COMMONWEALTH OF PENNSYLVANIA

DEPARTMENT OF HUMAN SERVICES

HEALTHCHOICES BEHAVIORAL HEALTH PROGRAM

PROGRAM STANDARDS AND REQUIREMENTS

PRIMARY CONTRACTOR

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HealthChoices Behavioral Health Definitions

Actuarially Sound Capitation Rate – Actuarially sound Capitation rates are projected to provide reasonable, appropriate and attainable costs that are required under the terms of the contract and for the operation of the Primary Contractor for the time period and the population covered under the terms of the contracts, and such Capitation rates are developed in accordance with the requirement in paragraph (b) of Section §438.4.

Actuary – An individual who meets the qualification standards, established by the American Academy of Actuaries for an actuary and follows the practices established by the Actuarial Standard Board.

Adjudicate - A determination to pay or reject a claim.

Administrative Services Organization (ASO) An uninsured health plan is where an administrator performs administrative services for a third party that is at risk but has not issued an insurance policy. The health plan bears all of insurance risk, and there is no possibility of loss or liability to the administrator caused by claims incurred related to the plan. Under an ASO plan, claims are paid from a bank account owned and funded directly by the uninsured plan sponsor; or, claims are paid from a bank account owned by the administrator, but only after receiving funds from the plan sponsor that are adequate to fully cover the claim payments.

Advanced Directives - means a written instruction, such as a living will or durable power of attorney for health care, recognized under State law (whether statutory or as recognized by the courts of the State), relating to the provision of health care when the individual is incapacitated.

Affiliate - Any individual, corporation, partnership, joint venture, trust, unincorporated organization or association, or other similar organization (hereinafter "Person"), controlled by or under common control with a Private Sector BH-MCO, including a Private Sector BH-MCO subcontracting with a county, Joinder, or a Private Sector BH-MCO's parent(s), whether such common control be direct or indirect. Without limitation, all officers, or persons, holding five (5%) percent or more of the outstanding ownership interest of the Private Sector BH-MCO's or Private Sector BH-MCO's parent(s), directors and subsidiaries of the Private Sector BH-MCO, shall be presumed to be Affiliates for purposes of this Agreement. For purposes of this definition, "control" means the possession, directly or indirectly, of the power (whether or not exercised) to direct or cause the direction of the management or policies of a Person, whether through the ownership of voting securities, other ownership interest, or by contract or otherwise, including but not limited to the power to elect a majority of the directors of a corporation or trustees of a trust, as the case may be.

Agreement – The HealthChoices Behavioral Health Agreement.

Alternative Payment Arrangement (APA) – refers to any of the various contractual agreements for reimbursement that are not based on a traditional fee for service model. Types of arrangements include but are not limited to the following: retainer payments; case rates; and subcapitation.

Behavioral Health Managed Care Organization (BH-MCO) - An entity, which manages the purchase and provision of Behavioral Health Services under this Agreement.

Behavioral Health Rehabilitation Services for Children and Adolescents (BHRS) (formerly EPSDT "Wraparound") - Individualized, therapeutic mental health, substance abuse, or behavioral interventions/services developed and recommended by an Interagency Team and prescribed by a physician or licensed psychologist.

Behavioral Health Residential Treatment Facility – A mental health or drug and alcohol residential treatment facility.

Behavioral Health Services – Services that are provided to Members to treat mental health and/or substance abuse diagnoses/disorders.

Behavioral Health (BH) Services Provider - A Provider, practitioner, or vendor/supplier which contracts with a BH-MCO to provide Behavioral Health Services or ordering or referring those services and is legally authorized to do so by the Department under the HealthChoices Behavioral Health Program.

Business Day – Normal business operations Monday through Friday except for those days recognized as federal holidays and/or Pennsylvania state holidays and business closures at the Governor's discretion.

Cancellation - Discontinuation of the Agreement for any reason prior to the expiration date.

Capitation - A payment the Department makes periodically to a Primary Contractor on behalf of each Member enrolled under a contract and based on the actuarially sound Capitation rate for the provision of services under the State Plan. The Department makes the payment regardless of whether the particular beneficiary receives services during the period covered by the payment.

Care Management/Manager - see Service Management/Manager.

Children and Adolescents in Substitute Care (CISC) - Children and adolescents living outside their homes in the legal custody of a public agency, in any of the following settings: shelters, foster family homes, group homes, supervised independent living, residential treatment facilities, residential placement (other than youth development centers) for children and adolescents who have been adjudicated dependent or delinquent.

Clean Claim – A claim that can be processed without obtaining additional information from the Provider of the service or from a third party. It includes a claim with errors originating in the Primary Contractor's claims processing computer system, and those originating from human errors. It does not include a claim under review for Medical Necessity, or a claim that is from a Provider who is under investigation by a governmental agency or the Primary Contractor or BH-MCO for fraud or abuse. However, if under investigation by the Primary Contractor or BH-MCO, the Department must have prior notification of the investigation.

Client Information System (CIS) - The Department's automated file of Medical Assistance eligible recipients.

Community HealthChoices (CHC) – Pennsylvania's managed care program that will use managed care organizations to coordinate physical health care and long-term services and supports (LTSS) for older persons, persons with physical disabilities, and persons who are dually

eligible for Medicare and Medicaid (dual eligibles).

Community HealthChoices Managed Care Organization (CH-MCO) – A Commonwealth-licensed risk-bearing entity which has entered into an Agreement with the Department to manage the purchase and provisions of physical health and long-term services and supports (LTSS) under Community HealthChoices.

Complaint – A dispute or objection regarding a participating health care Provider or the coverage, operations, or management of a BH-MCO, which has not been resolved by the BH-MCO and has been filed with BH-MCO or with the Department of Health or the Insurance Department, including, but not limited to: 1) a denial because the requested service is not a covered service; 2) the failure of the BH-MCO to meet the required time frames for providing a service; 3) the failure of the BH-MCO to decide a Complaint or Grievance within the specified time frames; 4) a denial of payment by the BH-MCO after a service(s) has been delivered because the service(s) was provided without authorization by a provider not enrolled in the Pennsylvania Medical Assistance Program; 5) a denial of payment by the BH-MCO after a service(s) has been delivered because the service(s) is not a covered services(s) for the member; (6) a denial of a Member's request to dispute a financial liability, including cost sharing, copayments, premiums, deductibles, coinsurance, and other Member financial liabilities; or (7) a member's dissatisfaction with the BH-MCO or a provider. Complaints do not include requests to reconsider a decision concerning the medical necessity and appropriateness of a covered health care service.

Concurrent Review - A review conducted by the BH-MCO during a course of treatment to determine whether services should continue as prescribed or should be terminated, changed or altered.

Co-Occurring Disorder Professional – An individual who is certified by a state or national certification body to provide integrated co-occurring psychiatric and substance use treatment, or trained in a recognized discipline, including but not limited to psychiatry, psychology, social work, or addictions, and has one year of clinical experience in the treatment of co-occurring disorders.

County Assistance Office - The county offices of the Department which administer the Medical Assistance program at the local level. Department staff in these offices perform necessary Medical Assistance functions such as determining recipient eligibility.

County Operated BH-MCO - An entity organized and directly operated by county government to manage the purchase and provision of Behavioral Health Services under the HealthChoices Program as a Primary Contractor.

Cultural Competency - The understanding of the social, linguistic, ethnic, and behavioral characteristics of a community or population and the ability to translate systematically that knowledge into practices in the delivery of Behavioral Health Services. Such understanding may be reflected, for example, in the ability to: identify and value differences; acknowledge the interactive dynamics of cultural differences; continuously expand cultural knowledge and resources with regard to populations served; collaborate with the community regarding service provisions and delivery; and commit to cross-cultural training of staff and develop policies to provide relevant, effective programs for the diversity of people served.

Day – A calendar day unless otherwise specified in the Agreement.

Deliverables - Those documents, records, and reports furnished to the Department for review and/or approval in accordance with the terms of the Agreement.

Denial of Services - A determination made by a BH-MCO in response to a Provider's or Member's request for approval to provide a service of a specific amount, duration and scope which:

a. disapproves the request completely, or
b. approves provision of the requested service(s), but for a lesser amount, scope or duration than requested, or
c. disapproves provision of the requested service(s), but approves provision of an alternative service(s), or
d. reduces, suspends, or terminates a previously authorized service.

Note: A denial of a request for service must be based upon one of the following four reasons, along with an explanation for the reason, which must be explicitly stated on the notice of action:

i) The service requested is not a covered service.
ii) The service requested is a covered service but not for this particular recipient (due to age, etc.)
iii) The information provided is insufficient to determine that the service is medically necessary.
iv) The service requested is not medically necessary.

Department/DHS - The Pennsylvania Department of Human Services

DHS Fair Hearing - A hearing conducted by the Department of Human Services, Bureau of Hearings and Appeals in response to an appeal by a BH-MCO Member.

Discretionary Funds (Profit) - Capitation payments and investment income that are not expended for purchase of services for plan Members (State Plan, in lieu of and in addition to services), administrative costs, risk and contingency, equity requirements or reinvestment.

Drug and Alcohol Addictions Professional - A nationally accredited addictions practitioner or a person possessing a minimum of a bachelor's degree in social science and two years' experience in treatment/case management services for persons with substance abuse/addiction disorders.

Eligibility Verification System (EVS) - An automated system available to MA Providers and other specified organizations for on-line verification of MA eligibility, MCO enrollment, third party resources, and scope of benefits.

Emergency Medical Condition - A medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in:

a) placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy,
b) serious impairment to bodily functions, or
c) serious dysfunction of any bodily organ or part.

Emergency Services - Covered inpatient and outpatient services that are furnished by a Provider qualified to furnish such services under the Medical Assistance Program and which are needed to evaluate or stabilize an Emergency Medical Condition.

Enrollment Assistance Program (EAP) - The program responsible to assist MA recipients in enrolling in the HC Program, including the selection of a PH-MCO and Primary Care Practitioner, and obtaining information regarding the HC physical and behavioral health programs.

Enrollment Specialist - The EAP individual who will be responsible to assist recipients with selecting a PH-MCO and Primary Care Practitioner and providing information about the HealthChoices PH and BH programs.

EPSDT - The Early and Periodic Screening, Diagnosis, and Treatment Program for individuals under age 21.

Federally Qualified Health Clinic (FQHC/ Rural Health Clinic (RHC)) – An entity which is receiving a grant as defined under the Social Security Act, 42 U.S.C.A. 1396d(1) or is receiving funding from such a grant under a contract with the recipient of such a grant and meets the requirements to receive a grant under 42 U.S.C.A. 1396d(1).

Federally Qualified Health Maintenance Organization (HMO) – An HMO that CMS has determined is a qualified HMO under section 1310(d) of the PHS Act.
Fee-for-Service (FFS) - Payment by the Department to Providers on a per-service basis for health care services provided to Medical Assistance recipients.

Grievance -A request to have a BH-MCO or utilization review entity reconsider a decision concerning the medical necessity and appropriateness of a covered service. A Grievance may be filed regarding a BH-MCO's decision to 1) deny, in whole or in part, payment for a service; 2) deny or issue a limited authorization of a requested service, including a determination based on the type or level of a service; 3) reduce, suspend, or terminate a previously authorized service; and 4) deny the requested service but approve an alternative service.

Health Care Quality Unit (HCQU) – Serves as the entity responsible to county intellectual disabilities programs for the overall health status of individual screening services in county intellectual disabilities programs.

HealthChoices Behavioral Health (HC-BH) Program – The mandatory managed care program which provides Medical Assistance recipients with Behavioral Health Services in the Commonwealth.

HealthChoices Physical Health (HC-PH) Program – The mandatory managed care program which provides Medical Assistance recipients with physical health services in the Commonwealth.

HealthChoices (HC) *Program* - The name of Pennsylvania's 1915(b) Waiver program to provide mandatory managed health care to Medical Assistance recipients.

HealthChoices Zone (HC Zone) – County groupings designated by the Department for participation in the HC-BH Program.

Health Maintenance Organization (HMO) - A Commonwealth licensed risk-bearing entity which combines delivery and financing of health care and which provides basic health services to enrolled Members for a fixed pre-paid fee.

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

Incentive Arrangement – Any payment mechanism under which a Primary Contractor may receive additional funds over and above the Capitation rates it was paid for meeting targets specified in the Agreement.

Indian Health Care Provider (IHCP) - a health care program operated by the Indian Health Service or by an Indian Tribe, Tribal Organization, or Urban Indian Organization as those terms are defined in section 4 of the Indian Health Care Improvement Act (25 U.S.C. 1603).

