APPENDIX A

ASSESSMENT INSTRUMENTS

Instrument	Use	Frequency
Scales of Independent Behavior-Revised	Initial ISP and FBA-Based ISP Development Outcome Measure	Intake Annually
Quality of Life Questionnaire	Outcome Measure	Intake Annually
Parental Stress Scale	Outcome Measure	Intake Annually
Functional Behavioral Assessment	FBA-Based ISP, Crisis Intervention Plan, and Behavioral Support Plan Development	Intake PRN

APPENDIX B

INCIDENT MANAGEMENT

The Contractor shall comply and require its Providers to comply with the attached bulletin and any subsequent bulletins regarding incident management issued by the Department. References in the bulletin to action to be taken by OMR or OMR regional staff should be read to be "action by BAS" or "by BAS regional staff." References in the bulletin to the counties do not apply. References to appendices in the bulletin apply to appendices to the bulletin, not to this Agreement.

Office of Developmental Disabilities, Bulletin# 6000-04-01, Incident Management can be accessed at

http://www.dpw.state.pa.us/PubsFormsReports/NewslettersBulletins/003673169.aspx?BulletinId=4031

Appendix C

CRISIS INTERVENTION PLAN

A crisis episode is an event that presents significant danger to the Participant or others or danger to valuable property because of the Participant's challenging behavior. The Crisis Intervention Plan is to be developed and implemented to respond to a crisis episode and is intended to protect the Participant or others and valuable property. A Crisis Intervention Plan is not intended to decrease instances of future challenging behavior. The Crisis Intervention Plan may include the use of brief physical restraint only to prevent injury when the Participant is at imminent risk of hurting himself or herself or others. Brief physical restraint under these circumstances is not treatment, but is to be used only to assure safety in an urgent situation.

The Crisis Intervention Plan must address the needs of the Participant both within and outside the Service Area. The Crisis Intervention Plan must include instructions that if a crisis episode occurs when the Participant is outside of the Service Area, the Contractor should be called for a phone consultation with the Participant and the Participant's representative, people accompanying the Participant and family members, if available, to discuss what can be done to deescalate or end the crisis episode; that if none of the Contractor's suggestions about how to deescalate or end the crisis episode work, the people accompanying the Participant should take the Participant to an emergency room and advise the emergency room personnel that they may contact the Contractor for additional information that may help resolve the crisis episode; and that the Participant, the Participant's representative, people accompanying the Participant, or family, should request that the discharge summary from the emergency room be sent to the Contractor.

The development, delivery, and follow-up of a Crisis Intervention Plan must include the following:

A. <u>DEVELOPMENT</u>

Determine and outline what precursor behaviors will alert the staff or others to a potential crisis and prompt those around the Participant to use de-escalation techniques to avoid a crisis episode.

1. Determine and outline what procedures will deescalate the challenging behavior.

2. Determine and outline what will be done to ensure safety of all involved.

3. Determine and outline what types of physical restraints may be used and the circumstances under which they may be used, including:

    a. How long the physical restraint may be applied.

    b. What physical problems require special attention during the use of restraint.

4. Determine and outline what procedures will require changes to the physical area (room clear, add pads, etc.)

5. Determine and outline how many people and who will be needed to implement the Crisis Intervention Plan.

6. Determine and outline how Contractor's staff, Providers, and others who are present during the crisis episode will know that the crisis episode is over.

7. Determine and outline what behaviors will alert Contractor's staff, Providers, and others who are present during the crisis episode that the Participant is safe and the crisis episode is over.

8. Determine training needed to implement the Crisis Intervention Plan, including:

    a. Who will receive training?

    b. Who will deliver the training and when?

B. DELIVERY

Determine the "stage" of the crisis episode (escalation, peak, or recovery) and implement the plan

C. FOLLOW-UP

1. Identify how the Participant resumes routine task/activities of the day and what supports are needed.

2. Identify the need for follow-up treatment and who will ensure the follow-up occurs.

3. Identify how the procedures used will be documented.

4. Identify how the response to the crisis episode will be evaluated.

5. Identify when the Team will get together to revisit the Crisis Intervention Plan and Behavioral Support Plan in an effort to avoid a crisis episode in the future.

APPENDIX D

SERVICE DEFINITIONS

A. Adult Day Habilitation provides assistance, through individualized activities, with acquiring, retaining, or improving self-help, socialization, and adaptive behaviors necessary to live successfully in the community and participate in home and community life, to enable a Participant to achieve the outcomes identified in the Participant's Initial ISP or FBA-Based ISP and to reinforce therapeutic outcomes targeted by other services or Providers. Adult Day Habilitation is furnished in a group setting other than the Participant's residence for up to 6 hours per day, five days per week on a regularly scheduled basis. Adult Day Habilitation does not include services that are available under Section 110 of the Rehabilitation Act of 1973.

Adult Day Habilitation includes personal assistance for Participants who cannot manage their personal care needs during the day habilitation activity and assistance with medications and the performance of health related tasks in accordance with state law. This service also provides transportation during day habilitation activities necessary for the Participant's participation in those activities.

Providers of Adult Day Habilitation must be licensed under 55 PA Code Chapter 2380 and Older Adult Day Services licensed under 6 PA Code Chapter 11.

B. Assistive Technology is an item, piece of equipment, or product system, whether acquired commercially, modified, or customized, specific to the individualized needs of a Participant that is used to increase, maintain, or improve functional capabilities of a Participant. Assistive Technology service means a service that directly assists a Participant in the selection, acquisition, or use of an assistive technology device.

Assistive Technology includes:

1. The evaluation of the assistive technology needs of a Participant, including a functional evaluation of the impact of the provision of appropriate assistive technology and appropriate services to the Participant in the customary environment of the Participant;

2. Purchasing, leasing, or otherwise providing for the acquisition of assistive technology devices for Participants;

3. Selecting, designing, fitting, customizing, adapting, applying, maintaining, repairing, or replacing assistive technology devices;

4. Coordination and use of necessary therapies, interventions, or services the Participant is receiving with assistive technology devices;

5. Training or technical assistance for the Participant, or, where appropriate, the family members, guardians, advocates, or representatives of the Participant;

6. Training or technical assistance for professionals or other individuals who provide services to, employ, or are otherwise substantially involved in the major life functions of Participants; and

7. Extended warranties, and replacement batteries.

All items shall meet the applicable standards of manufacture, design and installation. Assistive Technology shall not include items that do not provide a direct medical or remedial benefit to the Participant.

C. Behavioral Support is specialized interventions that assist a Participant to increase adaptive behaviors to replace or modify challenging or socially unacceptable behaviors that prevent or interfere with the Participant's inclusion in family or community life and that support the Participant in acquiring, retaining, or improving skills that directly improve the Participant's ability to live independently. Behavioral Support includes training people who interact with the Participant on a regular basis about the Behavioral Support Plan, monitoring the Participant's progress, and modifying the Behavioral Support Plan as appropriate.

D. Community Transition Services is reimbursement for one-time set-up expenses incurred when a Participant transitions from an institution to his or her own home, apartment or family/friend living arrangement. The funds may be used to pay the necessary expenses incurred by a Participant to establish his or her basic living arrangement and to move into that arrangement. They

cannot be used to pay for rent. The following are categories of expenses that may be reimbursed:

1. Equipment, essential furnishings and initial supplies, for example, household products, dishes, chairs, tables;

2. Moving expenses;

3. Security deposits or other such one-time payments that are required to obtain or retain a lease on an apartment, home, or community living arrangement;

4. Set-up fees or deposits for utility or service access, such as telephone, electricity, heating; and

5. Personal and environmental health and welfare assurances, for example, pest eradication, allergen control, one-time cleaning prior to occupancy.

E. Crisis Intervention Services are behavioral health care services that are provided in an outpatient setting, and are furnished in response to a behavioral episode manifesting itself by acute symptoms of sufficient severity such that a prudent layperson, who possesses an average knowledge of behavioral health and medicine, could reasonably expect the absence of immediate intervention to result in placing the Participant and/or the persons around the Participant in serious jeopardy including imminent risk of institutionalization, or place the Participant in imminent risk of incarceration, or result in the imminent damage to valuable property by the Participant.

F. Environmental Modifications are physical adaptations to the Participant's home or personal vehicle, not to exceed $20,000.00 over any four (4) year period and which are necessary to ensure the health, welfare, and safety of the Participant to function with greater independence in the home and without which the Participant would require institutionalization. Examples include the installation of ramps and grab-bars, widening of doorways, alarms, motion detectors, locks, fences, Plexiglas windows, or modification of bathroom facilities required to ensure the safety of the Participant and also contribute to Participant's independence in everyday life.

G. Family Counseling is counseling provided to the Participant's family and informal supports for the purpose of assisting to

develop and maintain stable, healthy relationships among all caregivers, including family members, with the goal of increasing the probability that the Participant will remain in or return to his or her home. Emphasis is placed on the acquisition of coping skills by building on the strengths of the family members and informal supports.

H. Habilitation consists of services designed to assist a Participant in acquiring, retaining, and improving the self-help, self-direction, socialization, and adaptive skills a Participant needs to reside successfully in home and community-based settings including college and trade school. This service includes supporting the Participant in activities that assist in integrating the Participant into the community, including areas such as transportation training, supporting a Participant's participation in volunteer work; and collecting and recording data on the Participant's progress toward the goals of the Initial ISP and the FBA-Based ISP, on the Participant's behavior, and on the Participant's response to interventions.

I. Homemaker/Chore Services - Homemaker services are services that enable the Participant or the family with whom the Participant resides to maintain their private residence. Services include cleaning and laundry, meal preparation, and other general household care.

Chore services are services needed to maintain the home where the Participant resides in a clean, sanitary, and safe condition. This service consists of heavy household activities such as washing floors, windows, and walls; tacking down loose rugs and tiles; moving heavy items of furniture in order to provide safe access and egress; ice, snow, or leaf removal; and yard maintenance. Maintenance in the form of upkeep and improvements to the Participant's residence is not included.

J. Non-Medical Transportation is transportation to enable a Participant to gain access to Authorized Services and, if other transportation resources are not available, to other services, community activities, and resources specified in the Participant's Initial ISP or FBA-Based ISP.

K. Personal Assistance Services includes the following:

1. Assistance with eating, bathing, dressing, personal hygiene, and other activities of daily living (ADLs);

2. Assistance with the preparation of meals;

3. Housekeeping chores including bed making, dusting, and vacuuming, and other activities of daily living that are incidental to the care furnished or which are essential to the health and welfare of the Participant rather than the Participant's family;

4. Health maintenance activities including bowel and bladder routines, ostomy care, catheter care, wound care, and range of motion exercises;

5. Routine wellness services to enable adequate nutrition, exercise, keeping of medical appointments and all other health regimens related to healthy living activities.

L. Pre-vocational Services are developmental work training activities provided in settings licensed under 55 PA Code Chapter 2390, or work experiences and other developmental work training activities provided outside licensed settings, designed to promote movement into a higher-level vocational program including enclaves, mobile work teams, or competitive employment. Activities include training designed to teach job-related skills, personal and work adjustment training designed to develop appropriate worker traits and teach an understanding of the work environment, and assessments of a Participant's vocational aptitude and potential. Pre-vocational services do not include services that are available under the Rehabilitation Act of 1973, as amended.

M. Residential Habilitation assists individuals in acquiring, retaining, and improving the communication, socialization, self-direction, self-help, and adaptive skills necessary to reside in the community. This service also includes any necessary assistance in performing activities of daily living (i.e., bathing, dressing, eating, mobility, and using the toilet) and instrumental activities of daily living (i.e., communication, survival skills, cooking, housework, shopping, money management, time management, and use of transportation). The intent of this service is to reduce the need for direct personal assistance by improving the Participant's capacity to perform activities of daily living and instrumental activities of daily living with greater independence.

Residential Habilitation is provided in two types of licensed facilities:

1. Community Homes (group settings) licensed under Title 55 Pa. Code Chapter 6400; and

2. Family Living Homes licensed under Title 55 Pa. Code Chapter 6500.

The Community Home must have a licensed capacity to serve four or fewer residents. The facility cannot be owned by the Participant or a family member of the Participant.

Residential Habilitation services include implementation of the Behavioral Support Plan and, if necessary, the Crisis Intervention Plan. Residential Habilitation includes collecting and recording data necessary to support review of the ISP and the Behavioral Support Plan.

If a Participant is receiving Residential Habilitation services, the Participant may not receive Habilitation services in the Participant's residence.

N. Respite is the short-term relief of a Participant's unpaid caregiver when the caregiver is temporarily unavailable to provide supports due to non-routine circumstances. Respite services include assisting the Participant with activities of daily living (grooming, eating, bathing, dressing, and personal hygiene) and functional living tasks; assistance with planning and preparing meals; transportation or securing transportation; ambulation and mobility; reinforcement of behavioral support or specialized therapies activities; taking medications and the performance of health related tasks in accordance with state law; and supervision of the Participant's safety and security. Respite services also includes habilitation activities that facilitate the Participant's inclusion in community activities, use of natural supports and typical community services available to all people, social interaction and participation in leisure activities, and development of socially valued behaviors and daily living and functional living skills. Respite can be provided either in or away from the Participant's home.

