientation packets, consent forms and treatment plans.

INDICATORS OF GUIDELINE APPLICATION

1. Consumers and family members receive cross-cultural communication supports at each point of entry in the service system.

2. Consumers and family members report their level of satisfaction with communication supports.

3. Staff is knowledgeable in the use of communication supports.

4. Interpreters are qualified, competent, and demonstrate knowledge of consumers' cultural experience; including deaf, hard of hearing, and deaf blind.

5. Communication supports demonstrate culturally accurate assessments, treatment/rehabilitation plans and service delivery.

6. Cross-cultural communication supports are available and comparable across all consumer cultural groups.

MEASURES OF GUIDELINE APPLICATION

1. Service systems increase the number of bicultural and bilingual staff, competent in the communication styles of the diverse cultures of consumers, as to minimize the use of interpreters.

2. A resource list of trained and qualified interpreters, updated annually, is maintained by facilities. Consumers and families are aware of the availability of interpreters through service advertisement efforts.

3. Certified qualified interpreters are available within 24-hour notice for routine situations, and within one hour for emergencies.

4. Service systems document consumer satisfaction of communication supports. A plan of correction and implemented action occur when consumer are not satisfied with communication supports.

5. Service systems document that staff receives training in the use of interpreters.

6. Service systems document that interpreters are certified (sign language interpreters), qualified and competent.

7. Service systems document that communication supports are comparable across consumer cultural groups.

CONTINUUM OF SERVICE/DISCHARGE PLANNING

Service and discharge planning begin at all points of entry along the continuum of services. It is provided by culturally competent providers in cooperation and collaboration with consumer, family, community support persons, and persons in consumer social networks. Service and discharge planning are done consistent with the values, norms and beliefs of consumers. These plans incorporate pertinent information from the cultural assessment, and include service/discharge factors that are culturally relevant and important to the consumer's recovery.

Plans identify personal, family, social environment, social network and cultural resources necessary for treatment and rehabilitation services that assure consumer recovery.

INDICATORS OF GUIDELINE APPLICATION

1. A culturally compatible continuum of service/discharge plan is developed for each consumer.

2. Plans include clear goals and recommendations for necessary services in the post-discharge continuum of care.

3. Plans use the resources of family and social networks.

4. Plans assure consumers remain connected to treatment/rehabilitation recovery services as needed.

Measures of Guideline Application

1. Service systems document service/discharge plans involve consumers, family members, community resources, and social supports. High levels of performance occur when family and community members are partnered with consumers and driving the planning process. Family and community members merely attending meetings is not an indicator of adequate performance.

2. Plan lists the resources and services utilized, and consumer accomplishments.

3. Consumer values, norms and beliefs are documented in the plan and drive the planning process.

4. Service systems document future treatment and rehabilitation goals.

5. Service systems document recommendations for the use of consumer, family, social networks and cultural resources in any subsequent treatment/rehabilitation setting.

QUALITY OF LIFE

Quality of life is achieved through a holistic integration of symptom reduction, family and community support, and spirituality, which maximizes the consumer's sense of personal meaning, fulfillment and well-being. Assuring consumers have a high quality of life enhances recovery. Quality of life is determined by an individual's freedom to make choices and enjoy the benefits of those choices.

INDICATORS OF GUIDELINE APPLICATION

1. Service system develops ways of assessing the quality of life for all consumers.

2. Consumers report improved quality of life through services.

3. Consumers direct the recovery planning and treatment process.

MEASURES OF GUIDELINE APPLICATION

1. Assessments, treatment/rehabilitation plans and services incorporate the goals, preferences, hopes and wishes of consumers.

2. Service systems compile, collect and interpret quality of life measures.

3. Service systems utilize quality of life information and data to evaluate and improve service delivery, and to develop new services.

SERVICES ACCOMMODATIONS

Programs respond to the needs of individuals and families from different cultures by ensuring the best *cultural fit* between persons' beliefs, their cultural/behavioral styles and the services provided. Based on information derived from cultural assessments (re: family styles, gender roles, sexual orientation, spirituality/religion, worldview, traditions, work ethic, communication styles, leadership and organizational styles cognitive and learning styles) services, interventions, modalities, and strategies are adapted or developed in order to better promote program engagement, treatment/rehabilitation, and retention. Particular consideration is given to the visible presence of different cultures throughout the program's physical environment. Culturally competent strategies are utilized to attract and recruit consumers and families. Varied induction methods that orient persons to types of services offered as well as how to utilize and participate in these services are available. Service outcome expectations as well as clarification of both staff and consumer roles and responsibilities are reviewed.

INDICATORS OF GUIDELINE APPLICATION

1. Program services interventions and modalities are modified and developed in order to enhance consumer engagement, treatment/rehabilitation, or retention.

2. Varied program induction methods are available.

3. Varied outreach and recruitment strategies are utilized.

Measures of Guideline Application

1. Information derived from cultural assessments is collated and summarized.

2. Programmatic needs to ensure responsiveness to persons from different cultures have been identified and prioritized.

3. Selected, prioritized services, interventions and modalities that have been modified are documented.

4. Examples of varied culturally compatible, program outreach and recruitment strategies are documented.

5. Examples of varied program induction methods utilized to engage consumers and families from different cultures are documented.