Institution for Mental Diseases (IMD) - a hospital, nursing facility, or other institution of more than 16 beds that is primarily engaged in providing diagnosis, treatment or care of persons with mental diseases, including medical attention, nursing care and related services. Whether an institution is an institution for mental diseases is determined by its overall character as that of a facility established and maintained primarily for the care and treatment of individuals with mental diseases, whether or not it is licensed as such.

Interagency Team - A multi-system planning team comprised of the child, when appropriate, the adolescent, at least one accountable family member, a representative of the county mental health and/or drug and alcohol program, the case manager, the prescribing physician or licensed psychologist, in person when possible, or by consultative conference call, and as applicable, representation from the county children and youth, juvenile probation, intellectual disabilities, and drug and alcohol agencies, a representative of the responsible school district, BH-MCO, PHSS and/or PCP, other agencies that are providing services to the child or adolescent, and other community resource persons as identified by the family. The purpose of the Interagency Team is to collaboratively assess the needs and strengths of the child and family, formulate the measurable goals for treatment, recommend the services, treatment approaches and methods, intensity and frequency of interventions and develop the discharge goals and plan.

Joinder - Local authorities of any county who have joined with the local authorities of any other county to establish a county mental health and intellectual disabilities program, subject to the provisions of the Mental Health and Intellectual Disability Act of 1966 (50 P.S. § 4201 et. seq.), or a drug and alcohol program pursuant to the Pa. Drug and Alcohol Abuse Control Act (71 P.S. § 1690.101 et. seq.).

Juvenile Detention Center - A publicly or privately administered, secure residential placement for:

- Children and adolescents alleged to have committed delinquent acts who are awaiting a court hearing;
- Children and adolescents who have been adjudicated delinquent and are awaiting disposition or awaiting placement; and
- Children and adolescents who have been returned from some other form of disposition and are awaiting a new disposition (e.g., court order regarding custody

of child, placement of child, or services to be provided to the child upon discharge from the Juvenile Detention Center).

Limited English Proficient – Enrollees or potential enrollees who do not speak English as their primary language and who have a limited ability to read, write, speak or understand English, may be eligible to receive language assistance for a particular type of service, benefit or encounter.

Long-Term Services and Supports – Services and supports provided to a CHC Member who has functional limitations or chronic illnesses that have a primary purpose of supporting the ability of the CHC Member to live or work in the setting of his or her choice, which may include the individual's home or worksite, a provider-owned or controlled residential setting, a nursing facility, or other institutional setting.

Managed Care Organization (MCO) - An entity that has, or is seeking to qualify for, a comprehensive risk contract under this part, and that is:

(1) A Federally qualified HMO that meets the advance directives requirements of subpart I of part 489 of 42 CFR; or
(2) Any public or private entity that meets the advance directives requirements and is determined by the Secretary to also meet the following conditions:

(i) Makes the services it provides to its Medicaid enrollees as accessible (in terms of timeliness, amount, duration, and scope) as those services are to other Medicaid beneficiaries within the area served by the entity.
(ii) Meets the solvency standards of § 438.116 of 42 CFR

Medically Frail – Includes individuals with disabling mental disorders (including adults with serious mental illness) individuals with chronic substance use disorders, individuals with serious complex medical conditions, individuals with a physical, intellectual or developmental disability that significantly impairs their functioning, or individuals with a disability determination based on Social Security criteria.

Medical Necessity - Clinical determinations to establish a service or benefit which will, or is reasonably expected to:

- prevent the onset of an illness, condition, or disability;
- reduce or ameliorate the physical, mental, behavioral, or developmental effects of an illness, condition, injury, or disability;
- assist the individual to achieve or maintain maximum functional capacity in performing daily activities, taking into account both the functional capacity of the individual and those functional capacities appropriate for individuals of the same age.

Member (Enrollee) - A Medicaid or Medical Assistance recipient who is currently enrolled in the HC-BH Program.

Member Month - One Member covered by the HC Behavioral Health Program for one month.

Mental Health Professional - A person trained in a generally recognized clinical discipline including, but not limited to, psychiatry, social work, psychology, and nursing who has a graduate degree and mental health clinical experience, or a Registered Nurse with at least two years of

mental health clinical experience.

Minority Business Enterprise (MBE) - A business concern which is: a sole proprietorship, owned and controlled by a minority; a partnership or joint venture controlled by minorities in which 51% of the beneficial ownership interest is held by minorities; or a corporation or other entity controlled by minorities in which 51% of the voting interest and 51% of the beneficial ownership interest are held by minorities.

Modified Adjusted Gross Income (MAGI) - MAGI is the adjusted gross income found on an individual's Federal Income Tax form, adjusted for certain items such as student loan deductions, IRA-contribution and deductions for higher education costs.

Multi-County Entity – Two or more counties which form a legally binding incorporated entity, such as a 501(c)(3), which has established Articles of Incorporation and intergovernmental agreements and has a single Agreement with the Department. This entity is established for the purpose of offering Behavioral Health Services for Medicaid eligible recipients under the HealthChoices Program as a Primary Contractor.

Network Provider – Any Provider, group of Providers, or entity that has a Network Provider agreement with the Primary Contractor or its BH-MCO, or a Subcontractor and receives Medicaid funding directly or indirectly to order, refer or render covered services as a result of the Department's contract with the Primary Contractor or its BH-MCO. A Network Provider is not a Subcontractor by virtue of the Network Provider agreement.

On-Site Reviews- A formal review process, periodically undertaken by Department staff and other designated representatives to determine the readiness of the Primary Contractor and a BH-MCO contractor to accept Members and to manage and administer the purchase and provision of Behavioral Health Services under this Agreement.

Out-of-Area Services - State Plan Services provided to a Member while the Member is outside the HealthChoices Zone.

Out-of-Network Provider - A Behavioral Health Services Provider who does not have a written Provider Agreement with the BH-MCO and is therefore not included or identified as being in the BH-MCO's Provider network.

Overpayment - Any payment made to a Network Provider by the Primary Contractor or its BH-MCO to which the Network Provider is not entitled to under Title XIX of the Act or any payment to the Primary Contractor or its BH-MCO by a State to which the Primary Contractor or is BH-MCO is not entitled to under Title XIX of the Act.

Parent - The biological or adoptive mother or father, or the legal guardian of the child, or a responsible relative or caretaker (including resource Parents) with whom the child regularly resides.

Pass-Through Payment - Any amount required by the Department to be added to the contracted payment rates, and considered in calculating the actuarially sound Capitation rate, between the Primary Contractor and hospitals, physicians, or nursing facilities that is not for the following purposes: A specific service or benefit provided to a specific enrollee covered under the

Agreement; a provider payment methodology permitted under 42 CFR § 438.6(c)(1)(i) through (iii) for services and enrollees covered under the Agreement; a subcapitated payment arrangement for a specific set of services and enrollees covered under the Agreement; GME payments; or FQHC or RHC wrap around payments.

Physical Health Managed Care Organization (PH-MCO) - An entity which has contracted with the Department to manage the purchase and provision of physical health services under the HC Program.

Physical Health Service System (PHSS) - Any system by which a Medical Assistance recipient receives physical health services (e.g. Fee for Service, HealthChoices Physical Health and voluntary MCOs.).

Preferred Provider Organization (PPO) - A Commonwealth licensed person, partnership, association or corporation which establishes, operates, maintains or underwrites in whole or in part a preferred provider arrangement, as defined in 31 Pa. Code § 152.2.

Prepaid Inpatient Health Plan (PIHP) - An entity that:

1) Provides services to enrollees under contract with the Department, and on the basis of Capitation payment, or other payment arrangements that do not use State Plan payment rates.
2) Provides, arranges for, or otherwise has responsibility for the provision of any inpatient hospital or institutional services for its enrollees.
3) Does not have a comprehensive risk contract.

Primary Care Practitioner (PCP) - A specific physician, physician group, or a certified registered nurse practitioner operating under the scope of his/her licensure who has received an exception from the Department of Health, responsible for supervising, prescribing and providing primary care services and locating, coordinating, and monitoring other medical care and rehabilitation services, and maintaining continuity of care on behalf of a Member.

Primary Contractor - A county, Multi-County Entity or a BH-MCO which has an Agreement with the Department to manage the purchase and provision of Behavioral Health Services.

Primary Diagnosis - The condition established after study to be chiefly responsible for occasioning the visit for outpatient settings or admission for inpatient settings.

Prior Authorization - A determination made by a Primary Contractor or its BH-MCO to approve or deny a Provider's request to provide a service or course of treatment of a specific duration and scope to a Member prior to the Provider's initiating provision of the requested service.

Prior Authorized Services - State Plan Services for which a BH services Provider must obtain, pursuant to Department approved BH-MCO policies and procedures, the BH-MCO's approval in advance of the Provider's initiating provision of the service.

Priority Population(s) – A specific description of the group(s) is provided in Appendix Q. Generally, however, such populations include: Members with serious mental illness and/or addictive disease, and children and adolescent Members with or at risk of serious emotional disturbance and/or who abuse substances and who, in the absence of effective behavioral health

treatment and rehabilitation services, care coordination and management are at risk of separation from their families through placement in long term treatment facilities, homelessness, or incarceration, and/or present a risk of serious harm to self or others. Drug and alcohol Priority Populations include pregnant injection drug users, pregnant substance users, injection drug users, overdose survivors and veterans.

Private Sector BH-MCO - A Commonwealth licensed BH-MCO which has contracted with the Department or county government to manage the purchase and provision of Behavioral Health Services under this Agreement.

PROMISe- (Provider Reimbursement and Operations Management Information System) is the HIPAA-compliant claims processing and management information system implemented by the Department in March 2004.

Provider – An individual, firm, corporation, or other entity which provides behavioral health or medical services or supplies to Medical Assistance recipients.

Provider Agreement - Any written agreement between the BH-MCO and a Provider or DHS and a Provider to render clinical or professional services to recipients to fulfill the requirement of the Agreement.

Quality Management - A formal methodology and set of activities designed to assess the quality of services provided and which includes a formal review of care, problem identification, and corrective action to remedy any deficiencies and evaluation of actions taken.

Rate Cell – A set of mutually exclusive categories of enrollees that is defined by one or more characteristics for the purpose of determining the Capitation rate and making a Capitation payment; such characteristics may include age, gender, eligibility category, and region or geographic area. Each enrollee should be categorized in one of the rate cells for each unique set of mutually exclusive benefits under the Agreement.

Rating Period - A period of 12 months selected by the Department for which the actuarially sound Capitation rates are developed and documented in the rate certification, submitted to CMS as required by 42 CFR §438.7(a).

Reinvestment Funds - Capitation revenues from DHS and investment income which are not expended during an Agreement period by the Primary Contractor for purchase of services for Members, administrative costs, Risk and Contingency Funds, and equity requirements but may be used in a subsequent Agreement period to purchase start-up costs for State Plan Services, development or purchase of in lieu of and in addition to services or non-medical services, contingent upon DHS prior approval of the Primary Contractor's reinvestment plan.

Related Parties - Any Affiliate that is related to the Primary Contractor or its BH-MCO by common ownership or control (see definition of "Affiliate") and:

(1) Performs some of the Primary Contractor or its BH-MCO's management functions under contract or delegation; or
(2) Furnishes services to Members under a written agreement; or
(3) Leases real property or sells materials to the Primary Contractor or its BH-MCO at

a cost of more than $2,500 during any year of a HealthChoices Behavioral Health Agreement with the Department.

Retrospective Review - A review conducted by the BH-MCO to determine whether or not services were delivered as prescribed and consistent with the BH-MCO's payment policies and procedures.

Risk and Contingency Funds – Capitation payments received by the Primary Contractor pursuant to the Agreement, which are not expended on services (State Plan, in lieu of and in addition to services) or administrative functions and which are in excess of the Equity Reserve required to be maintained under the Agreement. Risk and Contingency Funds do not include Reinvestment Funds, or funds designated in a reinvestment plan submitted to DHS.

Risk Assuming PPO - A Commonwealth licensed PPO which meets the definition of a Risk Assuming PPO pursuant to regulations at 31 Pa. Code § 152.2.

Rural - Consists of territory, persons, and housing units in places which are designated as having less than 2,500 persons, as defined by the US Census Bureau.

Service Management/Manager - The BH-MCO function/staff with responsibility to authorize and coordinate the provision of State Plan Services. Care Management/Manager is synonymous.

Special Needs Populations - Members whose complex medical, psychiatric, behavioral or substance abuse conditions, living circumstances and/or cultural factors necessitate specialized outreach, assistance in accessing services and/or service delivery and coordination on the part of the MCO and its Provider network.

Start Date - The first date on which Members are eligible for Behavioral Health Services under the Agreement, and on which the Primary Contractor is at risk for providing Behavioral Health Services to Members.