O. Supported Employment are services that are needed for a Participant to sustain paid work including job finding, training, and ongoing support needed to maintain employment. Supported Employment services are provided for Participants for whom competitive employment at or above the minimum wage is unlikely without these supports, and who, because of their disability, need intensive ongoing support to perform in a work setting. Supported Employment services do not include supervisory activities rendered as a normal part of the business setting or adaptations employers would be expected to provide for other employees not receiving supported employment.

P. Supports Coordination includes:

1. Chairing the Team to develop the Initial ISP and the FBA-Based ISP;

2. Ensuring Participant choice by providing information to assist a Participant or a Participant's representative, as appropriate, in making fully informed decisions;

3. Assisting a Participant in gaining access to Authorized Services, as well as needed medical, social, educational and other services, regardless of the funding source;
4. Working with the Participant whenever possible to identify, coordinate, and facilitate Authorized Services and other services;

5. Providing advocacy for services from local resources, and coordinating services to achieve maximum Participant input and support;

6. Providing monthly monitoring of the provision of services included in the Participant's Initial ISP and FBA-Based ISP;

7. Ensuring that each Participant has a comprehensive Initial ISP and FBA-Based ISP;

8. Initiating reevaluation of the Participant's FBA-Based ISP.

Q. Visiting Nurse services are provided to a Participant who requires a nurse to perform involved medical routines. The Participant's PCP shall determine the types of nursing services needed.

APPENDIX E

DEPARTMENT TRAINING REQUIREMENTS

COURSE	WHO	WHEN[1]
Individualized participant resources and training	Individuals who provide periodic/intermittent medical/physical health services to a Participant	Before contact with a participant
ASD, What it is and isn't	Anyone providing direct and ongoing habilitative, therapeutic, personal assistance, or behavioral support to a Participant	Before contact with a Participant
Communication Challenges	Anyone providing direct and ongoing habilitative, therapeutic, personal assistance,or behavioral support to a Participant	Before contact with a Participant
Positive Behavior Supports	All community staff[2]	Within 45 days of hire date
Assessment for life and social skills	All community staff[2]	Within 45 days of hire date
Life Skills-Evidence Based Practices	All community staff[2]	Within 90 days of hire date
Health Care	Anyone providing direct and ongoing habilitative, therapeutic, personal assistance, or behavioral support to a Participant	Within 90 days of hire date
Transition to work	All community staff[2]	Within 90 days of hire date
Functional Behavioral Assessment	Behavioral Health Practitioner and Behavioral Health Specialist	Before contact with a Participant or assumption of duties

[1] Supports Coordinator, Behavioral Health Practitioner, and Behavioral Health Specialist must take all subjects before contact with a Participant.

2 Community staff includes persons delivering habilitation, adult day habilitation, personal assistance services, pre-vocational services, supported employment, family counseling, residential support, and respite.

APPENDIX F

REQUEST FOR ADDITIONAL INFORMATION LETTER

[Date Letter Mailed]

Mailing Date

Participant's Name
Address
City, State Zip

Participant ID: **********

Subject: Request for Additional Information from Your Team

Dear **[Participant's Name]**:

[Contractor's name] received a request for **[describe specific services/items]** from your Team on **[date received]**.

In order to decide if this service is Medically Necessary for you, **[Contractor's name]** has asked for the following information from your Team by **[date that is 7 days from date of letter]:**

[List specific information requested]

[Contractor's name] will make a decision on the requested services within 2 business days after receiving the information from your Team. **[Contractor's name]** will send you a letter within 2 business days after making its decision.

If we do not receive the information within 7 days, the decision to approve or deny the service will be made based on the information that we already have. **[Contractor's name]** will send you a letter within 2 business days after we should have received the information.

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

Sincerely,

[Contractor's name]

cc: Team
Supports Coordinator
[Participant's representative, if appropriate]

[The following statement must appear in English, Russian, Cambodian, Vietnamese, Spanish, Chinese, and any other language as required by the Agreement].

This notice has important information about your health care benefits. The information in this notice is available in other languages and formats by calling [Contractor's Name] at [Contractor's Participant service's #/Toll-free TTY #].

APPENDIX G

COMPLAINT, GRIEVANCE, AND DPW FAIR HEARING PROCESSES

A. General Requirements

1. All Complaint, Grievance, and DPW Fair Hearing policies and procedures must receive prior written approval by the Department.

2. The Contractor may not charge Participants a fee for filing a Complaint or Grievance.

3. The Contractor must have written policies and procedures for registering, responding to, and resolving Complaints and Grievances. These policies and procedures must be made available upon request.

4. The Contractor must maintain written documentation of each Complaint and Grievance and the actions taken by the Contractor.

5. The Contractor must have a toll free number that is used for Complaints and Grievances. Participants must be able to use this number to file Complaints and Grievances, request information about the Compliant and Grievance process, and ask any questions about the status of a Complaint or Grievance.

6. The Contractor must ensure that Participants have access to all relevant documentation pertaining to the subject of the Complaint or Grievance.

7. The Contractor must have a data system to process, track, and trend all Complaints and Grievances.

8. The Contractor must ensure that there is a link between the Complaint and Grievance processes and its plan of Quality Assurance and Improvement.

9. The Contractor must designate and train sufficient staff to be responsible for receiving, processing, and responding to Complaints and Grievances in accordance with the requirements in this Appendix.

10. Contractor staff and members of the Plan Advisory Committee performing Complaint and Grievance reviews must have the necessary orientation, clinical training, and experience to make an informed and impartial determination regarding issues assigned to them.

11. The Contractor may not use the time frames or procedures of the Complaint and Grievance process to avoid the medical decision process or to discourage or prevent the Participant from receiving Medically Necessary care in a timely manner.

12. The Contractor must accept Complaints and Grievances from individuals with disabilities which are in alternative formats including: TTY/TDD for telephone inquiries and Complaints and Grievances from Participants who are hearing impaired; Braille; tape; or computer disk; and other commonly accepted alternative forms of communication. Employees of the Contractor who receive telephone Complaints and Grievances should also be made aware of the speech limitation of some Participants with disabilities so they can treat these individuals with patience, understanding, and respect.

13. The Contractor must provide Participants with disabilities assistance in presenting their case at Complaint or Grievance reviews at no cost to the Participants. This includes:

    a. Providing qualified sign language interpreters for Participants who are severely hearing impaired;

    b. Providing information submitted on behalf of the Contractor at the Complaint or Grievance review in an alternative format accessible to the Participant filing the Complaint or Grievance. The alternative format version should be supplied to the Participant at or before the review, so the Participant can discuss and/or refute the content during the review; and

    c. Providing personal assistance to Participants with other physical limitations in copying and presenting documents and other evidence.

14. The Contractor must provide language interpreter services when requested by a Participant, at no cost to the Participant.

15. The Contractor must offer Participants the assistance of a staff person throughout the Complaint and Grievance processes at no cost to the Participant.

16. The Contractor must ensure that anyone who participates in making the decision on a Complaint or Grievance was not involved in or does not supervise a person involved in any review or decision-making on the issue that is the subject of the Compliant or Grievance or in the development of the Participant's Initial ISP or FBA-Based ISP, including the Crisis Intervention Plan and Behavioral Support Plan.

17. The Contractor must hire and retain a Customer Service Representative responsible for attempting to resolve any disputes or objections regarding a Provider or the operations or management policies of the Contractor before a formal Complaint is filed. The Contractor shall not require a Participant to attempt to resolve a dispute or objection through the Customer Service Representative before filing a formal Compliant.

    The Customer Service Representative must:

    a. Attempt to resolve all disputes or objections and notify the Participant or the Participant's representative of the resolution as expeditiously as the Participant's health condition requires, but in no more than 7 days from being informed of the dispute or objection.

    b. Inform the Participant of the right to file a formal Complaint.

    c. Inform the Participant that the resolution is available in writing and provide the resolution in writing if a Participant requests.

    d. Consult with the Behavioral Health Practitioner or Medical Director as appropriate if a clinical issue is involved.

e. Prepare a summary of the issues presented and how they were resolved and maintain a copy of this summary.

18. The Contractor must notify the Participant when the Contractor fails to decide a Complaint or Grievance within the timeframes specified in this Appendix, using the template supplied by the Department (Appendix G [1]). This notice must be mailed one (1) day following the date the decision was to be made (day 31).

19. The Contractor must notify the Participant when it denies payment after a service has been delivered because the service/item was provided without authorization by a Provider not enrolled in the Pennsylvania Medical Assistance Program using the template supplied by the Department (Appendix G [2]). This notice must be mailed to the Participant on the day the decision was made to deny payment.

20. The Contractor must notify the Participant when it denies payment after a service has been delivered because the service/item provided is not an Authorized Service for the Participant, using the template supplied by the Department (Appendix G [3]). This notice must be mailed to the Participant on the day the decision is made to deny payment.

21. The Contractor must notify the Participant when it denies payment after a service has been delivered because the Contractor determined that the service was not Medically Necessary, using the template supplied by the Department (Appendix G [4]). This notice must be mailed to the Participant on the day the decision is made to deny payment.

B. **Complaint Requirements**

1. Complaint

A dispute or objection regarding a Provider or the operations or management policies of the Contractor, which has not been resolved by the Contractor and has been filed with the Contractor, including but not limited to:

a. The denial of a service/item because the requested service/item is not a Covered Service; or

b. The failure of the Contractor to meet the required timeframes for providing a service/item; or

c. The failure of the Contractor to decide a Complaint or Grievance within the specified timeframes; or

d. The denial of payment by the Contractor after a service/item has been delivered because the service/item was provided without authorization by a Provider not enrolled in the Pennsylvania Medical Assistance Program; or

e. The denial of payment by the Contractor after a service/item has been delivered because the service/item provided is not an Authorized Service/Item for the Participant; or

f. The decision to involuntarily disenroll the Participant from the Plan.

The term does not include a Grievance.

2. Complaint Process

a. The Contractor must permit a Participant or Participant's representative, which may include the Participant's Provider, with proof of the Participant's written authorization for the representative to act on the Participant's behalf, or the legal representative of a deceased Participant's estate, to file a Complaint either in writing or orally. Oral requests must be committed to writing by the Contractor if not confirmed in writing by the Participant and must be provided to the Participant or the Participant's representative for signature. The Participant's signature may be obtained at any point in the process, and failure to obtain a signed Complaint may not delay the Complaint process. If the Complaint disputes the failure of the Contractor to decide a Complaint or Grievance within the specified timeframes; challenges the failure to meet the required timeframes for providing a service/item; disputes a denial made for the reason that a service/item is not a Covered Service; disputes a denial of payment after the service(s) has been delivered because the service/item was provided

without authorization by a Provider not enrolled in the Pennsylvania Medical Assistance Program; or disputes a denial of payment after a service(s) has been delivered because the service/item provided is not an Authorized Service for the Participant, the Participant must file a Complaint within forty-five (45) days from the date of the incident complained of or the date the Participant receives written notice of the decision. For all other Complaints, there is no time limit for filing a Complaint.

b. A Participant who files a Complaint to dispute a decision to discontinue, reduce or change a service/item that the Participant has been receiving on the basis that service/item is not a Covered Service, must continue to receive the disputed service/item at the previously authorized level, up to the amount, duration, and scope of the current request, pending resolution of the Complaint, if the Complaint is hand delivered or post-marked within ten (10) days from the mail date on the written notice of decision.

c. A Participant who files a Complaint to dispute a decision to disenroll the Participant, must continue to receive Authorized Services pending resolution of the Complaint, if the Complaint is hand delivered or post-marked within ten (10) days from the mail date on the written notice of decision to involuntarily disenroll the Participant.

d. Upon receipt of the Complaint, the Contractor shall send the Participant and the Participant's representative, if the Participant has designated one, an acknowledgment letter using the template supplied by the Department (Appendix G [5]).

e. The Complaint review for Complaints not involving a clinical issue must be conducted by a Complaint review committee made up of three (3) or more individuals who were not involved and do not supervise an individual involved in any previous review or decision-making on the issue that is the subject of the Complaint or in the development of the Participant's Initial ISP or FBA-Based ISP, including the Crisis Intervention Plan and Behavioral Support Plan.

f. The Complaint review for Complaints involving a clinical issue must be conducted by a Complaint review committee made up of three (3) or more individuals who were not involved and do not supervise an individual involved in any previous reviews or decision making on the issue that is the subject of the Complaint or in the development of the Participant's Initial ISP or FBA-Based ISP, including the Crisis Intervention Plan and Behavioral Support Plan. The Complaint review committee must include, depending on the issue under review, either a licensed physician or an individual with the same qualifications as a Behavioral Health Practitioner. Other members of the Complaint review committee must participate in the review, but the licensed physician or the individual with the same qualifications as a Behavioral Health Practitioner must decide the Complaint.

g. At least one-third of the Complaint review committee may not be employees of the Contractor or a related subsidiary or affiliate.

h. The Complaint review committee may include members of the Plan Advisory Committee.

i. The Participant must be afforded a reasonable opportunity to present evidence and allegations of facts or law in person as well as in writing. The Contractor shall be flexible when scheduling the Complaint review to facilitate the Participant's attendance. The Participant shall be given at least seven (7) days advance written notice of the review date. If the Participant cannot appear in person at the Complaint review, an opportunity to communicate with the Complaint review committee by telephone or videoconference must be provided. The Participant may elect not to attend the Complaint review but the meeting must be conducted with the same protocols as if the Participant was present.

j. The decision of the Complaint review committee must be based solely on the information presented at the review.

k. The Complaint review committee shall complete its review of the Complaint as expeditiously as the Participant's health condition requires, but no more than thirty (30) days from the Contractor's receipt of the Participant's Complaint, which may be extended by fourteen (14) days at the request of the Participant.

l. The Complaint review committee must prepare a summary of the issues presented and decisions made, which must be maintained as part of the Complaint record.

m. The Contractor must send a written notice of the Complaint decision, using the template supplied by the Department (Appendix G [6]) to the Participant, Participant's representative, if the Participant has designated one, service Provider, if applicable, prescribing Provider, if applicable, and the Team within five (5) business days from the Complaint review committee's decision.

n. If the Complaint disputes the failure of the Contractor to provide a service/item or to decide a Complaint or Grievance within specified time frames, or disputes a denial made for the reason that a service/item is not a Covered Service, or disputes a denial of payment after a service(s) has been delivered because the service/item was provided without authorization by a provider not enrolled in the Pennsylvania Medical Assistance Program; or disputes a denial of payment after a service(s) has been delivered because the service/item provided is not an Authorized Service for the Participant; or disputes a decision to involuntarily disenroll a Participant from the Plan, the Participant may file a request for a DPW Fair Hearing within thirty (30) days from the mail date on the written notice of the Contractor's Complaint decision.

3. Expedited Complaint Process

a. The Contractor must conduct expedited review of a Complaint if a Participant or Participant's representative, with proof of the Participant's written authorization for a representative to act on the Participant's behalf, provides the Contractor with a

certification from his or her Provider that the Participant's life, health, or ability to attain, maintain, or regain maximum function would be placed in jeopardy by following the regular Complaint process. This certification is necessary even when the Participant's request for the expedited review is made orally. Oral certifications must be committed to writing by the Contractor. The Provider's signature is not required.

b. A request for expedited review of a Complaint may be filed either in writing, by fax or orally. Oral requests must be committed to writing by the Contractor. The Participant's signature is not required.

c. The expedited review process is bound by the same rules and procedures as the Compliant review process except as modified in this section.

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

e. If the Provider certification is not included with the request for an expedited review, the Contractor must inform the Participant that the Provider must provide a certification as to the reasons why the expedited review is needed. The Contractor must make a reasonable effort to obtain the certification from the Provider. If the Provider certification is not provided within one (1) business day of the Participant's request for expedited review, the Contractor shall decide the Complaint within the standard timeframes as set forth in this Appendix. The Contractor must make a reasonable effort to give the Participant prompt oral notice that the Complaint is to be decided within the standard timeframe and send a written notice within two (2) days of the decision to deny expedited review, using the template supplied by the Department (Appendix G [9]).

f. A Participant who files a request for expedited review of a Complaint to dispute a decision to discontinue, reduce or change a service/item that the Participant has been receiving on the basis that the service/item is not a

Covered Service, must continue to receive the disputed service/item at the previously authorized level, up to the amount, duration, and scope of the current request, pending resolution of the Complaint, if the request for expedited review of a Complaint is hand delivered or post-marked within ten (10) days from the mail date on the written notice of decision.

g. The Complaint shall be reviewed by an expedited Complaint review committee made up of two (2) or more individuals who were not involved and do not supervise an individual involved in any previous review or decision making on the issue that is the subject of the expedited Complaint or in the development of the Participant's Initial ISP or FBA-Based ISP, including the Crisis Intervention Plan and Behavioral Support Plan. The expedited Complaint review committee must include, depending on the issue under review, either a licensed physician or an individual with the same qualifications as a Behavioral Health Practitioner. Other members of the expedited Complaint review committee must participate in the review, but the licensed physician or the individual with the same qualifications as a Behavioral Health Practitioner must decide the Complaint.

h. The Contractor must issue the decision resulting from the expedited review in person or by phone to the Participant, Participant's representative, if the Participant has designated one, and service Provider, and prescribing Provider, if applicable, within three (3) business days of receiving the Participant's request for an expedited review. In addition, the Contractor must send a written notice of the Compliant decision, using the template supplied by the Department (Appendix G [10]), to the Participant, Participant's representative, if the Participant has designated one, service Provider, prescribing Provider, if applicable, and the Team within two (2) days of the expedited Complaint review committee's decision

i. The Contractor must ensure that punitive action is not taken against a Provider who either requests expedited resolution of a Complaint or supports a Participant's request for expedited review of a Complaint.

j. The Participant may file a request for a DPW Fair Hearing within thirty (30) days from the mail date on the written notice of the expedited Complaint decision.

C. **Grievance Requirements**

1. Grievance

A request to have the Contractor reconsider a decision solely concerning the Medical Necessity and appropriateness of a Covered Service. A Grievance may be filed regarding the Contractor's decision to

1) Deny, in whole or in part, payment for a service/item;

2) Deny or issue an authorization of a requested service/item, including the type or level of service/item, in an amount, duration, or scope different from what was requested;

3) Reduce, suspend, or terminate a previously authorized service/item; and

4) Deny the requested service/item but approve an alternative service/item.

The term does not include a Complaint.

2. Grievance Process

a. The Contractor must permit a Participant or Participant's representative, which may include the Participant's Provider, with proof of the Participant's written authorization for the representative to act on the Participant's behalf, or the legal representative of a deceased Participant's estate, to file a Grievance either in writing or orally. Oral requests must be committed to writing by the Contractor if not confirmed in writing by the Participant and must be provided to the Participant or the Participant's representative for signature. The Participant's signature may be obtained at any point in the process, and failure to obtain a signed Grievance may not delay the Grievance process. Participants will be given forty-five (45) days

from the date the Participant receives the written notice to file a Grievance.

b. A Participant who files a Grievance to dispute a decision to discontinue, reduce or change a service/item that the Participant has been receiving must continue to receive the disputed service/item at the previously authorized level, up to the amount, duration, and scope of the current request, pending resolution of the Grievance, if the Grievance is hand delivered or post-marked within ten (10) days from the mail date on the written notice of decision.

c. Upon receipt of the Grievance, the Contractor shall send the Participant and the Participant's representative, if the Participant has designated one, an acknowledgment letter using the template supplied by the Department (Appendix G [7]).

d. A Participant who consents to the filing of a Grievance by a Provider may not file a separate Grievance. The Participant retains the right to rescind consent throughout the Grievance process upon written notice to the Contractor and the Provider.

e. In order for the Provider to represent the Participant in the conduct of a Grievance, the Provider must obtain the written consent of the Participant. A Provider may obtain the Participant's written permission at the time of treatment. A Provider may NOT require a Participant to sign a document authorizing the Provider to file a Grievance as a condition of treatment. The written consent must include:

    i. The name and address of the Participant, the Participant's date of birth and identification number;

    ii. If the Participant is legally incompetent, the name, address and relationship to the Participant of the person who signed the consent;

    iii. The name, address, and identification number of the Provider to whom the Participant is providing consent;

iv. The name and address of the Contractor;

v. An explanation of the specific service/item for which coverage was provided or denied to the Participant to which the consent will apply;

vi. The following statement: The Participant or the Participant's representative may not submit a Grievance concerning the services/items listed in this consent form unless the Participant or the Participant's representative rescinds consent in writing. The Participant or the Participant's representative has the right to rescind consent at any time during the Grievance process;

vii. The following statement: The consent of the Participant or the Participant's representative shall be automatically rescinded if the Provider fails to file a Grievance or fails to continue to prosecute the Grievance through the Grievance review process;

viii. The following statement: The Participant or the Participant's representative, if the Participant is legally incompetent, has read, or has been read this consent form, and has had it explained to his or her satisfaction. The Participant or the Participant's representative understands the information in this consent form; and

ix. The dated signature of the Participant, or the Participant's representative, and the dated signature of a witness.

f. The Grievance shall be reviewed by a Grievance review committee made up of three (3) or more individuals, who were not involved and do not supervise an individual involved in any previous review or decision making on the issue that is the subject of the Grievance or in the development of the Participant's Initial ISP or FBA-Based ISP, including the Crisis Intervention Plan and Behavioral Support Plan. The Grievance review committee must include, depending on the issue under review, either a

licensed physician or an individual with the same qualifications as a Behavioral Health Practitioner. Others members of the Grievance review committee must participate in the review, but the licensed physician or the individual with the same qualifications as a Behavioral Health Practitioner must decide the Grievance.

g. At least one-third of the Grievance review committee may not be employees of the Contractor or a related subsidiary or affiliate.

h. The Grievance review committee may include members of the Plan Advisory Committee.

i The Participant must be afforded a reasonable opportunity to present evidence and allegations of fact or law, in person as well as in writing. The Contractor shall be flexible when scheduling the Grievance review to facilitate the Participant's attendance. The Participant shall be given at least seven (7) days advance written notice of the review date. If the Participant cannot appear in person at the Grievance review, an opportunity to communicate with the Grievance review committee by telephone or videoconference must be provided. The Participant may elect not to attend the Grievance review but the review must be conducted with the same protocols as if the Participant was present.

j. The decision of the Grievance review committee must be based solely on the information presented at the review.

k. The Grievance review committee shall complete its review of the Grievance as expeditiously as the Participant's health condition requires, but no more than thirty (30) days from the Contractor's receipt of the Participant's Grievance, which may be extended by fourteen (14) days at the request of the Participant.

l. The Grievance review committee must prepare a summary of the issues presented and decisions made, which must be maintained as part of the Grievance record.

m. The Contractor must send a written notice of the Grievance decision, using the template supplied by the Department (Appendix G [8]), to the Participant, Participant's representative, if the Participant has designated one, service Provider, prescribing Provider, if applicable, and the Team within five (5) business days from the Grievance review committee's decision.

n. The Participant may file a request for a DPW Fair Hearing within thirty (30) days from the mail date on the written notice of the Contractor's Grievance decision.

3. Expedited Grievance Process

a. The Contractor must conduct expedited review of a Grievance if a Participant or Participant's representative, with proof of the Participant's written authorization for a representative to act on the Participant's behalf, provides the Contractor with a certification from his or her Provider that the Participant's life, health, or ability to attain, maintain, or regain maximum function would be placed in jeopardy by following the regular Grievance process. This certification is necessary even when the Participant's request for the expedited review is made orally. Oral certifications must be committed to writing by the Contractor. The Provider's signature is not required.

b. A request for expedited review of a Grievance may be filed either in writing, by fax or orally. Oral requests must be committed to writing by the Contractor. The Participant's signature is not required.

c. The expedited review process is bound by the same rules and procedures as the Grievance review process except as modified in this section.

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

e. If the Provider certification is not included with the request for an expedited review, the Contractor must inform the Participant that the Provider must provide a certification as to the reasons why the expedited review is needed. The Contractor must make a reasonable effort to obtain the certification from the Provider. If the Provider certification is not provided within one (1) business day of the Participant's request for expedited review, the Contractor shall decide the Grievance within the standard timeframes as set forth in this Appendix. The Contractor must make a reasonable effort to give the Participant prompt oral notice that the Grievance is to be decided within the standard timeframe and send a written notice within two (2) days of the decision to deny expedited review, using the template supplied by the Department (Appendix G [9]).

f. A Participant who files a request for expedited review of a Grievance to dispute a decision to discontinue, reduce or change a service/item that the Participant has been receiving must continue to receive the disputed service/item at the previously authorized level, up to the amount, duration, and scope of the current request, pending resolution of the Grievance, if the request for expedited review of a Grievance is hand delivered or post-marked within ten (10) days from the mail date on the written notice of decision.

g. The Grievance shall be reviewed by an expedited Grievance review committee made up of two (2) or more individuals who were not involved and do not supervise an individual involved in any previous review or decision making on the issue that is the subject of the expedited Grievance or in the development of the Participant's Initial ISP or FBA-Based ISP, including the Crisis Intervention Plan and Behavioral Support Plan. The expedited Grievance review committee must include, depending on the issue under review, either a licensed physician or an individual with the same qualifications as a Behavioral Health Practitioner. Other members of the expedited Grievance review committee must participate in the review, but the licensed physician or the individual with the same qualifications as a Behavioral Health Practitioner must decide the Grievance.

h. The Contractor must issue the decision resulting from the expedited review in person or by phone to the Participant, Participant's representative, if the Participant has designated one, and service Provider, and prescribing Provider, if applicable, within three (3) business days of receiving the Participant's request for an expedited review. In addition, the Contractor must send a written notice of the Grievance decision, using the template supplied by the Department (Appendix G [10]), to the Participant, Participant's representative, if the Participant has designated one, service Provider, prescribing Provider, if applicable, and the Team within two (2) days of the expedited Grievance review committee's decision

i. The Contractor must ensure that punitive action is not taken against a Provider who either requests expedited resolution of a Grievance or supports a Participant's request for expedited review of a Grievance.

j. The Participant may file a request for a DPW Fair Hearing within thirty (30) days from the mail date on the written notice of the expedited Grievance decision.