State Plan Services – State Plan Services approved by CMS in the State Medicaid Plan, which are included in the HC-BH Capitation rate and are the payment responsibility of the Primary Contractor.

Subcontract - Any contract (except Provider Agreements, utilities, and salaried employees) between the Primary Contractor or a contracting BH-MCO and an individual, firm, university, governmental entity, or nonprofit organization to perform part or all of the BH-MCO's responsibilities.

Subcontractor – An individual or entity that has a contract with a Primary Contractor or its BH-MCO that relates directly or indirectly to the performance of the Primary Contractor or its BH-MCO's obligation under its contract with the Department.

Third Party Liability (TPL) – Any individual, entity, (e.g., insurance company) or program (e.g., Medicare) that may be liable for all or part of a Member's health care expenses.

Title XVIII (Medicare) - The federal health insurance program for people 65 years of age or older, certain younger people with disabilities, and people with end-stage Renal Disease (permanent

kidney failure with dialysis or a transplant, sometimes called ESRD).

Urban - Consists of territory, persons, and housing units in places which are designated as having 2,500 persons or more, as defined by the US Census Bureau. These places must be in close geographic proximity to one another.

Urgent - Any illness or severe condition which under reasonable standards of medical practice would be diagnosed and treated within a 24 hour period and if left untreated, could rapidly become a crisis or emergency situation. Additionally, it includes situations such as when a Member's discharge from a hospital will be delayed until services are approved or a Member's ability to avoid hospitalization depends upon prompt approval of services.

Utilization Management - The process of evaluating the necessity, appropriateness, and efficiency of behavioral health care services against established guidelines and criteria.

Waiver - A process by which a state may obtain an approval from CMS for an exception to a federal Medicaid requirement(s).

Withhold Arrangement - Any payment mechanism under which a portion of a Capitation payment is withheld from the Primary Contractor and a portion of or all of the withheld amount will be paid to the Primary Contractor for meeting targets specified in the Agreement. The targets for a withhold arrangement are distinct from general operational requirements under the Agreement. Arrangements that withhold a portion of a Capitation payment for noncompliance with general operational requirements are a penalty and not a withhold arrangement.

Women's Business Enterprise- A small business concern which is: a sole proprietorship, owned and controlled by a woman; a partnership or joint venture controlled by women in which at least 51% of the beneficial ownership interest is held by women; or a corporation or other entity controlled by women in which at least 51% of the voting interest and 51% of the beneficial ownership interest is held by women.

ACRONYMS

ACA	The Patient Protection and Affordable Care Act and the Health Care Education Reconciliation Act of 2010, as amended
ADA	Americans with Disabilities Act
AFDC	Aid to Families with Dependent Children
AIDS	Acquired Immune Deficiency Syndrome
APA	Alternative Payment Arrangement
APD	Advanced Planning Document
ARD	Accelerated Rehabilitation Decision
ASAM	American Society of Addiction Medicine
ASCII	American Standard Code for Information Interchange
ASD	Autism Spectrum Disorder
BEC	Basic Education Circular
BHEF	Behavioral Health Encounter File
BH-MCO	Behavioral Health Managed Care Organization
BHRS	Behavioral Health Rehabilitation Services for Children and Adolescents
BMWBO	Bureau of Minority and Women Business Opportunities
BNDD	Bureau of Narcotic Drugs and Devices
BSU	Base Service Unit
CAO	County Assistance Office
CASSP	Child and Adolescent Service System Program
CAU	County Administrative Unit
CCBHC	Certified Community Behavioral Health Clinic
CCRS	Consolidated Community Reporting System
CCYA	County Children and Youth Agency

CFO	Chief Financial Officer
CFR	Code of Federal Regulations
C/FST	Consumer/Family Satisfaction Team
CHADD	Children with Attention Deficit Disorders
CHC	Community HealthChoices
CHC-MCO	Community HealthChoices Managed Care Organization
CIS	Client Information System
CISC	Children and Adolescents in Substitute Care
CLIA	Clinical Laboratory Improvement Amendment
CMS	Centers for Medicare and Medicaid Services
COB	Coordination of Benefits
CQI	Continuous Quality Improvement
CRCS	Capitation Rate Calculation Sheet
CRD/LIC	Credentials/License
CRF	Consumer Registry File
CRNP	Certified Registered Nurse Practitioner
CRR	Community Residential Rehabilitation
CSI	Consumer Satisfaction Instruments
CSP	Community Support Program
CST	Consumer Satisfaction Team
C&Y	Children and Youth
D&A	Drug and Alcohol
DAP	Disability Advocacy Program
DDAP	Department of Drug and Alcohol Programs
DEA	Drug Enforcement Agency

DHHS	U.S. Department of Health and Human Services
DHS	Department of Human Services
DME	Durable Medical Equipment
DMIRS	Data Management and Information Retrieval System
DOH	Department of Health
DSH	Disproportionate Share
DSM	Diagnostic and Statistical Manual of Mental Disorders
DUR	Drug Utilization Review
EAP	Enrollment Assistance Program
ECC	Electronic Claims Capture
ECM	Electronic Claims Management
EIN	Employee Identification Number
EMC	Electronic Media Claims
EPSDT	Early and Periodic Screening, Diagnosis and Treatment
EQRO	External Quality Review Organization
ER	Emergency Room
ERISA	Employee Retirement Income Security Act, 1974
EVS	Eligibility Verification System
FA	Fiscal Agent
FBMHS	Family Based Mental Health Services
FFS	Fee-For-Service
FPL	Federal Poverty Level
FQHC	Federally Qualified Health Center
FRR	Financial Reporting Requirements
FST	Family Satisfaction Team

FTE	Full Time Equivalent
FTP	File Transfer Process
FWA	Fraud, Waste and Abuse
GA	General Assistance
GAAP	Generally Accepted Accounting Principles
GME	Graduate Medical Education
HC	HealthChoices
HC BH	HealthChoices Behavioral Health
HC-L/C	HealthChoices Lehigh/Capital
HC N/C	HealthChoices North/Central
HC-NE	HealthChoices Northeast
HCPCS	CMS Common Procedure Coding System
HCQU	Health Care Quality Unit
HC-SE	HealthChoices - Southeast
HC-SW	HealthChoices - Southwest
HEDIS	Healthcare Effectiveness Data and Information Set
HIO	Health Insuring Organizations
HIPAA	Health Insurance Portability and Accountability Act
HIV/AIDS	Human Immuno Deficiency Virus/Acquired Immune Deficiency Syndrome
HMO	Health Maintenance Organization
IBNR	Incurred But Not Reported Claims
ICD	International Classification of Diseases
ICF	Intermediate Care Facility
ICF/ID	Intermediate Care Facilities for Persons with Intellectual Disabilities
ICP	Integrated Care Plan

ID	Insurance Department
IFB	Invitation for Bid
IHCP	Indian Health Care Provider
IMD	Institutions For Mental Diseases
ISP	Individualized Service Plan
JDC	Juvenile Detention Center
JPO	Juvenile Probation Office
L/C	Lehigh/Capital
LEP	Limited English Proficient
LGBTQI	Lesbian, Gay, Bisexual, Transgender, Questioning and Intersex
LTC	Long Term Care
LTSS	Long Term Services and Support
MA	Medical Assistance
MAGI	Modified Adjusted Gross Income
MAID	Medical Assistance Identification Number
MATP	Medical Assistance Transportation Program
MBE	Minority Business Enterprise
MBE/WBE	Minority Business Enterprise/Women Business Enterprise
MCO	Managed Care Organization
MIS	Management Information System
MOE	Method of Evaluation
MPL	Minimum Participating Levels
NCE	Non-Continuous Eligibility
NCQA	National Committee for Quality Assurance
NDC	National Drug Code

NMP	Non-money payment
OBRA	Omnibus Budget Reconciliation Act
OCYF	Office of Children, Youth & Families
ODP	Office of Developmental Programs
OIP	Other Insurance Paid
OMAP	Office of Medical Assistance Programs
OMHSAS	Office of Mental Health and Substance Abuse Services
ORC	Other Related Conditions
OTC	Over the Counter
PCIS	Patient Census Information System
PCO	Private Coverage Organization
PCP	Primary Care Practitioner
PDA	Pennsylvania Department of Aging
PH-MCO	Physical Health Managed Care Organization
PHSS	Physical Health Service System
PIHP	Prepaid Inpatient Health Plan
PIN	Parents Involved Network
PMPM	Per Member Per Month
POM	Performance Outcome Measures
POMS	Performance Outcome Management System
POSNet	Pennsylvania Open Systems Network
PPO	Preferred Provider Organization
PROMISe	Provider Reimbursement and Operations Management Information System in electronic format
PRTF	Psychiatric Residential Treatment Facility

QARI	Quality Assurance Reform Initiative
QM	Quality Management
QMB	Qualified Medicare Beneficiaries
QSF	Quarterly Status File
RBUC	Received But Unpaid Claims
RFP	Request for Proposal
RHC	Rural Health Clinic
RTF	Residential Treatment Facility
SAP	Statutory Accounting Principles
SBP	State Blind Pension
SCA	Single County Authority
SE	Southeast
SMH	State Mental Hospital
SMM	State Medicaid Manual
SNF	Skilled Nursing Facility
SNU	Special Needs Unit
SPR	System Performance Review
SSA	Social Security Administration
SSI	Supplemental Security Income
SSN	Social Security Number
SUD	Substance Use Disorder
SUR	Surveillance and Utilization Review
SURS	Surveillance and Utilization Review System
SW	Southwest
TANF	Temporary Assistance to Needy Families

TPL	Third Party Liability
TTY	Text Telephone Typewriter
UM	Utilization Management
UM/QM	Utilization Management/Quality Management
UPIN	Unique Physician Identification Number
USC	United States Code
WBE	Women's Business Enterprise

PART I. GENERAL INFORMATION

I-1. PURPOSE

The Department is the single state agency with responsibility for the implementation and administration of the Medical Assistance Program (Medicaid or MA). Medicaid is a federal and state program which provides payment of medical expenses for eligible persons who meet income or other criteria.

The purpose of this document is to set forth the standards and requirements for the HC-BH Program operating under CMS Waiver Section 1915(b) of the Social Security Act, through counties that are Primary Contractors.

County governments which demonstrate capacity to meet the standards and requirements for the HC-BH Program are provided the first opportunity to enter into a capitated contract with the Commonwealth (the "Agreement"). Subject to the Department's approval, a county may implement the Agreement directly or enter into a contract with a Private Sector BH-MCO. In areas in which the county is unable to meet the HC-BH Program standards and requirements or chooses not to participate in this initiative, the Department will select a Primary Contractor through a competitive process resulting in a direct contract with a qualified Private Sector BH-MCO.

I-2. ISSUING OFFICE

This document is issued for the Commonwealth by the Office of Mental Health and Substance Abuse Services, Department of Human Services.

I-3. SCOPE

This document describes Behavioral Health Services standards and requirements with which the Primary Contractors and their BH-MCO must comply. It also includes information on the policies and procedures the Department will follow in carrying out its program management and oversight responsibilities.

A county is the smallest geographic unit for which the Department enters into a HealthChoices behavioral health contract, and the Primary Contractor must be capable of delivering specified services to all Members in the county. A Multi-County Entity must identify an entity as the Primary Contractor. The Department will contract with this entity and conduct all business through this entity.

I-4. TYPE of AGREEMENT

The Department enters into a full-risk prepaid capitated contract using a flat fee per Member in the counties. The Primary Contractor is responsible for all medically necessary State Plan Services. Should the Primary Contractor incur costs which exceed the Capitation payments, the Department is not responsible for providing additional funds to cover the deficits. The method of payment is monthly; however, the method of payment will be delayed by one month. Example: A program starts on July 1, 2019; the Capitation payment for the month of July 2019 will be made on or before August 15, 2019. The one

(1) month payment delay will be reconciled upon termination of the Agreement. Negotiations may be undertaken with qualified vendors demonstrating qualifications, responsibility, and capability for performing the contract work as to price and other factors.

Primary Contractors assume risk for providing services to Members upon the effective date of the Agreement. Subject to the availability of state and federal funds, the Department reserves the right to renew the Agreement for additional periods. The Department will notify the Primary Contractor of its intention to renew prior to the expiration of the Agreement.