D. Department's Fair Hearing Requirements

1. Department's Fair Hearing Process

a. Participants must exhaust the Complaint or Grievance process prior to filing a request for a DPW Fair Hearing.

b. The Participant, the Participant's representative, or the legal representative of a deceased Participant's estate may request a DPW Fair Hearings within thirty (30) days from the mail date on the written notice of the Contractor's Complaint or Grievance decision for any of the following:

i. The denial, in whole or part, of payment for a requested service/item if based on lack of Medical Necessity;

ii. The denial of a requested service/item on the basis that the service/item is not a Covered Service;

iii. The denial or issuance of an authorization of a requested service/item, including the type or level of service/item in an amount, duration, or scope different from what was requested;

iv. The reduction, suspension, or termination of a previously authorized service/item;

v. The denial of a requested service/item but approval of an alternative service/item;

vi. The failure of the Contractor to provide services/items in a timely manner, as defined by the Department;

vii. The failure of the Contractor to decide a Complaint or Grievance within the timeframes specified in this Appendix;

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

ix. The denial of payment after a service(s) has been delivered because the service/item provided is not an Authorized Service for the Participant;

x. The Contractor's involuntary disenrollment of the Participant from the Plan.

c. The request for a DPW Fair Hearing must include a copy of the written notice of the decision that is the subject of the request. Requests must be sent to:

Department of Public Welfare
OMAP – Adult Community Autism Program
Complaint, Grievance and Fair Hearings
P.O. Box 2675
Harrisburg, Pennsylvania 17105-2675

d. A Participant who files a request for a DPW Fair Hearing to dispute a decision to discontinue, reduce, or change a service/item that the Participant has been receiving must continue to receive the disputed service/item at the previously authorized level, up to the amount, duration, and scope of the current request, pending resolution of the DPW Fair Hearing, if the request for a DPW Fair Hearing is hand delivered or post-marked within ten (10) days from the mail date on the written notice of the Contractor's Complaint or Grievance decision.

e. A Participant who files a request for a DPW Fair Hearing to dispute a decision to disenroll the Participant, must continue to receive Authorized Services pending resolution of the DPW Fair Hearing, if the request for a DPW Fair Hearing is hand delivered or post-marked within ten (10) days from the mail date on the written notice of the Contractor's Complaint decision.

f. Upon receipt of the request for a DPW Fair Hearing, the Department's Bureau of Hearings and Appeals or a designee will schedule a hearing. The Participant and the Contractor will receive notification of the hearing date by letter at least ten (10) days in advance, or a shorter time if requested by the Participant. The letter will outline the type of hearing, the location of the hearing (if applicable), and the date and time of the hearing.

g. The Contractor is a party to the hearing and must be present. The Contractor, which may be represented by an attorney, must be prepared to explain and defend the issue on appeal. The Department's decision is based solely on the evidence presented at the hearing. The failure of the Contractor to appear at the hearing will not be reason to postpone the hearing.

h. The Contractor must provide the Participant, at no cost, with records, reports, and documents relevant to the subject of the DPW Fair Hearing.

i. If the Bureau of Hearings and Appeals has not issued a decision within ninety (90) days of the receipt of the request for a DPW Fair Hearing, the Contractor shall

follow the requirements at 55 Pa. Code 275.4 regarding the provision of interim assistance upon the request for such by the Participant. When the Participant is responsible for delaying the hearing process, the time limit for final administrative action will be extended by the length of the delay attributed to the Participant.

j. The Bureau of Hearings and Appeals' adjudication is binding on the Contractor unless reversed by the Secretary of Public Welfare. Either party may request reconsideration from the Secretary within fifteen (15) days from the date of the adjudication. Only the Participant may appeal to Commonwealth Court within thirty (30) days from the date of adjudication (or from the Secretary's final order, if reconsideration was granted). The decisions of the Secretary and the Court are binding on the Contractor.

E. **Expedited Fair Hearing Process**

a. A request for an expedited DPW Fair Hearing may be filed by the Participant or the Participant's representative with the Department either in writing or orally.

b. Participants must exhaust the Complaint or Grievance process prior to filing a request for an expedited DPW Fair Hearing.

c. An expedited DPW Fair Hearing will be conducted if a Participant or Participant's representative provides the Department with written certification from the Participant's Provider that the Participant's life, health, or ability to attain, maintain, or regain maximum function would be placed in jeopardy by following the regular DPW Fair Hearing process. This certification is necessary even when the Participant's request for the expedited Fair Hearing is made orally. The certification must include the Provider's signature. If the Provider does not submit a written certification, the Provider may also testify at the DPW Fair Hearing to explain why using the usual timeframes would place the Participant's health in jeopardy.

d. A Participant who files a request for an expedited Fair

Hearing to dispute a decision to discontinue, reduce or change a service/item that the Participant has been receiving must continue to receive the disputed service/item at the previously authorized level, up to the amount, duration, and scope of the current request, pending resolution of the DPW Fair Hearing, if the request for an expedited Fair Hearing is hand delivered or post-marked within ten (10) days from the mail date on the written notice of the Contractor's Grievance decision.

e. Upon 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 Contractor is a party to the hearing and must be present. The Contractor, which may be represented by an attorney, must be prepared to explain and defend the issue on appeal. The Department's decision is based solely on the evidence presented at the hearing. The failure of the Contractor to appear at the hearing will not be reason to postpone the hearing.

g. The Contractor must provide the Participant, at no cost, with records, reports, and documents relevant to the subject of the DPW Fair Hearing.

h. The Bureau of Hearings and Appeals has three (3) business days from the receipt of the Participant's oral or written request for an expedited review to issue a decision.

i. The Bureau of Hearings and Appeals' adjudication is binding on the Contractor unless reversed by the Secretary of Public Welfare. Either party may request reconsideration from the Secretary within fifteen (15) days from the date of the adjudication. Only the Participant may appeal to Commonwealth Court within thirty (30) days from the date of adjudication (or from the Secretary's final order, if reconsideration was granted). The decisions of the Secretary and the Court are binding on the Contractor.

F. **Provision of and Payment for Services/Items following Decision**

1. If the Contractor or the Bureau of Hearings and Appeals reverses a decision to deny, limit, or delay services/items that were not furnished during the Complaint, Grievance, or DPW Fair Hearing process, the Contractor must authorize or provide the disputed services/items promptly and as expeditiously as the Participant's health condition requires. If the Contractor requests reconsideration from the Secretary of Public Welfare, the Contractor must authorize or provide the disputed services/items pending reconsideration unless the Contractor requests a stay of the Bureau of Hearings and Appeals decision and the stay is granted.

2. If the Contractor or the Bureau of Hearings and Appeals reverses a decision to deny authorization of services/items, and the Participant received the disputed services/items during the Complaint, Grievance, or DPW Fair Hearing process, the Contractor must pay for those services/items.

APPENDIX G (1)

NOTICE FOR FAILURE OF CONTRACTOR TO MEET COMPLAINT OR GRIEVANCE TIMEFRAMES

[Date Notice Mailed (1 day after the date the decision was to be made)]

Participant Name
Address
City, State Zip

Participant ID:*********

Subject: Your **[Complaint] [Grievance]** About **[Issue]**

Dear **[Participant Name]**:

[Contractor Name] has not decided your **[complaint] [grievance]** about **[identify subject of complaint/grievance],** filed on **[date]**, within [**number that is fewer than 30 days]** days, as required**. [Contractor Name]** expects to be able to decide the **[complaint] [grievance]** by **[date].**

If you are unhappy that **[Contractor Name]** has not decided your **[complaint] [grievance]** within **[#]** days of receiving it, you can file a complaint with **[Contractor Name]** about the delay in deciding your **[complaint] [grievance]**. You must file the complaint **within 45 days from the date you get this notice.**

A decision will be made on your complaint no later than **[30, unless Contractor will be using a shorter time frame to decide complaints]** days from when we receive it.

To file a complaint:

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

[Contractor Address for filing complaint]

If you need help filing a complaint or have any other questions, you may call **[Contractor Name]** at **[Contractor Phone #/Toll-free TTY #]**, Pennsylvania Legal Services at 1-800-322-7572 (www.palegalservices.org), or the Pennsylvania Health Law Project at 1-800-274-3258 (www.phlp.org).

Sincerely,

[Contractor Name]

cc: **[Provider, if grievance]**
[Participant Representative, if designated]

[The following statement must appear in English and the prevalent non-English languages spoken in the Service Area:]

The information in this notice is about the [complaint] [grievance] you filed with [Contractor Name]. It is available in other languages and formats by calling [Contractor Name] at [Phone #/Toll-free TTY #].

Appendix G (2)

NOTICE FOR PAYMENT DENIAL BECAUSE THE SERVICE(S)/ITEM(S) WAS PROVIDED WITHOUT AUTHORIZATION BY A PROVIDER NOT ENROLLED IN THE PENNSYLVANIA MEDICAL ASSISTANCE PROGRAM

THIS IS NOT A BILL

[Date Notice Mailed (date decision is made to deny payment)]

Participant Name
Address
City, State Zip

Participant ID: ********

Dear **[Participant Name]**:

[Contractor Name] has reviewed the request for payment from **[Provider's name]** for **[identify specific service/item]**, 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 **[Contractor Name]** for approval to provide the service/item to you.

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

If you do not agree with this decision, you may file a complaint with **[Contractor Name]** **within 45 days from the date you get this notice.** A decision will be made on your complaint no later than **[30, unless the Contractor will be using a shorter time frame to decide complaints]** days from when we receive it.

To file a complaint:

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

[Contractor Address for filing complaint]

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

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

[Contractor Address for records information]

If you need help filing a complaint or have any other questions, you may call **[Contractor Name]** at **[Contractor Phone #/Toll-free TTY #]**, Pennsylvania Legal Services at 1-800-322-7572 (www.palegalservices.org), or the Pennsylvania Health Law Project at 1-800-274-3258 (www.phlp.org).

Sincerely,

[Contractor Name]

cc: **[Provider]**

[The following statement must appear in English and the prevalent non-English languages spoken in the Service Area:]

The information in this notice is about payment for medical services. It is available in other languages and formats by calling [Contractor Name] at [Phone #/Toll-free TTY #].

Appendix G (3)

NOTICE FOR PAYMENT DENIAL BECAUSE THE SERVICE(S)/ITEM(S) IS NOT AN AUTHORIZED SERVICE FOR THE PARTICIPANT

THIS IS NOT A BILL

[Date Notice Mailed (date decision is made to deny payment)]

Participant Name
Address
City, State Zip

Participant ID: ********

Dear **[Participant Name]**:

[Contractor Name] has reviewed the request for payment from **[Provider's name]** for **[identify specific service/item]**, which you received on **[date]**. Your Provider's request for payment has been denied because the service you received was not authorized for you by **[Contractor Name]**.

[PROVIDER'S NAME] MAY BILL YOU FOR THIS SERVICE/ITEM ONLY IF [PROVIDER'S NAME] TOLD YOU THAT YOU WOULD HAVE TO PAY FOR THE SERVICE/ITEM BEFORE YOU GOT THE SERVICE/ITEM.

If you do not agree with this decision, you may file a complaint with **[Contractor Name] within 45 days from the date you get this notice.** A decision will be made on your complaint no later than **[30, unless the Contractor will be using a shorter time frame to decide complaints]** days from when we receive it.

To file a complaint:

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

[Contractor Address for filing complaint]

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

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

[Contractor Address for records information]

If you need help filing a complaint or have any other questions, you may call **[Contractor Name]** at **[Contractor Phone #/Toll-free TTY #]**, Pennsylvania Legal Services at 1-800-322-7572 (www.palegalservices.org), or the Pennsylvania Health Law Project at 1-800-274-3258 (www.phlp.org).

Sincerely,

[Contractor Name]

cc: **[Provider]**

[The following statement must appear in English and the prevalent non-English languages spoken in the Service Area:]

The information in this notice is about payment for medical services. It is available in other languages and formats by calling [Contractor Name] at [Phone #/Toll-free TTY #].