The Department has the option of entering into a single contract covering all of the counties covered by a Multi-County Entity. In the event of a Multi-County Entity submitting a single proposal, an entity must be identified as the Primary Contractor. The Department will conduct all business through this entity. Under a multi-county arrangement, each county in the Multi-County Entity will be required to sign one contract with the Department. In addition, one multi-county Capitation rate for each rate cell will be developed covering all of the counties in the Multi-County Entity. Risk for one county may not be assumed by another county or counties in the Multi-County Entity. In its contract with the Department, the Multi-County Entity would be held to the same HC-BH Program requirements as counties entering into individual county contracts with the Department. The participating counties will not be required to be contiguous and the Department will permit Multi-County Entities consisting of counties in different HealthChoices Zones. A re-procurement will occur for any county that withdraws from the Multi-County Entity. DHS will select a private sector BH-MCO as a Primary Contractor for that county. The remaining county(ies) in a Multi-County Entity must continue to meet the Department's requirements.

In addition to the multi-county contracting option and in order to ensure efficiency in administrative costs, the Department requires HealthChoices Behavioral Health contractors to cover a minimum of 10,000 HealthChoices Members as follows:

- An individual county with less than 10,000 HealthChoices Members that contracts directly with the Department must contract with a BH-MCO that covers or will cover at least 10,000 HealthChoices Members. The Members covered by the BH-MCO may be from other HealthChoices counties or other HealthChoices Zones.

- A Multi-County Entity that chooses to jointly contract with the Department must cover at least 10,000 HealthChoices Members or must contract with a BH-MCO that covers or will cover at least 10,000 HealthChoices Members.

Requirements of this document are part of the Agreement and are not subject to negotiation by the Primary Contractor. The Department will develop a transition plan should it choose to cancel or not extend a contract with one or more Primary Contractors operating the behavioral health program.

The Department reserves the right to terminate or cancel the Agreement for failure to perform as required by Agreement terms, non-availability of funds, failure to secure/retain necessary federal contract and/or Waiver approvals, or change in applicable federal or Commonwealth law, regulations, public policy, or at the convenience of the Department. A Primary Contractor and its BH-MCO must be able to provide services to all Members

residing within the county or counties that it proposes to serve.

I-5. ON-SITE REVIEWS

The Department periodically conducts On-Site Reviews of selected Primary Contractors and its BH-MCO. The purpose of an On-Site Review is to determine a Primary Contractor and its BH-MCO's initial and ongoing compliance with respect to meeting work statement tasks and program, standards and requirements. The Department reserves the right to suspend implementation of the Agreement and/or Member enrollment for any Primary Contractor or its BH-MCO that does not demonstrate to the Department's satisfaction, compliance with any critical program standard.

I-6. INCURRING COSTS

The Department is not liable for any costs incurred by potential Primary Contractors prior to the implementation date.

I-7. HEALTHCHOICES RATE INFORMATION

The Department releases historical cost data by rate cell and category of service for the various HealthChoices Zones. Additional data and/or information may also be provided to assist the Primary Contractor in constructing or responding to a Capitation rate proposal.

I-8. RESPONSIBILITY TO EMPLOY CASH ASSISTANCE BENEFICIARIES

The Primary Contractor and its BH-MCO shall make a good faith effort to outreach, train, and employ cash assistance beneficiaries in accordance with the provisions of Appendix C.

I-9 SMALL DIVERSE BUSINESS INFORMATION

The Department encourages participation by small diverse businesses as prime contractors and encourages all prime contractors to make a significant commitment to use small diverse businesses as subcontractors and suppliers.

A Small Diverse Business is a Department of General Services -certified minority-owned business, service-disabled veteran-owned business or veteran-owned business, or United States Small Business Administration-certified 8(a) small disadvantaged business concern that qualifies as a small business.

A small business is a business in the United States which is independently owned, not dominant in its field of operation, employ no more than 100 full-time or full-time equivalent employees and earn less than $20 million in gross annual revenues ($25 million in gross annual revenues for those businesses in the information technology sales or service business).

Questions regarding this Program can be directed to:

Department of General Services
Bureau of Small Business Opportunities
Room 611, North Office Building
Harrisburg, PA 17125
Phone: (717) 783-3119
Fax: (717) 787-7052
Email: gs-bmwbo@pa,gov
Website: www.dgs@pa.gov

The DGS directory of Bureau of Diversity, Inclusion, and Small Business Opportunities ("BDISBO")-verified minority, women, veteran and service disabled veteran-owned businesses can be accessed at:
http://www.dgs.internet.state.pa.us/SBPI/AlphaResults.aspx

I-10. CONTRACTOR RESPONSIBILITY and OFFSET PROVISIONS

The Primary Contractor certifies that it is not currently under suspension or debarment by the Commonwealth, any other state, or the federal government.

If the Primary Contractor enters into contracts or employs under this Agreement any Sub-contractors/individuals currently suspended or debarred by the Commonwealth or the federal government or who become suspended or debarred by the Commonwealth or federal government during the term of this Agreement or any extensions or renewals thereof, the Commonwealth shall have the right to require the Primary Contractor to terminate such contracts or employment.

The Primary Contractor agrees to reimburse the Commonwealth for the reasonable costs of investigation incurred by the Office of the Inspector General for investigations of the Primary Contractor's compliance with terms of this or any other agreement between the Primary Contractor and the Department which result in the suspension or debarment of the Primary Contractor. Such costs shall include, but not be limited to, salaries of investigators, including overtime; travel and lodging expenses; and expert witness and documentary fees. The Primary Contractor shall not be responsible for investigative costs for investigations which do not result in the Primary Contractor's suspension or debarment. The Primary Contractor may obtain the current list of suspended and debarred contractors by contacting:

Department of General Services
Office of Chief Counsel
603 North Office Building
Harrisburg, PA 17125
Telephone: (717) 783-6472
FAX: (717) 787-9138

The Primary Contractor agrees that the Commonwealth may offset the amount of any state tax liability or other debt of the Primary Contractor or its subsidiaries owed to the Commonwealth and not contested on appeal against any payment due the Primary

Contractor under this or any other contract with the Commonwealth.

I-11. LOBBYING CERTIFICATION and DISCLOSURE

Commonwealth agencies will not contract with outside firms or individuals to perform lobbying services, regardless of the source of funds. With respect to an award of a federal contract, grant or cooperative agreement exceeding $100,000, or an award of a federal loan or a commitment providing for the United States to insure or guarantee a loan exceeding $150,000, all recipients must certify that they will not use federal funds for lobbying and must disclose the use of non-federal funds for lobbying by filing required documentation. See Lobbying Certification Form and Disclosure of Lobbying Activities Form attached as Appendix D. The Primary Contractor must complete and return the Lobbying Certification Form along with the signed Agreement.

I-12. CONTRACTOR'S CONFLICT OF INTEREST

The Primary Contractor and its BH-MCO must comply with the conflict of interest safeguards described in §438.58 and with the prohibitions described in section 1902(a)(4)(C) of the Act applicable to contracting officers, employees, or independent contractors.

The Primary Contractor and its BH-MCO hereby assures that it presently has no interest and will not acquire any interest, direct or indirect, which would conflict in any manner or degree with the performance of its services hereunder. The Primary Contractor and its BH-MCO further assures that in the performance of this Agreement, it will not knowingly employ any person having such interest. The Primary Contractor and its BH-MCO hereby certifies that no member of its Board of Directors or equivalent authorized governing body, or any of its officers or directors has such an adverse interest.

I-13. PROHIBITED AFFILIATIONS

The Primary Contractor and its BH-MCO may not knowingly have a relationship with the following:

A. An individual or entity who is debarred, 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.

B. An individual or entity who is an Affiliate, as defined in the Federal Acquisition Regulation, of a person described in paragraph (A) above.

C. An individual or entity that is excluded from participation in any Federal health care program under section 1128 or 1128A of the Social Security Act.

For the purpose of this section, "relationship" means the following:

- A director, officer or partner of the Primary Contractor or its BH-MCO.
- A person with beneficial ownership of five percent (5%) or more of the BH-MCO's

equity.

- A person with employment, consulting or other arrangement with the Primary Contractor's or its BH-MCO's obligations under this Agreement.

I-14. INTEREST OF THE COMMONWEALTH AND OTHERS

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

I-15. PRIMARY CONTRACTOR RESPONSIBILITIES

The Primary Contractor is required to assume responsibility for all services offered in this document and Agreement whether it directly provides or contracts for the provision of the services. Further, the Department will consider the Primary Contractor to be the sole point-of-contact with regard to contract matters.

Where the Primary Contractor or its BH-MCO changes ownership or undergoes a major restructuring, including any major change to the submitted organizational chart or acquisition of another MCO, such change must be reported to the Department 30 days prior to the change or within 48 hours of confirmation of the change. Major organizational changes may result in the Department conducting a complete On-Site Review to assess continued adherence to the terms of the Agreement by the new structure. Continuation of the Agreement is contingent on a finding of the On-Site Review that the terms of the Agreement will be adhered to under the change/restructuring.

Office space, equipment, and logistical support are the responsibility of the Primary Contractor. The BH-MCO's administrative offices, from which the program is operated, must be located in close geographic proximity to the county or counties in which State Plan Services are provided.

I-16. FREEDOM OF INFORMATION AND PRIVACY ACTS

The Primary Contractor should be aware that all materials associated with this Agreement may be subjected to the terms of the Freedom of Information Act (5 U.S.C. Section 552 et seq.), the Privacy Act of 1974 (5 U.S.C. Section 552a), the Right-to-Know Law (65 P.S. Section 66.1 et seq.) and all rules, regulations, and interpretations of these Acts, including those from the offices of the Attorney General of the United States, Health and Human Services (HHS), and CMS.

I-17. NEWS RELEASES

News releases pertaining to this initiative will not be made without prior Commonwealth approval, and then only in coordination with the Department.

I-18 COMMONWEALTH PARTICIPATION

The Department's Office of Mental Health and Substance Abuse Services (OMHSAS) provides the Project Office for formal oversight of the HC BH Program. The OMHSAS in collaboration with the Department's Office of Medical Assistance Programs (OMAP) and the Department of Drug and Alcohol Programs (DDAP), provides responses to requests for clarification and questions. The Department will not provide offices space, reproduction facilities, or other logistical support to any Primary Contractor.

The Department provides enrollment and disenrollment activities for the HealthChoices Program by contract as described in Appendix G.

I-19. PROJECT MONITORING

Project monitoring is the responsibility of the OMHSAS, in collaboration with OMAP and DDAP, and/or other offices, as well as consumers, persons in recovery and family members, as determined by the Department. Designated staff coordinates the project, provide or arrange technical assistance, monitor the Agreement for compliance with requirements, the approved Waiver, and program policies and procedures.

In addition to Department oversight, CMS may also monitor the HC-BH Program through its regional office in Philadelphia, Pennsylvania, and its Office of Managed Care in Baltimore, Maryland.

I-20. CHANGES TO CERTAIN APPENDICES

The following Appendices may be updated, from time to time, by the Department through issuance of an operations memo, and/or policy clarification, or through the Department's internet, and does not require an amendment to this Agreement to be effective and enforceable:

- Appendix L: Guidelines for Consumer/Family Satisfaction Teams and Member Satisfaction Surveys
- Appendix O: HealthChoices Data Support for BH-MCOs
- Appendix P: The HealthChoices Behavioral Health Financial Reporting Requirements
- Appendix X: HealthChoices Category/Program Status Coverage Chart
- Appendix V: The HealthChoices Behavioral Health Recipient Coverage Document

1-21. Accreditation by a Private Independent Accrediting Entity

The Primary Contractor and its BH-MCO must inform the Department if it has been accredited by a private independent accrediting entity.

The Primary Contractor and/or its BH-MCO that has received accreditation by a private independent accrediting entity must authorize the private independent accrediting entity to provide the Department with a copy of its most recent accreditation review, including:

- Accreditation status, survey type, and level (as applicable)
- Accreditation results, including recommended actions or improvements, corrective action plans, and summaries of findings; and
- Expiration date of the accreditation.

PART II. WORK STATEMENT – STANDARDS AND REQUIREMENTS

II-1. OVERVIEW

The goal of the HC-BH program is to improve the accessibility, continuity, and quality of services for Pennsylvania's MA populations, while controlling the program's rate of cost increases. The Department intends to achieve these goals by enrolling eligible MA recipients in BH-MCOs which provide a specified scope of benefits to each enrolled Member in return for a capitated payment made on a PMPM basis.

II-2. OBJECTIVES

A. General

The Department is interested in working with counties and/or Private Sector BH-MCOs to administer the mandatory HC-BH Program within each county in the Commonwealth of Pennsylvania.

B. Specific Objectives

The HC-BH Program provides for the delivery of medically necessary mental health, drug and alcohol, and behavioral services. Specific objectives are:

1) Structure Objectives

a. To contract with each of the counties in the HealthChoices Zone, individually or in Multi-County Entities, to manage the purchase and provision of Behavioral Health Services in either one or more of the specified counties.

b. To provide county government the option to directly manage the program through a County Operated BH-MCO or to contract with a Private Sector BH-MCO. Such contracts do not relieve the county of ultimate responsibility for compliance with program and fiscal requirements, including program solvency. Counties may, however, include additional requirements and incentives in their contracts as needed to provide appropriate management oversight and flexibility in addressing local needs.

c. For counties not able to or not interested in contracting for the managed care program, the Department will contract with a Private Sector BH-MCO to directly manage the purchase and provision of Behavioral Health Services to Members.

2) Program Objectives

a. To promote resiliency-oriented and recovery-oriented best-practices that are cost effective.

b. To create systems of care management that are developed based on input from and responsive to the needs of consumers, persons in recovery, and their families representative of the various cultures and ethnic groups in the county, who depend on public services.

c. To provide incentives to implement Utilization Management techniques resulting in expanded use of less restrictive services while assuring appropriateness of care and increasing prevention and early diagnosis and treatment.

d. To promote partnerships between the public and private sectors that take advantage of the public sector's experience in serving persons with the most serious illnesses and disabilities who often have few resources and supports, and the private sector's expertise in managing financial risk for Behavioral Health Services.

e. To remove incentives to shift costs between behavioral health and other publicly funded human service and correctional programs.

f. To create geographic service areas of optimal size for managing risk under Capitation financing which allow for regional variations in program design and result in administrative cost savings.

g. To develop consumer and family satisfaction mechanisms in partnership with consumers, persons in recovery, and their families representative of the diverse ethnic, cultural and disability groups in the county who are affected by mental illness and addictive diseases.

h. To improve coordination of substance abuse and mental health services, including the development of specialized programs for persons with both psychiatric and substance use disorders.

i. To create new integrated partnerships across child serving systems to reduce duplication and increase responsiveness of services to families and their children and adolescents, including coordination with early intervention and early childhood care and education programs.

j. To shift the focus of state monitoring from process management to outcome management with an emphasis on reduction of out-of-home placements for children and adolescents, increased community tenure, improved health status, and improved vocational and educational functioning.

k. To accelerate the administration's state mental hospital rightsizing initiative.

l. To improve coordination of care between physical and Behavioral Health Services including disease management, programs to improve health outcomes, educate consumers and Providers, and increase access to Providers.

II-3. NATURE AND SCOPE OF THE PROJECT

The HealthChoices Program ensures that Members have access to quality physical and Behavioral Health Services while allowing the Commonwealth to stabilize the rate of growth in health care costs. Primary Contractors and their BH-MCOs for the behavioral health component of the HealthChoices Program are responsible for locating, coordinating, and monitoring the provision of designated Behavioral Health Services on behalf of Members.

A. Enrollment Process

1) HealthChoices Behavioral Health Care

Members are enrolled in the BH-MCO operating in their county of residence on or after being determined eligible for MA. Eligible individuals must be enrolled regardless of their race, color, ethnicity, national origin, sex, actual or perceived sexual orientation, gender identity, gender expression or disability. As Members are enrolled, information will be forwarded to the BH-MCO. The BH-MCO must establish mechanisms to inform the CAO of any change or update to the Member's residency or eligibility status within 10 days of the date of learning of the change.

The BH-MCO must have in effect written administrative policies and procedures for newly enrolled Members. The BH-MCO must also have a transition plan and procedure for providing Behavioral Health Services for newly enrolled Members. The Department will provide the BH-MCO with enrollment information for its Members including the beginning and ending effective dates of enrollment. It is the responsibility of the BH-MCO to take necessary administrative steps consistent with the dates determined and provided by the Department to determine periods of coverage and responsibility for services.

As directed by the Department, the BH-MCO must make an effort to conduct an initial screening of each enrollee's needs, within 90 days of the effective date of enrollment for all new enrollees. Subsequent attempts to make an initial screening of enrollee's needs should be made if the initial attempt to contact the enrollee is unsuccessful.

B. HealthChoices Program Eligible Groups

The HC-BH population consists of seven different eligible groups, or aid categories which may change from time to time. Qualification for the HC-BH Program is based on a combination of factors, including family composition, income level, insurance status, and/or pregnancy status, depending on the aid category in question. The scope of benefits and program requirements vary by the MA category. Should the Department choose to implement cost sharing options at a future date, these options may also be determined by MA category.

1) The eligible groups (see Appendix X for details) are:

a. Temporary Assistance to Needy Families (TANF) and TANF-Related MA: A federal block grant program, matched with state funds, which provides cash payments and MA, or MA only (Medically Needy Only and Non-Money Payment), to families which contain dependent children who are deprived of the care or support of one or both Parents due to absence, incapacity, or unemployment of a parent.

b. Healthy Horizons: An MA program which provides non-money payment (NMP) MA and/or payment of the Medicare premium, deductibles, or coinsurance to disabled persons and persons age 65 and over. Exception: An individual who is determined eligible for Healthy Horizons for cost sharing coverage only (categories PG and PL) will not be enrolled in the HC Program.

c. SSI with Medicare: Monthly cash payments made to persons who are aged, blind, or determined disabled for over two years under the authority of Title XVI of the Social Security Act, as amended, Section 1616(A) of the Social Security Act, or Section 212(A) of Pub. L. 93-66. This category automatically receives MA.

d. SSI without Medicare: Monthly cash payments made to persons who are aged, blind, or have been disabled for less than two years and will become eligible for Medicare when the disability has lasted for two years, under the authority of Title XVI of the Social Security Act, as amended, Section 1616(A) of the Social Security Act, or Section 212(A) of Pub. L. 93-66. This category automatically receives MA.

e. SSI-Related: An MA category which has the same requirements as the corresponding category of SSI. Persons who receive MA in

SSI-Related categories are aged, blind or disabled. This includes Medically Needy Only and Non-Money Payment.

f. State-Only GA: A state funded program which provides cash grants and MA (Categorically Needy) or MA only (Medically Needy Only and Non-Money Payment) to Pennsylvania individuals and families whose income and resources are below established standards and who do not qualify for the TANF program.

g. Eligible Groups Under MAGI Rule: MG 00 – Children ages 1-5 inclusive and income at or below 157% FPL. Youth ages 6-18 inclusive and income at or below 119%. Infants and pregnant women at or below 215% FPL. MG19 – Youth ages 6-18 inclusive with income at or below 119% FPL. MG27 – Income at or below 33% FPL. MG 71 – Transitional Medical Assistance.

h. Newly Eligible Groups Under ACA

Childless adults with income less than or equal to 133% of the applicable FPL.

Parents and designated care takers and individuals ages 19 or 20 with income between 4% and 133% of the applicable FPL.

2) MAGI Recipient

The Department will make Capitation payments to the Primary Contractor for eligible Members having a category of assistance "MG" at the TANF rate that is appropriate for the age of the Member.

3) Eligibility Determination

The Department has sole authority for determining whether individuals or families meet any of the eligibility criteria specified in items a. through i. above. The Department performs eligibility determination using trained eligibility staff. These individuals are stationed at CAOs located throughout the Commonwealth.

4) Guaranteed Eligibility

Individuals who attain eligibility due to a pregnancy are guaranteed eligibility for comprehensive services through the last day of the month in which the 60 days postpartum or post-loss of pregnancy period ends and their newborns are guaranteed coverage for one year, as long as mother and child continue to live together during that year.

5) Involuntary Mental Health Commitment

Whenever a Member residing in one HealthChoices county is made subject

to involuntary examination and/or treatment in another HealthChoices county, the BH-MCO in the county in which the Member resides shall be responsible for the cost of examination and/or involuntary treatment provided in the other county. The BH-MCO providing services in the county in which the HealthChoices Member resides shall abide by the examination and/or involuntary treatment decisions made in the county in which services are rendered. The BH-MCO in the county where the Member receives examination and/or treatment shall notify the Member's BH-MCO within 24 hours of commitment.

6) Placement of Adults and Children NOT in Substitute Care in Behavioral Health Residential Treatment Facilities (see Appendix V – H.).

7) Children and Adolescents in Substitute Care Issues (see Appendix V – H.)

8) For children and adolescents placed in a juvenile detention facility, the BH-MCO is responsible for medically necessary State Plan Services delivered in treatment settings outside (off site) the juvenile detention facility during the first 35 consecutive days of detention. However, the BH-MCO is not responsible at any time for services delivered within the juvenile detention facility.

9) Children whose adoptions have been finalized and for whom the CCYA is continuing to provide support through an adoption assistance agreement with the adoptive Parents residing in the HC Zone are to be enrolled in the BH-MCO of the county where the adoptive family resides.

10) The BH-MCO will be required to pay for medically necessary Behavioral Health Services for Members provided within a private Intermediate Care Facility for persons with intellectual disabilities (ICF/ID) facility within the HC Zone.

11) In order to serve an individual less than 21 years of age in a psychiatric hospital setting and be reimbursed through Medical Assistance for the services, the facility must be accredited by a national accrediting organization approved by CMS or undergo a State survey conducted by the Department of Health to determine whether the hospital meets the requirements to participate in Medicare (or Medicaid) as a psychiatric hospital under 42 CFR §482.60.

C. Rating Period

A period of 12 months selected by the Department for which the actuarially sound Capitation rates are developed and documented in the rate certification submitted to CMS as required by §438.7(a)

For the second, fourth and fifth rating periods, the Department will adjust Capitation rates, if necessary, to maintain actuarial soundness based upon a material and demonstrated impact caused by any or all of the following:

Changes in medical costs;

1) Changes in utilization patterns; or

3) Programmatic changes that affect the Primary Contractor and/or its BH-MCO's delivery or coverage of benefits.

In the event that no adjustments are made, pursuant to C.1), 2) or 3) above, the rates applicable to the previous rating period will apply. The Department will disclose to the Primary Contractor the basis and assumptions of its determination with respect to adjustments to the second, fourth and fifth rating period rates.

At the Department's discretion, Capitation rates may be negotiated for the third rating period. In the event the Department does not negotiate Capitation rates for the third rating period, the Department will adjust Capitation rates, if necessary, as provided for the second, fourth and fifth rating period.

If agreement is not reached prior to the start of an Agreement period, the rates applicable to the previous rating period will continue to apply until new rates are agreed upon and effective.

If the Department exercises its option to renew the Agreement for an additional three year period, pursuant to Part I-4, rate negotiations will commence promptly after notice of same for the sixth rating period. Capitation rates will be adjusted for the seventh and eighth rating period.

The Department reserves the right to expand or contract the scope of the HealthChoices Program during the term of the Agreement to include additional services or reduce services, or covered populations.

D. Termination/Cancellation

The Department reserves the right to terminate or cancel the Agreement for failure to perform as required by Agreement terms, non-availability of funds, failure to secure/retain necessary federal contract and/or Waiver approvals, or change in applicable federal or Commonwealth law, regulation, public policy, or at the option of the Department.

For Agreements with an individual county, DHS requires the Primary Contractor to provide a minimum of 120 days' notice of intent to terminate the Agreement. For an Agreement with a Multi-County Entity, DHS requires a minimum of 180 days' notice in the event the Primary Contractor intends to terminate the Agreement and also if one or more counties intend to withdraw from the Multi-County Entity during the Agreement period. The Agreement will remain in effect for the remaining counties who continue to meet Department requirements and the rates will be recalculated accordingly.

In the event a county or county group intends to release a Request for Proposal

(RFP) in order to reprocure a BH-MCO, OMHSAS requires the Primary Contractor to provide written notice 180 days before the effective date of the Initial Term of the Agreement between the Primary Contractor and selected BH-MCO.

Upon termination/Cancellation or expiration of the Agreement, the Primary Contractor must:

1) Provide the Department with all information deemed necessary by the Department within 30 days of the request;

2) Be financially responsible for Provider claims with dates of service through the day of termination, except as provided in D.3) below, including those submitted within established time limits after the day of termination;

3) Be financially responsible for Members placed in inpatient and residential treatment facilities through the dates specified in Section E of the HC-BH Recipient Coverage Document (Appendix V).

4) Be financially responsible for services rendered through 11:59 p.m. on the day of termination, except as provided in D.3) above, for which payment is denied by the BH-MCO and subsequently approved upon appeal by the Provider; and

5) Arrange for the orderly transition of Members and records to those Providers who will be assuming ongoing care for the Members.

During the final quarter of the Agreement, the Primary Contractor and its BH-MCO will work cooperatively with, and supply program information to, any subsequent Primary Contractor. Both the program information and the working relationship between the Primary Contractors will be defined by the Department.