Appendix G (4)

NOTICE FOR DENIAL OF PAYMENT AFTER A SERVICE(S) HAS BEEN DELIVERED BECAUSE THE SERVICE(S) WAS NOT MEDICALLY NECESSARY

THIS IS NOT A BILL

[Date Notice Mailed (date decision is made to deny payment)]

Participant Name
Address
City, State Zip

Participant ID: *********

Dear **[Participant Name]**:

[Contractor 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,

[Contractor Name]

cc: **[Provider]**

[The following statement must appear in English and the prevalent non-English languages spoken in the Service Area:]

The information in this notice is about payment for medical services. It is available in other languages and formats by calling [Contractor Name] at [Phone #/Toll-free TTY #].

Appendix G (5)

COMPLAINT ACKNOWLEDGMENT LETTER

[Date Letter Mailed]

Participant Name
Address
City, State Zip

Participant ID:*********

Subject: Your Complaint About **[Complaint Issue]**

Dear **[Participant Name]**:

[Contractor Name] received your complaint about **[identify subject of complaint]** on **[date of receipt]**.

Complaint Process

A committee of three or more people, including at least one person who does not work for **[Contractor Name]**, 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 **[Contractor Name]**, in writing, the name of that person and how we can reach him or her.

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

[Contractor Address]

You and your representative may appear at the complaint review in person, by phone or by videoconference, if available, by calling **[Contractor Name]** at **[Contractor Phone #/Toll-free TTY #] within ten days from the date on this letter**. 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 get help with your complaint

- If you need help with your complaint, call **[Contractor Name]** at **[Contractor Phone #/Toll-free TTY #]** and **[Contractor Name]** will assign a staff person who has not been involved in the complaint issue to help you.
- If you have any other questions, you may call **[Contractor Name]** at **[Contractor Phone #/Toll-free TTY #]**, Pennsylvania Legal Services at 1-800-322-7572 (www.palegalservices.org), or the Pennsylvania Health Law Project at 1-800-274-3258 (www.phlp.org).

If your complaint is described correctly at the top of this letter, please sign below and return this letter to:

[Contractor Address]

If your complaint is not described correctly, please call **[Contractor Name]** at **[Contractor Phone #/Toll-free TTY #]**.

Sincerely,

[Contractor Name]

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

[The following statement must appear in English and the prevalent non-English languages spoken in the Service Area:]

The information in this letter is about the complaint you filed with [Contractor Name]. It is available in other languages and formats by calling [Contractor Name] at [Phone #/Toll-free TTY #].

I agree that my complaint is described correctly.

_____ _____

Participant's or Participant's Representative Signature

Date

Appendix G (6)

COMPLAINT DECISION NOTICE

[Date Notice Mailed (no more than 5 business days after the complaint decision)]

Participant Name
Address
City, State Zip

Participant ID: *********

Subject: Decision About Your Complaint

Dear **[Participant Name]**:

[Contractor Name] has reviewed your complaint about **[issue]**, received on **[date]**.

Based on a review of all information provided, the complaint 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.]**

You may ask for a copy of the rules or other guidelines used to make the decision by calling **[Contractor Name]** at **[Contractor Phone #/Toll-free TTY #]** or by sending a written request to:

[Contractor Name and Address]

[Contractor: Include the following paragraph only if the Complaint challenges a denial because the service/item is not a Covered Service.]

To continue getting services

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

[Contractor: Include the following paragraphs on Fair Hearings only if the complaint is about one of the following: Failure to provide services/items in a timely

manner; failure to decide a complaint or grievance within 30 days; denial because the service/item is not a Covered Service; denial of payment because the service/item was not an Authorized Service/Item for the Participant; denial because the service/item was provided without authorization by a non MA enrolled provider; or the decision to involuntarily disenroll a Participant from the Plan.]

If you do not agree with this 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 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. **[Contractor: Include this last item only for complaints challenging a denial because the service/item is not a Covered Service or a denial of payment because the service/item was not an Authorized Service/Item for the Participant or because the service/item was provided without authorization by a non-MA provider.]**

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

Department of Public Welfare
OMAP – Adult Community Autism Program
Complaint, Grievance and Fair Hearings
P.O. Box 2675
Harrisburg, PA 17105-2675

The Department will issue a decision within 60 days from when it receives your request.

To ask for an early decision

If your Provider 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 **[**###-###-####**]**, or fax your request to the Department at **[**###-###-####**]**;
- Your Provider must fax a signed letter to **[**###-###-####**]** explaining why taking the usual amount of time to decide your request for a Fair Hearing could harm your health. If your Provider does not send a letter, your Provider 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 request for a Fair Hearing

If you need help filing a request for a Fair Hearing or have any other questions, you may call **[Contractor Name]** at **[Contractor Phone #/Toll-free TTY #]**, Pennsylvania Legal Services at 1-800-322-7572 (www.palegalservices.org), or the Pennsylvania Health Law Project at 1-800-274-3258 (www.phlp.org).

Sincerely,

[Contractor Name]

cc: **[Participant Representative, if designated]**
[Service Provider, if applicable]
[Prescribing Provider, if applicable]
[Team]

[The following statement must appear in English and the prevalent non-English languages spoken in the Service Area:]

The information in this notice is about the complaint you filed with [Contractor Name]. It is available in other languages and formats by calling [Contractor Name] at [Phone #/Toll-free TTY #].

Appendix G (7)

GRIEVANCE ACKNOWLEDGMENT LETTER

[Date Letter Mailed]

Participant Name
Address
City, State Zip

Participant ID:*********

Subject: Your Grievance About **[Grievance Issue]**

Dear **[Participant Name]**:

[Contractor Name] received your grievance about **[identify subject of grievance]** on **[date of receipt].**

Grievance Process

A committee of three or more people, who have not been involved in the issue you filed your grievance about, will review your grievance. The committee will include a **[licensed doctor] [professional with autism experience]** and at least one person who does not work for **[Contractor Name].** 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 **[Contractor Name]**, in writing, the name of that person and how we can reach him or her.

You or your representative may ask **[Contractor Name]** to see any information relevant to your grievance. You may also send information that you have about your grievance to **[Contractor Name]**:

[Contractor Address]

You and your representative may appear at the grievance review in person, by phone or by videoconference, if available, by calling **[Contractor Name]** at **[Contractor Phone #/Toll-free TTY #] within ten days from the date on this letter.** 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 get help with your grievance

- If you need help with your grievance, call **[Contractor Name]** at **[Contractor Phone #/Toll-free TTY #]** and **[Contractor Name]** will assign a staff person who has not been involved in the grievance issue to help you.
- If you have any other questions, you may call **[Contractor Name]** at **[Contractor Phone #/Toll-free TTY #]**, Pennsylvania Legal Services at 1-800-322-7572 (www.palegalservices.org), or the Pennsylvania Health Law Project at 1-800-274-3258 (www.phlp.org).

If your grievance is described correctly at the top of this letter, please sign below and return this letter to:

[Contractor Address]

If your grievance is not described correctly, please call **[Contractor Name]** at **[Contractor Phone #/Toll-free TTY #]**.

Sincerely,

[Contractor Name]

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

[The following statement must appear in English and the prevalent non-English languages spoken in the Service Area:]

The information in this letter is about the grievance you filed with [Contractor Name]. It is available in other languages and formats by calling [Contractor Name] at [Phone #/Toll-free TTY #].

I agree that my grievance is described correctly.

_____ _____

Participant's or Participant's Representative Signature Date

Appendix G (8)

GRIEVANCE DECISION NOTICE

[Date Notice Mailed (no more than 5 business days after the grievance decision)]

Participant Name
Address
City, State Zip

Participant ID: *********

Subject: Decision About Your Grievance

Dear **[Participant Name]**:

[Contractor Name] has reviewed your grievance about **[issue],** received on **[date]**.

Based on a review of all information provided, the grievance 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.]**

You may ask for a copy of the rules or other guidelines used to make the decision by calling **[Contractor Name]** at **[Contractor Phone #/Toll-free TTY #]**, or by sending a written request to:

[Contractor Name and Address]

To continue getting services

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

If you do not agree with this 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 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 Public Welfare
OMAP – Adult Community Autism Program
Complaint, Grievance and Fair Hearings
P.O. Box 2675
Harrisburg, PA 17105-2675

The Department will issue a decision within 60 days from when it receives your request.

To ask for an early decision

If your Provider 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 **[**###-###-####**]**, or fax your request to the Department at **[**###-###-####**]**;
- Your Provider must fax a signed letter to **[**###-###-####**]** explaining why taking the usual amount of time to decide your request for a Fair Hearing could harm your health. If your Provider does not send a letter, your Provider 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 request for a Fair Hearing

If you need help filing a request for a Fair Hearing or have any other questions, you may call **[Contractor Name]** at **[Contractor Phone #/Toll-free TTY #]**, Pennsylvania Legal Services at 1-800-322-7572 (www.palegalservices.org), or the Pennsylvania Health Law Project at 1-800-274-3258 (www.phlp.org).

Sincerely,

[Contractor Name]

cc: **[Participant Representative, if designated]**
[Service Provider]
[Prescribing Provider, if applicable]
[Team]

[The following statement must appear in English and the prevalent non-English languages spoken in the Service Area:]

The information in this notice is about the grievance you filed with [Contractor Name]. It is available in other languages and formats by calling [Contractor Name] at [Phone #/ Toll-free TTY #].

Appendix G (9)

NOTICE OF FAILURE TO RECEIVE PROVIDER CERTIFICATION FOR AN EXPEDITED COMPLAINT OR GRIEVANCE

[Date Notice Mailed (no more than 2 days after date of decision to deny expedited review)]

Participant Name
Address
City, State Zip

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

Subject: Request for "Expedited" **[complaint][grievance]**

Dear **[Participant]**:

[Contractor Name] received your **[complaint][grievance]** about **[identify subject of complaint/grievance]**, and your request to have the **[complaint][grievance]** decided more quickly than the usual **[30, unless the Contractor will be using a shorter time frame to decide complaint/grievances]**-day time frame on **[date]**. As we told you when you filed your **[complaint][grievance]**, in order for your **[complaint][grievance]** to be decided more quickly, your Provider needed to provide us with a statement that taking the usual amount of time to decide the **[complaint][grievance]** could harm your health. **[Contractor Name]** also asked your Provider for this statement.

Your Provider has not provided **[Contractor Name]** with this statement, so your **[complaint][grievance]** will be decided within the usual time frame of **[30, unless the Contractor will be using a shorter time frame to decide complaint/grievances]** days from when we first got your **[complaint][grievance]**.

[Contractor: Choose one of the following two paragraphs:

Complaint Process

A committee of three or more people, who have not been involved in the issue you filed your complaint about, will review your complaint. The committee will include a **[licensed doctor] [professional with autism experience]** and at least one person who does not work for **[Contractor Name].** This is called the "complaint review." A decision will be made by **[date that is no more than 30 days from receipt of the complaint]**. A letter will be mailed to you within five business days after the decision is made, telling you each reason for the decision.

OR

Grievance Process

A committee of three or more people, who have not been involved in the issue you filed your grievance about, will review your grievance. The committee will include a **[licensed doctor] [professional with autism experience]** and at least one person who does not work for **[Contractor Name].** 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 **[complaint][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 **[Contractor Name]**, in writing, the name of that person and how we can reach him or her.

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

[Contractor Address]

You and your representative may appear at the **[complaint][grievance]** review in person, by phone or by videoconference, if available, by calling **[Contractor Name]** at **[Contractor Phone #/Toll-free TTY #] within ten days from the date on this notice**. 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 get help with your [complaint][grievance]

- If you need help with your **[complaint][grievance],** call **[Contractor Name]** at **[Contractor Phone #/Toll-free TTY #]** and **[Contractor Name]** will assign a staff person who has not been involved in the **[complaint][grievance]** issue to help you.
- If you have any other questions, you may call **[Contractor Name]** at **[Contractor Phone #/Toll-free TTY #],** Pennsylvania Legal Services at 1-800-322-7572 (www.palegalservices.org), or the Pennsylvania Health Law Project at 1-800-274-3258 (www.phlp.org).

Sincerely,

[Contractor Name]

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

[The following statement must appear in English and the prevalent non-English languages spoken in the Service Area:]

The information in this notice is about the [complaint[[grievance] you filed with [Contractor Name]. It is available in other languages and formats by calling [Contractor Name] at [Phone #/Toll-free TTY #].

Appendix G (10)

EXPEDITED [COMPLAINT][GRIEVANCE] DECISION NOTICE

[Date Notice Mailed (no more than 2 days after the [complaint][grievance] decision)]

Participant Name
Address
City, State Zip

Participant ID: *********

Subject: "Expedited" Decision About Your **[Complaint][Grievance]**

Dear **[Participant Name]**:

[Contractor Name] has reviewed your **[complaint][grievance]** about **[issue]**, received on **[date]**.

Based on a review of all information provided, the **[complaint][grievance]** 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.]**

You may ask for a copy of the rules or other guidelines used to make the decision by calling **[Contractor Name]** at **[Contractor Phone #/Toll-free TTY #]**, or by sending a written request to:

[Contractor Name and Address]

To continue getting services

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

If you do not agree with this decision, you may ask for a Fair Hearing from the Department of Public Welfare.

If your Provider 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 **[###-###-####]**, or fax your request to the Department at **[###-###-####]**;
- Your Provider must fax a signed letter to **[###-###-####]** explaining why taking the usual amount of time to decide your request for a Fair Hearing could harm your health. If your Provider does not send a letter, your Provider 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 Public Welfare. 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 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 Public Welfare
OMAP – Adult Community Autism Program
Complaint, Grievance and Fair Hearings
P.O. Box 2675
Harrisburg, PA 17105-2675

To get help with a request for a Fair Hearing

If you need help filing a request for a Fair Hearing or have any other questions, you may call **[Contractor Name]** at **[Contractor Phone #/Toll-free TTY #]**, Pennsylvania Legal Services at 1-800-322-7572 (www.palegalservices.org), or the Pennsylvania Health Law Project at 1-800-274-3258 (www.phlp.org).

Sincerely,

[Contractor Name]

cc: **[Participant Representative, if designated]**
[Service Provider]
[Prescribing Provider, if applicable]
[Team]

[The following statement must appear in English and the prevalent non-English languages spoken in the Service Area:]

The information in this notice is about the [complaint][grievance] you filed with [Contractor Name]. It is available in other languages and formats by calling [Contractor Name] at [Phone #/Toll-free TTY #].

Appendix H Protocol

Chapter 1
GENERAL INFORMATION & ORGANIZATION

I. DESCRIPTION OF THE CONTRACTOR

A. Describe how the Contractor is organized under State law. If the Contractor does business as (d.b.a.) a name or names different from the name shown on its articles of incorporation, provide such name(s). Provide the name the Contractor will use for ACAP.

B. If the Contractor is part of a corporate entity, describe the Contractor's relationship to the corporate board and to any parent, affiliate or subsidiary corporate entities and provide an organizational chart.

C. Briefly describe the history of the Contractor's organization and its current operations. Include significant aspects of the Contractor's current financial, marketing, general management, and health services delivery activities that would support the Contractor's ability to serve adults with a diagnosis of Autism Spectrum Disorders (ASD). Include the extent to which the Contractor currently provides services to adults with a diagnosis of ASD.

II. PERSONNEL REQUIREMENTS (Article II, Section 2.5.I; Appendix D)

A. Submit an organizational chart that shows the personnel required by the Agreement. The organizational chart should indicate if any of the required personnel have a relationship to any other organizational entities in addition to the Contractor.

B. Provide a copy of the position descriptions and resumes for the Executive Director, Chief Financial Officer, Behavioral Health Practitioners, Medical Director, Supports Coordinator(s), and Habilitation Worker(s).

C. Provide a copy of the position description for the Behavioral Health Specialist.

III. GOVERNING BODY (Article II, Section 2.5.A; Article VI, Section 6.1.A.5)

A. List who will be on the Governing Body, including their positions and the knowledge and experience that they have that is appropriate to the Governing Body's functions.

B. Provide the name and phone number for a contact person for the Governing Body.

C. Explain how the Governing Body will do the following:

1. Plan, organize, administer, oversee and evaluate the operations and performance of the Plan;

2. Be responsible for the Contractor's fiduciary obligations and for ensuring that the Contractor satisfies its obligations to the Department and Participants; and

3. Review reports and records submitted as a result of the plan of Quality Assurance and Improvement.

IV. PLAN ADVISORY COMMITTEE (Article II, Section 2.5.B; Article V, Section 5.1.A; Article XI, Sections 6.1.B.1 & 6.1.C.1)

A. List who will be on the Plan Advisory Committee and explain why each person was chosen to be on the Plan Advisory Committee.

B. Explain how the Plan Advisory Committee will perform the following:

1. Report to and advise the Governing Body; and

2. Establish committees on matters related to the complaint and grievance processes, quality management and utilization review processes, and ethics; support these committees; and be accountable to the Governing Body on issues addressed by these committees.

V. NATURAL DISASTERS (Article II, Section 2.1.AA)

Provide a copy of the procedures to manage natural disasters in the Service Area.

Chapter 2
ACAP ADMINISTRATION

I. TRAINING (Article II, Section 2.1.V; Article VIII, Section 8.1.B; Appendix E)

Explain the Contractor's training program. Include the following:

A. A detailed description of how the Contractor will determine if its staff and Network Providers are competent to deliver the services they are to provide;

B. How and when the Contractor's staff and Network Providers will receive the training developed by the Department and required by Appendix E;

C. How and when the Contractor's staff and Network Providers will receive training in CPR and crisis prevention and intervention including training on Seclusion and Restraint consistent with the Agreement's requirements on Seclusion and Restraint; and

D. How the Contractor will train its staff on HIPAA privacy policies.

II. PROGRAM INTEGRITY (Article II, Section 2.5.H.4; Article IX, Sections 9.9 & 9.10)

A. Provide a copy of the compliance plan that contains the elements included in the Agreement from CMS publication "Guidelines for Constructing a Compliance Program for Medicaid Managed Care Organizations and Prepaid Health Plans" found at www.cms.hhs.gov/states/fraud.

B. Submit written policies and procedures for the prevention, detection, investigation, and reporting of suspected fraud and abuse, including the policies required under the Deficit Reduction Act, 42 U.S.C. § 1396a(a)(68).

C. Indicate the process used to ensure that the Contractor does not do the following:

1. Subcontract with providers that have been excluded from participation in Medicare or any State Medicaid or other health care program; and

2. Has a Relationship, as defined in the Agreement, with an individual or an Affiliate, of an individual, as defined in the Federal Acquisition Regulation, 48 CFR Parts 1-51, who is barred,

suspended, or otherwise excluded from participating in procurement activities under the Federal Acquisition Regulation or from participating in non-procurement activities under regulations issued under Executive Order No. 12549 or under guidelines implementing Executive Order No. 12549.

D. Describe how the Contractor will ensure that no member of the Governing Body, any of it officers or directors, or its employees currently has or will acquire any interest, direct or indirect, which would conflict in any manner or degree with the Contractor's performance of the Agreement.

III. PARTICIPANT RECORDS (Article II, Section 2.1.C)

A. Explain how the Contractor will ensure that Providers maintain a record for each Participant and that the record documents all care provided.

B. Explain how the Contractor will ensure that it has a record for each Participant that contains all of the elements specified in the Agreement.

IV. ADMITTANCE TO AN INSTITUTION FOR MENTAL DISEASE (Article II, Section 2.1.HH)

Explain how the Contractor will monitor a Participant that is admitted to an Institution for Mental Disease (IMD).

V. MORAL OR RELIGIOUS OBJECTIONS TO SERVICES (Article II, Section 2.1.S).

List any counseling or referral services the Contractor objects to providing or arranging on moral or religious grounds and describe how the Contractor will inform Applicants prior to enrollment that the Contractor does not provide or arrange for the provision of these services.

VI. INCIDENT REPORTS (Article II, Section 2.1.K)

Explain how the Contractor will ensure that it responds, reports, and follows up on all incidents as specified in Appendix B of the Agreement.

VII. INFORMATION SYSTEMS (Article II, Section 2.5.E)

A. Describe the computer software and required licenses the Contractor has or will purchase for the Contractor's and the Department's use that will

allow for electronic communication and transfer of information between the Contractor and the Department and will allow the Contractor to collect, analyze, integrate, and report data.

B. Describe where the backup files for all electronically stored information will be located.

VIII. FEDERAL REQUIREMENTS (Article IX, Section 9.12)

Describe how the Contractor will determine if it and Providers are complying with the federal requirements specified in Article IX, Section 9.12 of the Agreement.

Chapter 3
PROVIDERS

I. PROVIDER SELECTION (Article II, Section 2.5.H)

Submit the policies and procedures for the selection and retention of Network Providers.

II. CONTRACTED SERVICES (Article II, Sections 2.1.G, H, I; 2.5.G.2 & 4-6; Article XI, Section 9.9.H)

A. Provide a list of all Provider subcontracts that includes the Provider name, address, phone number, services provided under the subcontract, subcontract expiration date, and whether or not the subcontract is automatically renewable.

B. Explain how the Contractor has determined that its Network is sufficient to provide Participants with prompt access to Covered Services that are not required to be delivered directly by the Contractor and a choice of at least two (2) Network Providers in the following disciplines: Primary care (including family practitioners and general internists), psychiatry, neurology, gynecology, urology, gastroenterology, endocrinology, dentistry, and optometry.

C. Explain how the Contractor will ensure the following:

1. Network Providers offer hours of operation that are no less than the hours of operation offered to commercial patients or comparable to the hours offered for individuals who receive Medical Assistance services in the fee-for-service deliver system;

2. Providers respond, report, and follow up on critical incidents as specified in Appendix B of the Agreement;

3. Provider facilities and offices are accessible to individuals with disabilities; and

4. Providers are enrolled in the Medical Assistance Program.

D. Provide a copy of a sample Provider subcontract for the purchase of services.

III. PRIMARY CARE PROVIDERS (Article II, Sections 2.1.J)

A. Describe the Contractor's process for assigning Primary Care Providers (PCP), including how the Contractor will ensure that Participants will be offered a choice of at least two (2) PCPs, how the Contractor will determine if a Participant should be assigned a PCP that is a specialist, and how the Contractor will assign a PCP if a Participant fails to choose a PCP within fourteen (14) days of enrollment in the Plan.

B. Submit the procedures and policies for allowing Participants to change PCPs.

IV. AFTER-HOURS CALL-IN SYSTEM (Article II, Sections 2.1.D & E)

Describe the Contractor's after hours call in system, including how the Contractor will ensure that a physician and a Behavioral Health Specialist are on call twenty-four (24) hours per day, seven (7) days per week, three-hundred sixty-five (365) days per year.

V. PROVIDER MONITORING (Article VI, Section 6.1.A.2 & 3)

A. Explain how the Contractor will monitor Provider compliance with the standards for timely access to care and services specified in the Agreement and how the Contractor will ensure that problems with timely access to care and services are fixed.

B. Describe how the Contractor will monitor the performance of its Providers on an ongoing basis, including how the Contractor will formally review all Providers at least annually and how if any deficiencies or areas of improvement are identified, the Contractor will ensure that these are corrected.

VI. PROVIDER TERMINATION (Article II, Section 2.5.G.9)

A. Explain how the Contractor will determine who should be sent a written notice if a Provider terminates or the Contractor terminates a Provider.

B. Describe how the Contractor will ensure continuity of service when a Provider terminates or is terminated by the Contractor.

Chapter 4
FINANCIAL

I. FISCAL SOUNDNESS

A. Provide the independently certified audited financial statements for the three (3) most recent fiscal years or, if operational for a shorter period of time, for each fiscal year the Contractor has been in operation. The financial statements are to include:

1. Opinion of a certified public accountant;

2. Statement of revenues and expenses;

3. Balance sheet;

4. Statement of cash flow;

5. Explanatory notes;

6. Management letters; and

7. Statements of changes in net worth.

B. Provide a copy of the Contractor's most recent year-to-date un-audited financial statement.

C Provide independently certified audited financial statements of guarantors, and lenders (organizations providing loans, letters of credit or other similar financing arrangements, excluding banks).

D. Provide financial projections for a minimum of one year from the date of the latest submitted financial statement. Include projections from the date of the latest financial statement through one year beyond break even. Describe the financing arrangements and include all documents supporting these arrangements for any projected deficits.

Financial projections should be prepared using the accrual method of accounting in conformity with generally accepted accounting principles **(GAAP).** Prepare projections using the pro-forma financial statement methodology. For a line of business, assumptions need only be submitted to support the projections of the line. Projections must be given in gross dollars as well as on a per member per month basis. Quarters should be consistent with standard calendar year quarters. Include year-end totals.

If the Contractor has a category of revenue and/or expense that is not included in the Financial Report Format (see Attachment II of the Agreement), provide an explanation.

Projections must include the following:

1. Quarterly balance sheets for the Contractor;

2. Quarterly statements of revenues and expenses for the Contractor. If ACAP is a line of business, the Contractor should also complete a statement of revenue and expenses for the line-of-business;

3. Quarterly statements of cash flows; and

4. Operating and capital budget breakdowns

II. RISK RESERVE (Article II, Section 2.5.M)

A. Describe the Contractor's plan for a risk reserve in the event the Contractor becomes insolvent.

B. Demonstrate that the Contractor has arrangements in place in the amount of one (1) month's total capitation revenue and one (1) month's average payment to Providers to cover expenses in the event the Contractor becomes insolvent.