E. Compliance with Federal and State Laws, Regulations, Department Bulletins and Policy Clarifications

The Primary Contractor and its BH-MCO must assure that Network Providers delivering State Plan Services participate in the MA program and, in the course of such participation, provide those services essential to the care for individuals being served, and comply with all federal and state laws generally and specifically governing participation in the Medical Assistance Program. The Primary Contractor's BH-MCO and Behavioral Health Services Providers must also agree to comply with all applicable Department regulations and policy bulletins and clarifications. The Primary Contractor and its BH-MCO and its Subcontractors must agree to comply with all applicable federal and state laws and regulations including: Title VI and VII of the Civil Rights Act of 1964 (42 U.S.C. Section 2000 d. et. seq. and 2000 e. et. seq.); Section 504 of the Rehabilitation Act of 1973 (29 U.S.C. Section 701 et. seq.); The Age Discrimination Act of 1975 (42 U.S.C. Section 6101 et. seq.); the Americans with Disabilities Act of 1990 as amended (42 U.S.C. Section 12101 et. seq.) (ADA) the Pennsylvania Human Relations Act of 1955 (71 P.S. Section 941 et. seq.); The Pennsylvania Managed Care Consumer Protection Act

(Act 68) of 1998 (Article XXI of the Insurance Company Law of 1921, as amended, 40 P.S. 991.2101 et. seq.); as amended and Title IX of the Education Amendment of 1972 (regarding education programs and activities), 45 CFR Parts 160 and 164 (Standards for Privacy of Individually Identifiable Health Information) and 45 CFR Part 74, Appendix A and section 1557 of the Patient Protection and Affordable Care Act.

The Primary Contractor and/or its BH-MCO agrees to comply with future changes in federal and state laws, federal and state regulations, Medicaid State Plan, Federal Waivers and Department requirements and procedures related to changes in the Medicaid program.

The Primary Contractor and/or its BH-MCO must comply with the requirements mandating Provider identification of Provider-preventable conditions as a condition of payment, as well as the prohibition against payment for Provider-preventable conditions as set forth in 42 CFR §438.3(g) and §447.26. The Primary Contractor and its BH-MCO must report all identified provider-preventable conditions in a form and frequency as specified by the Department.

F. False Claims

The Primary Contractor recognizes that payments by the Department to the Primary Contractor will be made from federal and state funds and that any false claim or statement in documents or any concealment of material fact may be a cause for prosecution under applicable federal and state laws. Payments are contingent upon availability of state and federal funds.

G. Major Disasters or Epidemics

In the event of a major disaster or epidemic as declared by the Governor of the Commonwealth, the Primary Contractor and its BH-MCO shall require Providers to render all services provided for in this document and the Agreement as is practical within the limits of Providers' facilities and staff which are then available. The Primary Contractor and its BH-MCO shall have no obligation or liability for any Provider's failure to provide services or for any delay in the provision of services when such a failure or delay is the direct or proximate result of the depletion of staff or facilities by the major disaster or epidemic.

H. Performance Standards and Damages

1) Performance Standards for the HC BH Program

Performance standards for the HC BH Program are included throughout this document. Additional standards may be developed for inclusion in subsequent related contracts. The Primary Contractor may develop performance standards consistent with this document. The Department reserves the right to institute incentive payments related to performance standards in the future.

2) Corrective Actions

The Department may take corrective actions for non-compliance with, or failure to meet performance and program standards indicated in the Agreement and/or subsequent related agreements, including but not limited to:

a. Requiring the Primary Contractor to submit a corrective action plan.
b. Imposing sanctions,
c. Imposing liquidated damages as set forth in the Agreement,
d. Suspension or denial of payments,
e. Terminating the Agreement.

3) CMS Review and Approval

The Department must submit to CMS for review and approval, the Primary Contractor's rate certifications concurrent with the review and approval process for HC BH Agreements as specified in §438.3(a).

The Department may take corrective actions as set forth in section H.2 above if signed HC BH Agreements or amendments are not returned to the Department by a date specified. As specified in §438.3(a), proposed final Agreements must be submitted to CMS for review no later than 90 days prior to the effective date of the Agreement.

4) Profit, Discretionary Funds and Reinvestment Arrangement

a. Counties and Multi-County Entities as Primary Contractors and management or oversight entities formed by or organized on behalf of the counties or Multi-County Entities are not permitted to retain any Discretionary Funds. After the closure of each Agreement period, any county or Multi-County Entity's Discretionary Funds which have not been included in a DHS approved reinvestment plan must be returned to DHS (Appendix N, Reinvestment Parameters)

b. BH-MCOs as Primary Contractors to DHS or Private Sector BH-MCOs as contractors to a county are permitted to retain profit in accordance with the terms of their contract with the Primary Contractor. Profit will be monitored by DHS and will be a factor in future DHS rate adjustments and negotiations with the Primary Contractor.

II-4. TASKS

A. State Plan Services

The program includes medically necessary mental health, substance abuse and behavioral services.

1) The BH-MCO shall provide timely access to behavioral health diagnostic, assessment, referral, and treatment services for Members. At a minimum, State Plan Behavioral Health Services must be provided in the amount, duration and scope set forth in the MA FFS Program and be based on the Recipient's benefit package, unless otherwise specified by the Department. The BH-MCO must ensure that the services are sufficient in amount, duration, or scope to reasonably be expected to achieve the purpose for which the services are furnished. Additionally, all medically necessary 1905(a) services that correct and ameliorate mental illness and conditions or substance use disorders are covered for EPSDT-eligible beneficiaries ages birth to twenty-one, in accordance with 1905(a) of the Social Security Act. If services or eligible consumers are added to the Pennsylvania MA Program or HC program, or if covered services or eligible consumers are expanded or eliminated, implementation by the BH-MCO must be on the same day as Department's unless the BH-MCO is notified by the Department of an alternative implementation date.

2) The Primary Contractor and its BH-MCO must require that Network Providers offer hours of operation that are no less than the hours of operation offered to commercial members or comparable to MAFFS, if the Provider serves only MA Members. Hours of operation should be flexible in order to accommodate the particular scheduling needs of Members (i.e. inclusion of evening and/or weekend hours). In addition, Providers must have services available 24 hours a day, seven days a week when medically necessary.

3) The Primary Contractor or its BH-MCO must have procedures for authorization and payment for State Plan Services, which are required but not available within the Provider network and for providing Emergency Services for Members who are temporarily out of the HealthChoices Zone.

4) Member Liability

a. Members will not be held liable for:

i) State Plan Services provided to the Member for which the Department does not pay the Primary Contractor.

ii) State Plan Services provided to the Member for which the Department does not pay the individual or health care Provider that furnishes the services under a contractual, referral, or other arrangement.

iii) State Plan Services to the extent that those payments are in excess of the amount that the Member would owe if the Primary Contractor or its BH-MCO provided the services directly.

b. The Primary Contractor and its BH-MCO must coordinate with and

make timely payments to Out-of-Network Providers for medically necessary covered services as otherwise provided for in this Agreement, including, but not limited to, when:

i) Services were rendered to treat an Emergency Medical Condition;

ii) Services were prior authorized;

iii) Services were not available in network;

iv) The Primary Contractor and its BH-MCO denied Prior Authorization of services but the Department determined, after a hearing, that the services should have been authorized.

c. The Primary Contractor and its BH-MCO may not impose any cost to the Member for using an Out-of-Network Provider that is greater than what the costs would have been if a Network Provider furnished the services.

5) The Primary Contractor or its BH-MCO must provide comprehensive Service Management, with clear access and lines of authority. Each Member's plan of care, including the commencement, course, and continuity of treatment and support services, must be documented in such a way as to permit effective review of care and demonstrate care coordination with services covered by the Primary Contractor or its BH-MCO.

6) For Priority Populations, a clearly defined program of care which incorporates longitudinal and disease state management is expected. In addition, evidence of a coordinated approach must be demonstrated for those persons with co-existing mental health and drug and alcohol conditions as well as for older adults with psychiatric and substance use disorders, particularly those with co-existing physical impairments, and other Special Needs Populations who experience mental health and/or drug and alcohol disorders (e.g., persons with intellectual disabilities, homeless persons, persons diagnosed with Autism Spectrum Disorder (ASD), persons discharged from correctional facilities, persons with HIV/AIDS and physical disabilities).

7) The Primary Contractor or its BH-MCO is required to maintain 24 hour telephone accessibility, staffed at all times by qualified personnel, to provide information to Members and Providers, and to provide screening and referral, as necessary.

a. There must be 24 hour capacity for service authorization.
b. There must be 24 hour access to a physician for psychiatric and drug and alcohol clinical consultation and review.
c. All Member and Provider calls must be answered within 30

seconds.

d. Separate Member and Provider telephone lines are permitted.

e. The Member line must be answered by a live voice at all times.

f. BH-MCOs serving multiple counties in a HealthChoices Zone may establish a regional network with one telephone line for Member calls and one line for Provider calls.

g. Separate record keeping must be established for tracking and monitoring of both Provider and Member phone lines.

8) The Primary Contractor or its BH-MCO must have procedures for reminders, follow-up, and outreach to Members including:

a. Home visits and other methods to encourage use of needed services by Members who do not keep appointments, including notification of upcoming appointments.

b. Population groups with special needs and/or groups who under use needed Behavioral Health Services, such as older persons, persons who are homebound or homeless adults with intellectual disabilities, and persons diagnosed with ASD.

c. Administrative mechanisms for sending copies of information, notices and other written materials to an additional party upon the request and signed consent of the Member.

9) The Primary Contractor or its BH-MCO must have procedures to determine the EPSDT screen status for children receiving Behavioral Health Services. Referral to the child's PH-MCO PCP must be made for children whose EPSDT screens are not current, based on the American Academy of Pediatrics periodicity schedule. The BH-MCO must have procedures to collect and report EPSDT screen referral and status information.

10) A Primary Contractor or its BH-MCO that would otherwise be required to provide, reimburse for, or provide coverage of, a counseling or referral service, is not required to do so if the BH-MCO objects to the service on moral or religious grounds.

If the Primary Contractor or its BH-MCO elects not to provide, arrange for the provision of, or make payment for, a counseling or referral service because of an objection on moral and religious grounds, it must:

a. Furnish information to the Department describing the service(s) it does not cover:

i. include this information with its application for a Medicaid contract;

ii. notify the Department whenever it adopts the policy during the term of the Agreement.

b. Notify Members with the identity of the excluded services:

i. within 90 days of adopting the policy with the projected effective date; but
ii. at least 30 days before the effective date of the policy.

c. Inform Members how they can obtain information from the Department about how to access the excluded services.

B. In Lieu Of and In Addition To Services

The Primary Contractor or its BH-MCO may develop or purchase in lieu of or in addition to services that are not State Plan Services. Information regarding the enrollment process for providers of in lieu of or in addition to services is included in Appendix Z.

1) In Lieu Of Services

The Department may determine that certain in lieu of services, which are medically necessary and cost-effective alternatives to State Plan services or settings, may be provided by the Primary Contractor and its BH-MCO. The Primary Contractor and its BH-MCO are not required to provide in lieu of services but have the option to provide these approved services. If the Department approves the provision of in lieu services:

a. The Primary Contractor and its BH-MCO may not require its Members to use the in lieu of services.

b. The Department will take utilization and actual cost of in lieu of services into account when developing the relevant service component of the Capitation rate.

c. In lieu of services must be authorized and approved by the Department. Annually, the Department will provide to the Primary Contractor a list of approved in lieu of services that will be taken into account in developing the relevant service component of the Capitation rate.

e. The most commonly approved services include:
- Freestanding psychiatric facilities with more than 16 beds serving 21 – 64 year olds (Section 1.c does not apply).
- Non-hospital drug and alcohol rehabilitation (Section 1.c does not apply)
- Assertive Community Treatment
- Psychiatric Rehabilitation Services

Other approved in lieu of services, which may vary by Primary Contractor, may be provided in accordance with this section 1.a thru d. above.

2) In Addition To Services

The Primary Contractor and its BH-MCO may voluntarily cover services that are in addition to those covered under the State Plan and in lieu of services. The cost of these services will not be included when the payment rates are determined pursuant to 42 CFR §438.3.

C. Coordination of Care

1) The BH-MCO, CHC-MCO and the PHSS, operating in the county(ies) covered by the BH-MCO, are required to develop and implement written agreements regarding the interaction and coordination of services provided to Members. These agreements must be submitted to and approved by the Department. Complete agreements, including operational procedures, must be available for review by the Department at the time of On-Site Review. The agreements must be submitted for final review and approval to the Department at least 30 days prior to the implementation of the CHC Program in a new CHC Zone. The written agreements should include, but not be limited to:

a. Procedures which govern referral, collaboration, and coordination of diagnostic assessment and treatment, prescribing practices, the provision of emergency room services, and other treatment issues necessary for optimal health and prevention of illness or disease. The PHSS, CHC-MCO and the BH-MCO must collaborate in relation to the provision of Emergency Services; however, Emergency Services provided in general hospital emergency rooms are the responsibility of the Member's PHSS or CHC-MCO, regardless of the diagnosis or services provided. The only exception is for emergency room evaluations for voluntary or involuntary commitment pursuant to the 1976 Mental Health Procedures Act which will be the responsibility of the BH-MCO. Responsibility for inpatient admission will be based upon the Member's Primary Diagnosis. Procedures must define and explain how payment will be shared when the Member's Primary Diagnosis changes during a continuous hospital stay.

b. Procedures, including Prior Authorization, which govern reimbursement by the BH-MCO to the PHSS or CHC-MCO for HealthChoices Behavioral Health Services provided by the PHSS or CHC-MCO, or reimbursement by the PHSS or CHC-MCO to the BH-MCO for physical health services provided by the BH-MCO, and the resolution of any payment disputes for services rendered. Procedures must include provisions for assessment of persons with co-existing physical and behavioral health disorders, as well as provision for cost-sharing when both behavioral and physical health services are provided to a Member by a service Provider.

c. Procedures for the exchange of relevant enrollment and health-related information among the BH-MCO, the PHSS, CHC-MCO, the PCP, and BH, PH, and LTSS service Providers in accordance with

federal and state confidentiality laws and regulations (e.g., periodic treatment updates with identified primary and relevant specialty Providers).

d. Policy and procedures for obtaining releases to share clinical information and providing health records to each other as requested consistent with state and federal confidentiality requirements.

e. Procedures for training and consultation to each other to facilitate continuity of care and cost-effective use of resources.

f. A mechanism for timely resolution of any clinical and fiscal payment disputes; including procedures for entering into binding arbitration to obtain final resolution.

g. Procedures for serving on Interagency Teams, as necessary.

h. Procedures for the development of adequate Provider networks to serve Special Needs Populations and coordination of specialized service plans between the BH-MCO service managers and/or service Provider(s) and the PHSS or CHC-MCO PCP for Members with special health needs (e.g. children and adolescents in medical foster care, older Members with coexisting physical and behavioral health disorders such as asthma, diabetes, chronic obstructive pulmonary disease, coronary artery disease, congestive heart failure and a serious mental illness or ASD).

i. The BH-MCO is required to provide behavioral health crisis intervention and other necessary State Plan Services to Members with behavioral health Emergency Medical Conditions. The PHSS or CHC-MCO is responsible for payment of all emergency and medically necessary non-emergency ambulance services. The PHSS or CHC-MCO and BH-MCO must establish clear procedures for coordinating the transport and treatment of persons with behavioral health Emergency Medical Conditions who initially present themselves at general hospital emergency rooms to appropriate behavioral health facilities.

j. Procedures for the coordination of laboratory services.

k. Mechanisms and procedures to ensure coordination between the BH-MCO service managers, Member services staff and Provider network with the PHSS special needs unit and CHC-MCO Coordinator. The effectiveness of these mechanisms shall be included as an area for review by the BH-MCO Quality Management program and the PHSS Quality Management program.

l. Procedures for the PHSS and CHC-MCO to provide physical examinations required for the delivery of Behavioral Health Services, within designated timeframes for each service.

m. Procedures for the interaction and coordination of pharmacy services to include:

   i) All pharmacy services are the payment responsibility of the Member's PHSS or CHC-MCO. All prescribed medications are to be dispensed through PHSS or CHC-MCO network pharmacies. This includes drugs prescribed by the PHSS, and/or the CHC-MCO, and the Primary Contractor Providers. The only exception is that the Primary Contractor

is responsible for the payment of methadone when used in the treatment of substance use disorders and when prescribed and dispensed by Primary Contractor service Providers;

ii) Neither the PHSS, CHC-MCO nor the Primary Contractor is billed for medications administered during the course of an inpatient stay. Inpatient rates include the cost of all pharmaceuticals. Hospital inpatient rates are calculated to include ancillary costs, which are included in the per diem. Medications dispensed on an inpatient unit are an ancillary cost.

The PHSS or CHC-MCO may only restrict pharmacy services prescribed by a BH-MCO Provider if one of the following exceptions is demonstrated:

a) The drug is not being prescribed for the treatment of substance abuse/dependency/addiction or mental illness or to treat the side effects of psychopharmacological agents. Those drugs are to be prescribed by the PHSS or CHC-MCO PCP or specialists in the Member's physical care health network;

b) The prescribed drug does not conform to standard rules of the pharmacy services plan; e.g., use of generic or cost effective alternative(s), purchases from certain pharmacies, and quantity limited to a 30-day supply;

c) The drug is prescribed by a behavioral health Provider identified as not having a signed Provider Agreements with the BH-MCO; or

d) The prescription has been identified as an instance of fraud, abuse, gross overuse, or is contraindicated because of potential interaction with other medications.

iii) There must be BH-MCO representation on each HC PH-MCO's and CHC-MCO's panel of physicians and other clinicians selecting the PH-MCO formulary. The PH-MCOs and CHC-MCOs formularies or the reimbursable methods of administering drugs (e.g., use of injectables) must be reviewed and approved by OMAP, OLTL and OMHSAS prior to program implementation and for any subsequent change;

iv) procedures for monitoring behavioral health pharmacy services provided by the PHSS and CHC-MCO;

v) procedures for notifying each other of all prescriptions, and when deemed advisable, consultation between practitioners before prescribing medication, and sharing complete, up-to-date medication records;

vi) procedures for the timely resolution of any disputes which

arise from the payment for or use of pharmaceuticals (e.g., use of anticonvulsant medication as a mood stabilizer) including a mechanism for timely impartial mediation when resolution between the PHSS or CHC-MCO, and BH-MCO does not occur;

vii) procedures for sharing independently developed Quality Management/Utilization Management information related to pharmacy services, as applicable;

viii) policies and procedures to collaborate in adhering to a drug utilization review (DUR) program approved by the Department. This system is based on federal statute/regulations [Section 4401(g) of OBRA 1990, Section 4.26, guidelines 1927(g), 42 CFR 456]; and

ix) procedures for the BH-MCO to collaborate with the PHSS and/or CHC-MCO in identifying and reducing the frequency of patterns of fraud, abuse, gross overuse, or inappropriate or medically unnecessary care among physicians, pharmacists, and Members associated with specific drugs. Areas for particular attention include potential and actual adverse drug reactions; therapeutic appropriateness; over and under drug use; appropriate use of generic products; therapeutic duplication; drug/disease contraindications; drug to drug interactions; incorrect drug dosage or duration of treatment; drug allergy reactions; and clinical abuse/misuse.

x) The BH-MCO is required to provide the PHSS and/or CHC-MCO, upon its request, a listing of the physicians in its initial Provider network and, on a quarterly basis, changes including terminations and additions.

2) The BH-MCO must ensure through its Provider Agreements that its Providers interact and coordinate services with the PHSS and/or CHC-MCO and their PCPs.

Behavioral health clinicians, LTSS Providers, and PCPs have the obligation to coordinate care of mutual patients. Consistent with state and federal confidentiality laws and regulations, both must:

a. Ascertain the Member's PCP, and/or relevant physical health specialist, or behavioral health clinician, and/or LTSS Providers and obtain applicable releases to share clinical information.
b. Make referrals for social, vocational, education, or human services when a need for such service is identified through assessment.
c. Provide health records to each other, as requested.
d. Comply with the agreement between the BH-MCO and the PHSS and/or CHC-MCO to assure coordination between behavioral and physical health care including resolution of any clinical dispute.
e. Be available to each other for consultation.

3) HealthChoices Behavioral Health/Physical Health/LTSS Coordination

The Primary Contractor and its BH-MCO must work in collaboration with the PH-MCOs and CHC-MCOs through participation in joint initiatives to improve overall health outcomes of its Members and those activities that are prescribed by the Department.

4) Physical Health Medical Care

The Member's PHSS has a comprehensive benefit package provided in a manner comparable to the amount, duration, and scope set forth in the MA FFS program, unless otherwise specified by the Department. The comprehensive benefit package includes inpatient and outpatient hospital services, physician services, family planning services, prescription drugs, radiology, and other diagnostic and treatment services, outreach and follow-up, preventive care, home health services, and emergency transportation. Specific PHSS State Plan benefits include:
EPSDT services; emergency room services; physical examinations to determine abuse or neglect; AIDS Waiver program services for MA eligibles; HIV/AIDS targeted case management; medical foster care; medical services to HealthChoices Members, including Members placed in:

a. privately-operated ICF/IDs, and in ICF for persons with other related conditions;
b. mental health residential treatment facilities;
c. acute and extended acute psychiatric inpatient facilities;
d. non-hospital residential detoxification, rehabilitation and half-way house services for drug/alcohol abuse or dependence; and
e. juvenile detention facilities for up to 35 days.

All emergency room services in general hospitals are the responsibility of the Member's PHSS, regardless of the diagnosis or services provided except for evaluations for voluntary or involuntary commitment pursuant to the 1976 Mental Health Procedures Act. Such evaluation is the responsibility of the BH-MCO pursuant to the terms of the written agreement described in Section II-4.C.1.a. Responsibility for ensuring admissions will be based on the Member's Primary Diagnosis.

All emergency and non-emergency medically necessary ambulance transportation for both physical and Behavioral Health Services is the responsibility of the Member’s PHSS even when the diagnosis is provided by the BH-MCO.

5) Community HealthChoices Coordinator

The Primary Contractor or its BH-MCO must appoint a behavioral health professional as a CHC Coordinator whose primary function includes:

- Coordinate Members’ care needs with the CHC-MCO.

- Develop a process to coordinate behavioral healthcare between the BH-MCO and the CHC-MCO.
- Participate in the identification of best practices for behavioral health in a primary care setting.

6) Public Psychiatric Hospitalization

The Primary Contractor and its BH-MCO are not responsible for civil and forensic psychiatric hospitalizations at a state mental hospital are not covered by the Primary Contractor or its BH-MCO. However, the Primary Contractor and its BH-MCO shall coordinate with the state mental hospital and county mental health authority, as applicable, to develop and implement admission and discharge planning for the appropriate admissions and timely discharges and continuity of care for the Member.

7) Emergency Services: Coverage and Payment

The Primary Contractor and its BH-MCO may not deny payment for Emergency Services obtained when a representative of the entity instructs the Member to seek Emergency Services. Payment for non-participating Providers for emergency services must not be more than the amount that would have been paid if the services had been provided under the Department's MA FFS program.

The Primary Contractor and its BH-MCO may not limit what constitutes an Emergency Medical Condition on the basis of lists of diagnoses or symptoms.

The Primary Contractor and its BH-MCO may not refuse to cover Emergency Services based on the emergency room Provider, hospital or fiscal agent not notifying the Member's BH-MCO of the Members screening and treatment within 10 calendar days of presentation for Emergency Services.

A Member who has an Emergency Medical Condition may not be held liable for payment of subsequent screening and treatment needed to diagnose the specific condition or stabilize the patient. Responsibility for inpatient admission will be based upon the Member's Primary Diagnosis.

The attending emergency physician, or the Provider actually treating the Member, is responsible for determining when the Member is sufficiently stabilized for transfer or discharge and the determination is binding on the Primary Contractor and its BH-MCO.

8) The Primary Contractor or its BH-MCO must enter into a written agreement with the CCYA to include, at a minimum:

a. Procedures for referral, authorization and coordination of care, including overall requirements for children and adolescents in substitute care and specific requirements for referral, review of Medical Necessity prior to admission to and coordination of care

following discharge from accredited and non-accredited RTF services, and D&A non-hospital residential rehabilitation and detox programs.

b. Liaison relationships for individual cases and administration.
c. Release of records and BH-MCO representation in court.
d. Procedures to assure continuity of behavioral health care for children in substitute care at the time of program start-up.
e. Procedures to communicate denials of service by the BH-MCO.
f. Provision of BH-MCO Provider directories, including electronic transmission where children and youth agency capacities exist.

9) For children and adolescents who are served by multiple child serving systems, the Primary Contractor or its BH-MCO must:

a. Have well publicized written policies and procedures explaining the Primary Contractor or its BH-MCO is available to attend or convene Interagency Team meetings, at the request of or with the consent of the parent or custodian.
b. Treat as a formal request for service a prescriber's request for services pursuant to an Interagency Team recommendation, with the deadlines and Complaint, Grievance and DHS Fair Hearing rights outlined in Appendix H.
c. At the parent/custodian's or agency's request, serve on an Interagency Team to develop a comprehensive interagency plan which identifies the service, the responsible agency to deliver the service, and the source of funding for the service.
d. Coordinate specialized treatment plans for children and adolescents with special health needs, including early intervention.