III. INSOLVENCY (Article II, Section 2.5.N; Article XI, Section 11.4.A)

Describe how in the event of insolvency the Contractor will do the following:

A. Continue to provide Authorized Services until the Contractor finds other services for all of the Participants; and

B. Protect Participants from liability for payment of debts that are the Contractor's obligation.

IV. INSURANCE (DPW Addendum to Standard Contract Terms and Conditions)

Submit current certificates of insurance for malpractice insurance for the Contractor's health care personnel; workers compensation insurance for all of the Contractor's employees and those of any subcontractor, engaged in work at the Contractor's site; and public liability and property damage insurance to protect the Commonwealth, the Contractor, and any all subcontractors from claims 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 the Agreement or the failure to perform under the Agreement whether such performance or nonperformance be by the Contractor, by any subcontractor, or by anyone directly or indirectly employed by either.

V. COST AVOIDANCE (Article II, Section 2.5.J)

Describe how the Contractor will fulfill its responsibility for cost avoidance through the coordination of benefits for public and private resources, including but not limited to, Medicare, private health insurance, Employees Retirement Income Security Act of 1974 (ERISA), 29 U.S.C. §§ 1001, et. seq., plans and worker's compensation.

Chapter 5
OUTREACH AND MARKETING

OUTREACH AND MARKETING (Article IV, Section 4.1)

A. Provide a copy of the Contractor's plan for outreach, marketing, and enrollment that includes how outreach to potential Applicants will be made; how ACAP will be promoted; a schedule for the sequence and timing of promotional and enrollment activities in the Service Area; and development and procurement of resources needed for implementation. Describe also how the Contractor will inform potential Applicants of the basic features of the Plan, which populations are eligible and ineligible for ACAP, and the Plan's responsibilities for coordinating care.

B. Provide copies of all outreach and marketing materials the Contractor intends to distribute.

C. Identify the prevalent non-English languages spoken in the Service Area.

D. Explain how potential Applicants will be notified of the following:

   1. That outreach and marketing materials are available in prevalent non-English languages and how to access them; and

   2. That oral interpretation services are available for all outreach and marketing materials free of charge and how to access the service.

E. Provide examples of the alternative formats the Contractor will use for outreach and marketing materials that take into consideration the special needs of those, who for example, are visually limited or have limited reading proficiency. Explain how potential Applicants will be informed that alternative formats are available and how to access them.

F. Explain how the Contractor will ensure that all staff and Providers who have contact with potential Applicants are fully informed of and understand the Contractor's policies for outreach, enrollment, and disenrollment.

Chapter 6
SERVICES

I. SERVICE DELIVERY (Article II, Section 2.1.EE, M, U, & Z)

A. Describe how the Contractor will ensure that services are provided to all Participants, including those with limited English proficiency and diverse cultural and ethnic backgrounds, in a culturally competent manner.

B. Provide a copy of the procedures to coordinate the Authorized Services provided to a Participant with services he or she receives outside of the Plan and inform all Providers as necessary of the Participant's needs as identified by the Contractor and the Authorized Services delivered to the Participant to prevent duplication of activities.

C. Provide a copy of Contractor's performance standards.

D. Describe how the Contractor will ensure that the care and services required under the Agreement are provided and administered in accordance with accepted medical and behavioral health practices and professional standards.

II. ADDITIONAL SERVICES (Article II, Section 2.3.B)

List any services the Contractor will provide that are not Capitation Services and explain why the Contractor has chosen to provide these services and how the Contractor will ensure that these services are generally available to all Participants and authorized if medically necessary.

III. TEAM (Article II, Section 2.1.L & CC)

A. Describe how the membership of a Participant's Team will be determined and how the Contractor will ensure that Team members do not change except as necessary to meet the needs of the Participant.

B. Submit a copy of the Contractor's policies and procedures that address responsibility for scheduling and facilitating Team meetings, handling and resolving Team conflicts, and how Team members will be kept informed of the Participant's behavioral and health status.

IV. INDIVIDUAL SERVICE PLAN (ISP) (Article II, Section 2.1.L)

A. Submit a sample Initial ISP and an FBA-Based ISP, which includes a Behavioral Support Plan, a Crisis Intervention Plan, and a medication therapeutic management plan.

B. Explain how the Team will do the following:

1. Use the Person-Centered Planning process to develop the Initial ISP and develop, review, update, and revise the FBA-Based ISP; and

2. Develop an FBA-Based ISP that is consistent with and supports the Participant's functional behavioral assessment and includes a Behavioral Support Plan, a Crisis Intervention Plan, and a medication therapeutic management plan.

C. Explain how the Contractor will ensure that the Team develops an Initial ISP within fourteen (14) days of being notified by BAS that an Applicant is eligible to enroll in the Plan, develops an FBA-Based ISP within sixty (60) days of the Applicant's enrollment in the Plan, reviews the FBA-Based ISP at least every three (3) months and after each episode that triggers implementation of the Crisis Intervention Plan or the use of a Restraint, and reassess and updates the FBA-Based ISP at least annually.

V. PRACTICE GUIDELINES (Article II, Sections 2.1.Y)

A. Submit the practice guidelines established by the Contractor that will govern the authorization and delivery of services.

B. Describe how the Contractor will ensure that the practice guidelines are shared will all affected Providers, and upon request, with Participants and Applicants.

C. Describe the process the will be used to ensure that decisions regarding utilization management; Participant education; coverage of services; information provided to the Participant and, if appropriate, the Participant's representative concerning the Participant's diagnosis and treatment options; and other areas to which the guidelines apply are consistent with the guidelines.

VI. SERVICE AUTHORIZATION (Article II, Section 2.1.N & Section 2.4)

A. Submit the policies and procedures for the timely resolution of a request submitted on behalf of a Participant to initiate, terminate, reduce, or continue a service, including the role of the PCP and Team, consistent

application of the practice guidelines for authorization decisions, and consultation with the requesting Provider when appropriate.

B. List who will be responsible for making decisions to deny requests for services or authorize services in an amount, duration or scope that is less than requested. Include their clinical expertise and how each person will be compensated.

C. Explain how the Contractor will ensure the following:

2. Authorized Services are sufficient in amount, duration, and scope to reasonably be excepted to achieve the purpose for which the services are furnished;

2. Each Authorized Service is the least-restrictive, most-inclusive, and cost-effective feasible option that meets the Participant's needs;

3. Services are denied or authorized in an amount, duration, or scope less than requested only on the basis of lack of medical necessity or inconsistency with accepted medical and behavioral health practices and professional standards; and

4. That the amount, duration, or scope of a service is not arbitrarily denied, reduced, or terminated solely because of the diagnosis, illness, or condition of the Participant.

D. Explain how the Contractor will ensure that the timeframes for service authorization included in the Agreement are met.

E. Submit a sample of the notice that will be used to communicate the decision on the Initial ISP and FBA-Base ISP to the Supports Coordinator and PCP.

F. Explain how the Contractor will ensure that the explanation of why a service was denied or authorized in an amount, duration, or scope that is less than requested is written in a language that is readily understandable by a layperson, at a fourth-grade reading level.

VII. TIMELINESS OF SERVICES (Article II, Sections 2.1.F & O)

Explain how the Contractor will ensure the following;

A. Authorized Services are delivered promptly and consistent with the needs of the Participant;

B. Urgent medical or behavioral condition cases are scheduled by the Contractor with the PCP or the Behavioral Health Specialist to take place within twenty-four (24) hours of the request for an appointment and with other specialists to take place within twenty-four (24) hours of referral;

C. Routine appointments are scheduled by the Contractor with the PCP to take place within seven (7) days of the request for an appointment and with the specialist to take place within seven (7) days of referral;

D. Each Participant has a general physical examination within three (3) months and three (3) weeks of enrollment and annually thereafter, during the first three (3) months after the first Participant is enrolled in the Plan, unless the Participant had a complete physical examination within three (3) months before enrolling in the Plan and the Team agrees that an examination is unnecessary; and

E. Each Participant has a general physical examination within three (3) weeks of enrollment and annually thereafter, after the first three (3) months after the first Participant is enrolled in the Plan, unless the Participant had a complete physical examination within three (3) months before enrolling in the Plan and the Team agrees that an examination is unnecessary.

VIII. OUT OF NETWORK SERVICES (Article II, Section 2.1.P)

Describe how a Participant will access services out of network if the Contractor cannot directly or through Network Providers provide a Medically Necessary Covered Service.

Chapter 7 PARTICIPANT RIGHTS, RESPONSIBILITIES, AND EDUCATION

I. EXPLANATION OF RIGHTS AND RESPONSIBILITIES (Article IV, Section 4.2.C)

A. Describe how and when Participants will be informed verbally of their rights and responsibilities.

B. Explain how Participants that do not understand English will be informed of their right to written information in the prevalent non-English language of the Service Area and their right to free oral interpretation services in any language.

C. Explain how Participants with special needs, who are, for example visually impaired or have limited reading proficiency, will be informed of their right to information in an alternative format or manner that takes into consideration their special needs.

II. EDUCATION OF PROVIDERS ABOUT COMPLAINT, GRIEVANCES, AND FAIR HEARING RIGHTS (Article II, Section 2.5.G.7)

Describe how and when the Contractor will inform Providers of Participants' Grievance, Complaint, and DPW Fair Hearing rights.

III. ADVANCE DIRECTIVES (Article II, Section 2.5.L)

A. Submit the Contractor's policies and procedures on Advance Directives.

B. Submit the written information that will be given to all Participants at enrollment concerning the Contractor's polices and procedures on Advance Directives.

C. Describe how the Contractor will inform Participants of their right to request information on the Contractor's policies and procedures on Advance Directives annually.

IV. SECLUSION AND RESTRAINT (Article II, Section 2.2)

A. Submit the Contractor's policies and procedures on Seclusion and Restraint.

B. Explain how the Contractor will ensure that its staff and Providers do the following:

1. Do not use Seclusion for any reason;

2. Do not use a prone Restraint for any reason;

3. Use only clinically approved Restraints and receive training on the appropriate use of these Restraints.

4. Try all less intrusive alternatives to de-escalate a Participant's behavior prior to using a Restraint;

5. Use a Restraint only as a last resort and only to control acute episodic behavior that poses a threat to a Participant or others, to protect a Participant's health or safety, or to protect the heath and safety of others;

6. Consider a Participant's medical and behavioral health history prior to using a Restraint.

7. Use only the type of Restraint identified in the Behavioral Support Plan and change the position of the Restraint at least every ten (10) minutes.

8. When a Restraint is used, continuously observe the physical and emotional condition of the Participant and document the observations at least every ten (10) minutes in the Participant's record.

9. Immediately release a Participant from a Restraint as soon as it is determined that the Participant is no longer a threat to himself or herself or to others, which may not exceed thirty (30) minutes in a two (2) hour period;

10. When a Restraint is used, inform the Participant as early as possible in the Restraint process, what is needed for the Restraint to be released**.**

11. File an incident report any time a Restraint is used as specified in Appendix B.

12. Do not use a Restraint as a punishment, therapeutic technique, or for convenience.

V. COMPLAINT, GRIEVANCE, AND DPW FAIR HEARINGS (Article V, Section 5.1; Appendix G)

A. Submit a copy of the Contractor's Complaint, Grievance, and DPW Fair Hearing policies and procedures.

B. Describe the data system the Contractor will use to process, track, and trend all Complaints and Grievances.

C. Describe how data from Complaints and Grievances will be collected, aggregated, analyzed, trended, and included in the Quality Assurance and Improvement program.

D. Provide the toll free number that will be used for Complaints and Grievances.

E. List the staff that will be responsible for receiving, processing, and responding to Complaints and Grievances and include the training each staff person will receive.

F. Explain what assistance the Contractor's staff will offer to Participants throughout the Complaint and Grievance processes.

G. Explain how the Contractor will ensure that anyone who participates in making the decision on a Complaint or Grievance was not involved in or does not supervise a person involved in any review or decision-making on the issue that is the subject of the Compliant or Grievance or in the development of the Participant's Initial ISP or FBA-Based ISP, including the Crisis Intervention Plan and Behavioral Support Plan.

H. Provide the position description for the Customer Service Representative.

VI. PARTICIPANT EDUCATION (Article II, Section 2.1.Q)

Submit the policies and procedures regarding ongoing Participant education.

Chapter 8
QUALITY ASSURANCE & IMPROVEMENT

I. PLAN OF QUALITY ASSURANCE & IMPROVEMENT (Article VI, Section 6.1.A.5)

Provide a copy of the Contractor's Quality Assurance and Improvement plan.

II. MEASURING QUALITY AND IMPROVEMENT (Article X, Section 10.3; Appendix K)

A. Describe the methodology the Contractor will use to demonstrate the following:

1. Improvement in behavioral stability of the Participants as measured by:

a. Fewer episodes of:
   i. Law enforcement involvement
   ii. Psychiatric emergency room care
   iii. Psychiatric inpatient hospitalization
   iv. Crisis Intervention Plan use
   v. Mental health crisis interventions

b. Increases in:
   i. Percentage of Participants with jobs or engaging in volunteer work
   ii. Number of hours Participants work or are engaged in volunteer work
   iii. Participants' independence and social skills
   iv. Parental satisfaction and quality of life indicators
   v. Participant's quality of life

2. Improvement in access to medical services including:
   a. Initial visit with a PCP within three (3) weeks of enrollment
   b. Annual dental exams
   c. Improved diabetes management
   d. Annual gynecological exams

B. Describe how the Contractor will regularly evaluate Participants' satisfaction with services.

III. AUDITS OF MEDICAL AND SERVICE RECORDS (Article VI, Section 6.1.A.1)

Describe the Contractor's plan for performing quarterly audits of medical and service records to ensure record entries are appropriate, complete, and legible, and contain all required information such as assessments, progress notes, responsible Provider signatures, and recording of services delivered.

IV. COMMITTEES (Article V, Section 5.1.A; Article VI, Sections 6.1.A.4, B.1, & C.1)

A. List who will be on the Complaint and Grievance Committee and explain why each person was chosen to be on the Committee.

B. List who will be on the committee composed primarily of Participants that will report directly to the Plan Advisory Committee on, at a minimum, issues of Participant satisfaction, quality of care, and service delivery, and explain why each person was chosen to be on the Committee.

C. List who will be on the Ethics Committee and explain why each person was chosen to be on the Committee.

D. List who will be on the Quality Management Committee and explain why each person was chosen to be on the Committee.

Chapter 9
PARTICIPANT ENROLLMENT AND DISENROLLMENT

I. ELIGIBILITY TO ENROLL (Article IV, Section 4.3.C.5.b)

Explain how the Contractor will determine if an Applicant:

A. Is able to live in a community setting without sixteen (16) or more awake paid and unpaid staff and supervision hours per day without presenting a danger to self or others or a threat to property;

B. Does not exhibit levels of extremely problematic behaviors that would present a danger to self or others (such as suicidal or homicidal ideation, stalking, pedophilia, physical assaults, self-mutilations, bomb or fire threats) or threat to property;

C. Resides or plans to reside in the Service Area at the time of enrollment;

D. Is willing to disenroll from a Medical Assistance Managed Care Organization (MCO), if enrolled;

E. Is willing to enroll in the Contractor's Plan; and

F. Has a diagnosis of ASD.

II. ENROLLMENT PROCESS (Article IV, Sections 4.2.D & 4.3.C.5)

A. Describe what the Contractor plans to do during the in-home assessment.

B. Explain how the Contractor will ensure that it meets the timeframe for completion of the eligibility determination.

C. Explain the Contractor's process for reviewing the Participant Handbook and the Enrollment Agreement with the Participant or the Participant's representative, as appropriate.

III. IDENTIFICATION CARD SLEEVE/STICKER (Article IV, Section 4.3.E)

Submit a copy of the identification card sleeve/sticker for the Medical Assistance Card the Contractor will use to identify the Participant as a Participant in the Plan.

IV. DISENROLLMENT (Article IV, Section 4.4)

A. Describe how the Contractor will assist individuals who disenroll.

B. Describe how the Contractor will notify Participants annually of their right to terminate enrollment at any time.

C. Identify the Contractor staff involved in involuntary disenrollment decisions.

Chapter 10
PAYMENT

PARTICIPANT LIABILITY (Article 3, Section 3.1.C)

A. Describe how the Contractor will determine the amount of any Participant Liability.

B. Describe how the Contractor will collect any Participant Liability amount from the Participant.

Chapter 11
DATA COLLECTION, RECORD MAINTENANCE & REPORTING

I. MAINTENANCE OF RECORDS (Article VII, Sections 7.1 & 7.2)

A. Describe how the Contractor will maintain records, books, and data for the purposes of medical and financial audits, inspections, and examinations pertaining to the Contractor's performance under the Agreement to the extent and in such detail as shall properly substantiate claims for payment under the Agreement.

B. Explain how the Contractor will preserve the records, books, and data Contractor is required to maintain under the Agreement for a period of seven (7) years from the termination date of the Agreement and retain all documents relating to litigation, adjudicatory proceedings, claims negotiations, audits or other actions including appeals, commenced during the term of the Agreement and during the seven-year (7) post-Agreement period, until such proceedings have reached final disposition.

II. CONFIDENTIALITY *(*Article VIII, Sections 8.1.A & 8.2*)*

A. Describe how the Contractor will protect all information, records, and data collected in connection with the Agreement from unauthorized disclosure, including how the Contractor will ensure access to such information is limited to the Participant, the Contractor, Providers, and the Department or the Department's designee in performance of duties related to the Agreement.

B. Explain how the Contractor will ensure the physical security of data under its control.

III. REPORTING REQUIREMENTS (Article X, Section 10.1)

A. Describe how the Contractor will collect the data needed to submit financial reports, enrollment reports, complaint/grievance reports, third party liability reports, and services reports.

B. Explain how the Contractor will ensure that it submits reports in the format and frequency required by the Agreement.

APPENDIX I

CAPITATION RATE METHODOLOGY

The Capitation Rates were developed in accordance with rate-setting guidelines established by CMS including 42 CFR § 438.6(c). The Capitation Rate is based on generally accepted actuarial practices and principles applied by actuaries meeting the qualification standards of the American Academy of Actuaries for Medicaid populations and services covered under the Agreement.

There are two Capitation rates, 1) Community Support and 2) Institutionalized. If a Participant is not residing in an ICF or resided in an ICF for less than 24 consecutive months after enrollment in ACAP, services for the Participant will be reimbursed at the Community Support rate. If a Participant has resided in an ICF for at least 24 consecutive months after enrollment in ACAP, services for the Participant will be reimbursed at the Institutionalized rate.

Since this is a new program and there is no direct program experience to use as base data, only Capitation Services were included in the database. Base data for prior years for fee-for-service, managed care behavioral health, physical health, fee for service ICF, and community-based services for Medical Assistance recipients twenty-one (21) years of age and over who are diagnosed with ASD were adjusted using:

- Trend factors to forecast expenditures and utilization to the appropriate contract period;
- Blending of community and institutional experience to reflect anticipated institutional utilization the Community Support rate cell;
- Anticipated changes in utilization resulting from changes in care management and initial enrollment guidelines;
- Data smoothing; and
- Administration loading

Adjustments were made for anomalies and upward adjustments were made to fee-for-service data to account for beneficiary co-payments that do not apply to ACAP. Post eligibility treatment of income or amounts paid by the client for institutional services will be subtracted from the Capitation Rates so the per diem rates used to calculate institutional costs were not reduced for any client financial liability. Cost data is trended to the contract period

The Capitation Rate for our State Fiscal Year 2016/2017:

- Community Support $ 5,383.00
- Institutionalized $13,080.00

The projected expenditures for fiscal year 2016-2017 (based on an enrollment of 152 participants) are as follows:

Commonwealth - $ 4,712,924.00
Federal - $ 5,105,668.00
Total - $ 9,818,592.00

APPENDIX J
DISENROLLMENT LETTERS
Voluntary Disenrollment

Participant's Name
Address
Phone Number

Date

Re: Your Request to Disenroll from **[Contractor's Name]**

Dear

This letter is to confirm that in a **[telephone conversation/letter]** on **[date of conversation/letter]**, you asked to disenroll from **[Contractor's name]** because **[insert reason for request to disenroll].**

Unless you request a later date, you will no longer be able to receive services from **[Contractor's name]** after_____**[Insert last day Participant can receive services].** You must continue to get your services from **[Contractor's name]** until then.

If you have changed your mind and no longer want to disenroll, please call me before **_____ [Insert last day Participant can receive services]**, at **[Insert telephone number]**.

Sincerely,

<insert name>
Contractor's Employee

Involuntary Disenrollment

Participant's Name
Address
Phone number

DATE_____**[Must be at least 35 days prior to effective date of disenrollment]**

Re: Your enrollment in **[Contractor's Name]**

Dear

On_____**[Insert effective date of disenrollment.]** you will no longer be able to receive your services from **[Contractor's Name]** because **[Explain in detail every reason why the Participant will be disenrolled].**

After_____**[Insert effective date of disenrollment.]** you can get services from **[Explain in detail who will be providing service to the disenrolled Participant and what the Participant needs to do to access these services.]**

If you have any questions, please call **[Name of person that should be called about disenrollment questions]** at **[XXX-XXX-XXXX].**

If you want to continue to get your services from **[Contractor's Name]**, you may file a Complaint. If you file a Complaint within 10 days of the date on this letter, you will be able to continue to receive services from **[Contractor's Name]** after _____ **[Insert effective**

To file a Complaint:

- Call **[Contractor Name]** at **[Phone #/Toll-free TTY #]**; or
- Send your Complaint to **[Contractor Name]** at the following address:

[Contractor Address for filing complaint]

If you need help filing a complaint, you may call **[Contractor Name]** at **[Contractor Phone #/Toll-free TTY #]**, Pennsylvania Legal Services at 1-800-322-7572 (www.palegalservices.org), or the Pennsylvania Health Law Project at 1-800-274-3258 (www.phlp.org).

Sincerely,

cc: **[Participant's Representative, if designated]**

APPENDIX K

QUALITY ASSURANCE

The Contractor must submit reports to BAS as part of its Quality Assurance and Improvement plan that are based on outcome measures and include, at a minimum, the following elements:

A. Improvement in behavioral stability of the Participants as measured by:

1. Fewer episodes of:

a. Law enforcement involvement

b. Psychiatric emergency room care

c. Psychiatric inpatient hospitalization

d. Crisis Episode Incidents

e. Mental health crisis interventions

2. Increases in:

a. Percentage of Participants with jobs or engaging in volunteer work

b. Number of hours Participants work or are engaged in volunteer work

c. Participants' independence and social skills

d. Parental satisfaction and quality of life indicators

e. Participant's quality of life

B. Improvement in access to medical services including:

1. Initial visit with a PCP within three weeks of enrollment

2. Annual dental exams

3. Improved diabetes management

4. Annual gynecological exams

APPENDIX L

PROFIT SHARING ARRANGEMENT

The Department will share in profits realized by Keystone in each Fiscal Year. Keystone will be allowed to retain a portion of any profit gained from the Capitation Payments. Profit of up to 3% of the Capitation Payments will be retained at 100% by Keystone. Profit in excess of 3% of the Capitation Payments will be returned to the Department.

The profit sharing calculation will be based on Capitation Payments from the Department's payment system records and the expenditures reported in the financial reports provided by Keystone to the Bureau of Autism Services (BAS). Keystone's expenditures may include an expense related to the stabilization reserve established for the purpose of providing protection from excess service and administrative costs ("Stabilization Reserve"). Keystone will add an additional line to the quarterly financial reports that will indicate the quarterly and year-to-date balances in the Stabilization Reserve. The Stabilization Reserve will be funded at the discretion of Keystone and will have a maximum balance equal to one month's total capitation revenue. BAS may review the financial reports and additional data (e.g., person-level encounter data) to validate the expenditures reported in the financial reports. BAS may review Keystone's records used to develop the financial reports, and if necessary, make adjustments to the data reported by Keystone to ensure its accuracy.

The profit sharing calculation will be performed after the Fiscal Year financial reports are collected from Keystone. The financial reports are due to BAS 45 days after the end of each Fiscal Year. BAS will provide Keystone with the results of the profit calculation four months after the end of the Fiscal Year. Keystone will have 15 days to review the profit calculation and provide comments. BAS will notify Keystone of the final profit sharing calculation within 15 days of the data BAS received Keystone's comments on the profit sharing calculation. If the final profit sharing calculation results in Keystone having to repay the Department, BAS will notify Keystone of the repayment method at the same time BAS notifies Keystone of the final profit sharing calculation. BAS will either require Keystone to repay the Department within 30 days of notification of the final profit sharing calculation or will offset future Capitation Payments until the Department has recouped all amounts owed to the Department. If the Department will be offsetting future Capitation Payments, it will begin processing the recoupment to be effective on or after January 1 of the following Fiscal Year.

The timeline to support the profit sharing arrangement is as follows:

EVENT	DATE
Profit sharing period ends	June 30
Financial experience due from Keystone	August 14
Collection of additional data	July 1 – October 31
BAS to inform Keystone of profit sharing calculation results	October 31
Keystone reviews BAS' calculation and provides comments	November 15
BAS to inform Keystone of final profit sharing calculation results and method of repayment	November 30
Repayment to the Department Or Department to begin processing recoupment	December 30 On or after January 1

After the profit sharing calculation is complete, BAS may review the results of the profit sharing calculation if Keystone makes any material changes to the audited financial reports or person-level encounter data, BAS may recalculate the profit sharing calculation and recoup additional funds at its discretion. Recoupment can be through either a request for repayment by a certain date or through the offsetting of future Capitation Payments.