10) The Primary Contractor or its BH-MCO is required to coordinate service planning and delivery with human services agencies. The Primary Contractor or its BH-MCO is required to have a letter of agreement with:

a. Area Agency on Aging.
b. County Juvenile Probation Office (including the same components as the agreement with the CCYA in Section II-4.C.8).
c. County Drug and Alcohol Agency, including:
   i) A description of the role and responsibilities of the SCA.
   ii) Procedures for coordination with the SCA for placement and payment for care provided to Members in residential treatment facilities outside the HC Zone.
d. County offices of MH and ID, including coordination with the Health Care Quality Unit (HCQU).
e. Each school district in the county.
f. County MH/ID Program, County Prisons, County Probation Offices, Department of Corrections and Pennsylvania Board of Probation and Parole to ensure continuity of care and enhanced services for individuals as they enter and leave the criminal justice system.
g. Early intervention including:

(i) Infant-toddler early intervention (0-3 years) administered by the County ID office.
(ii) Pre-school intervention (3-5 years) administered by the local MAWA (mutually agreed upon written arrangement). The MAWA is most typically the Intermediate Unit.

11) The Primary Contractor or its BH-MCO must have in place written agreements with the other Primary Contractors or their BH-MCOs in the HC Zone to ensure continuity of care for Members who relocate from one HC county to another. The Primary Contractor or its BH-MCO must also have in place procedures to ensure continuity of care for Members who relocate to a county outside of the HC Zone or out-of-state on a temporary or permanent basis as well as disenrollment described below.

12) Certified Community Behavioral Health Clinics

The Department has been awarded a federal demonstration grant under section 223 of the Protecting Access to Medicare Act of 2014 (H.R.4302). The grant is part of a comprehensive effort to integrate behavioral health with physical health. The Primary Contractor and its BH-MCO will comply with the requirements contained in Appendix A.

The Primary Contractor and its BH-MCO will pay the CCBHC the Prospective Payment System payment rate, designated in the DHS-issued CCBHC Rate Letter, for individuals who are CCBHC members and who received a CCBHC-covered service during the Section 223 Demonstration program. The Primary Contractor and its BH-MCO will comply with the additional requirements contained in Appendix A when the CCBHC is located in the Primary Contractor's county(s) covered under their HC BH Agreement.

D. Member Services/Member Rights

1) The Primary Contractor and its BH-MCO must comply with any applicable federal and state laws that pertain to Members' rights and ensure that their staff takes those rights into account when furnishing services to Members.

2) Member Orientation

a. In consultation with the Department, the Primary Contractor and its BH-MCO must develop and distribute culturally/disability sensitive materials to Members regarding program features, policies, and procedures.
b. The Primary Contractor and its BH-MCO must conduct education sessions for Members and families to inform them of the benefits available and the access procedures. Such sessions must be in locations readily accessible and at times convenient for Members and families.

c. The Primary Contractor or its BH-MCO must provide to Members, within five days of enrollment, the names, locations, telephone numbers of, and non-English languages spoken by, current Network Providers in the Member's service area, including identification of Providers that are not accepting new patients. In addition, the Primary Contractor and MCO its BH-MCO must provide a list of current State Plan behavioral health Network Providers to the Member upon the Member's request. The Primary Contractor and its BH-MCO must make a good faith effort to give written notice of terminated contracts within 15 days after receipt or issuance of a termination notice, to each Member who receives primary care from or was seen on a regular basis by the terminated Provider.

d. The Primary Contractor and its BH-MCO must provide each Member a "point of contact" to explain plan services and assist the Member to access services.

e. The Primary Contractor or its BH-MCO must provide a Member handbook using the Member handbook template developed by the Department to all Members within five days of enrollment and make the handbook available to other interested parties, upon request (placeholder for link). The Primary Contractor or its BH-MCO may provide Members with the handbook in one of the following manners:

1) by mailing a printed copy of the information to the Member's mailing address;
2) by email after obtaining the Member's agreement to receive the information by email;
3) by posting a copy on its website and advising the Member in paper or electronic form that the information is available on the Internet and including the applicable internet address, provided that Members with disabilities who cannot access this information online are provided auxiliary aids and services upon request at no cost; or
4) by any other method that can reasonably be expected to result in the Member receiving the information.

The Primary Contractor or it's BH-MCO must inform Members what formats are available and how to access each format. The process for and method of distribution of the handbook must be submitted to the Department for prior approval. In addition, the Primary Contractor's BH-MCO must notify all Members of their right to request and obtain information related to the Provider network, benefits, Member rights and protections, and Complaint, Grievance, and DHS Fair Hearing procedures at least once a year. The Member handbook template will delineate the following responsibilities of the Primary Contractor and it's BH-MCO and the Member's rights and responsibilities:

i) the amount, duration and scope of State Plan Services and an explanation of any service limitations or exclusions;

ii) a specific statement that provides: "this managed care plan may not cover all your health care expenses. Read your contract (handbook) carefully to determine which health care services are covered;"

iii) how to contact Member Services and a description of its function;

iv) how to choose Providers within a level of care;

v) how to obtain emergency transportation and non-emergency medically necessary transportation;

vi) the extent to which and how Members may obtain benefits from Out-of-Network Providers;

vii) the counseling or referral services the Primary Contractor and its BH-MCO does not cover because of moral or religious objections. The Primary Contractor and its BH-MCO must inform Members on how they can obtain information from the Department about how and where to obtain the service;

viii) how to obtain services when a Member moves or visits out-of-county/out-of-state;

ix) explanation of the procedures for accessing Behavioral Health Services, including self-referred and Prior Authorized Services;

x) confidentiality protections, including access to clinical records by oversight agencies and through the Quality Management/Utilization Management program;

xi) information concerning methods for coordinating services for Members;

xii) how to obtain Medical Assistance Transportation Program (MATP) services;

xiii) phone numbers of the BH advocacy agencies;

xiv) phone number of the Department's Fraud and Abuse hotline;

xv) the Primary Contractor, its BH-MCO and contracted Providers must not discriminate against staff, agents or Members receiving services regardless of their race, color, national origin, ethnicity, actual or perceived sexual orientation, age, gender identity, gender expression or disability;

xvi) information on Advance Directives (mental health power of attorney and mental health declarations) for adult Members, including:

a) The description of State law, if applicable.

b) The process for notifying the Member of any changes in applicable State law as soon as possible, but no later than 90 days after the effective date of the change.

c) Any limitation the Primary Contractor or its BH-MCO has regarding implementation of Advanced Directives as a matter of conscience.

d) The process for Members to file a Complaint concerning noncompliance with the advanced directive requirements with the Primary Contractor, its BH-MCO and DOH.

e) How to request written information on Advance Directive policies.

xvii) information to adult Members regarding Member rights.

xviii) explanation of the operation of the BH-MCO.

xix) explanation of how Members are assisted in making appointments and obtaining services including the explanation of procedures for accessing self-referred and Prior Authorized Services.

xx) explanation of how Members are assisted to obtain transportation through MATP.

xxi) explanation of how Member Complaints and Grievances are handled.

xxii) explanation of rights, which must include the following:

a) each Member will be treated with respect and with due consideration for his or her dignity and privacy;

b) each Member will receive information on available treatment options and alternatives, presented in a manner appropriate to the Member's condition and ability to understand;

c) each Member will participate in decisions regarding his or her health care, including the right to refuse treatment unless the individual meets criteria for involuntary treatment under the Mental Health Procedures Act, as amended 1978;

d) each Member has the right to be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience or retaliation, as specified in other federal regulations on the use of seclusion and restraint;

e) each Member may request and receive a copy of his or her medical records and request that they be amended or corrected in accordance with the Federal Privacy Law;

f) each Member is free to exercise his or her rights and that the exercise of those rights does not adversely affect the way the Primary Contractor, its BH-MCO, Providers or and state agency treats the Member. Specifically, Members are given the opportunity to file a Complaint related to their race, national origin, ethnicity, age, sexual orientation, gender identity and gender expression;

g) each Member has the right to request a second opinion from a qualified health care professional within

the Provider network. The Primary Contractor's BH-MCO must provide for a second opinion from a qualified health care professional within the network or arrange for the ability of the Member to obtain one outside the network, at no cost to the Member.

xxiii) restrictions on the Member's freedom of choice among Providers.

xxiv) BH-MCO is required to provide the Member the option of continuity of care when:

a) BH-MCO terminates a contract with a participating Provider for reasons other than for cause and the Member is in an ongoing course of treatment with the Provider. Member shall be allowed to continue course of treatment with the same Provider, for a transition period of up to sixty (60) days from the date the Member was notified by the BH-MCO of the termination or pending termination, provided that the Provider is enrolled in the PA MA program.

b) new Member is in an ongoing course of treatment with a non-participating Provider which is not otherwise covered by the terminated coverage. Member shall be allowed to continue services with the non-participating Provider, for a transitional period of up to sixty (60) days from the effective date of enrollment with the BH-MCO as long as the Provider is enrolled in the PA MA program. The BH-MCO, in consultation with the Member and Provider, may extend the transitional period if determined to be clinically appropriate.

c) The BH-MCO will require non-participating and terminated Providers to agree to the same terms and conditions which are applicable to the BH-MCO's participating Provider.

f. The Primary Contractor and/or its BH-MCO must send written notice, approved by the Department, to directly affected Members and directly affected Provider at least thirty (30) days prior to the effective date of the change in covered benefits and must simultaneously amend all written materials describing its covered benefit or Provider Network. A change in covered benefits includes any reduction in benefits or a substantial change in the Provider Network which would negatively affect a Member's access to service.

g. In addition to including the following information in the Member handbook, the Primary Contractor and its BH-MCO must provide each Member written notice of any Department-approved change in the following information at least thirty (30) days before the intended date of the change:

i) Complaint, Grievance, and DHS Fair Hearing procedures and timeframes (as provided in Appendix H) that must include the following:
   a) For DHS Fair Hearings.
      i. the right to hearing.
      ii. the method for obtaining a hearing.
      iii. the rules that govern representation at the hearing.
   b) The right to file Complaints and Grievances.
   c) The requirements and timeframes for filing a Complaint or Grievance.
   d) The availability of assistance in the filing process.
   e) The toll-free numbers that the Member can use to file a Complaint or Grievance by phone.
   f) The fact that, when requested by the Member, benefits will continue if the Member files a Complaint (one of the five types of Complaints that allow for continuation of benefits, as specified in Appendix H), Grievance or request for DHS Fair Hearing within the timeframes specified for filing.
   g) Any appeal rights that the Department chooses to make available to Providers to challenge the failure of the organization to cover a service.

ii) Instructions for obtaining care in an emergency, including;
   a) locations of any emergency settings and other location at which Providers and hospitals furnish Emergency Services;
   b) the use of the 911-telephone system or its local equivalent;
   c) what constitutes an Emergency Medical Condition, Emergency Services;
   d) the fact that Prior Authorization is not required for Emergency Services;
   e) the fact that the Member has a right to use any hospital or other setting for Emergency Services.

3) The Primary Contractor and its BH-MCO must develop and implement programs for public education and prevention including behavioral health education materials and activities.

   Public education programs shall focus on prevention, available services, leading causes of relapse, hospitalization and emergency room use, utilization of advance directives, and shall address initiatives which target high risk population groups.

E. Member Disenrollment

1) General Authority

The Department has sole authority for terminating a HealthChoices Member from a HealthChoices BH-MCO, subject to the conditions described below.

2) Reasons for Disenrollment

The Department may terminate a Member from the BH-MCO on the basis of:

a. Member's loss of Medical Assistance eligibility.
b. Placement of the Member in a nursing facility for more than 30 consecutive days.
c. Placement of the Member in any state facility, including a state psychiatric hospital.
d. Placement of the Member in a Juvenile Detention Center for more than 35 consecutive days.
e. Change in permanent residence of the Member which places the Member outside the BH-MCO's service area.
f. Change in Member's status to a recipient group which is exempt from the HC Program.
g. Determination by the Department that the Member is eligible for the Health Insurance Premium Payment Program (HIPP).
   xxii) Member is disenrolled 30 days after enrollment in the Aging Waiver (also known as the Pennsylvania Department of Aging (PDA) Waiver).
   xxiii) Member residing in PA Veterans Administrative Home for more than 30 consecutive days.

3) The Primary Contractor or its BH-MCO shall not terminate any Member from the HC-BH Program.

4) A Member's termination from enrollment becomes effective on a date specified by the Department. The Primary Contractor and its BH-MCO must have policies and procedures to comply with any Department enrollment termination and for the Member's continuity of care as described in Section II-4.C.

F. Complaint and Grievance System

1) General

The Primary Contractor's BH-MCO must establish Complaint and Grievance mechanisms through which Members and Providers can seek redress against the BH-MCO. The Primary Contractor or its BH-MCO may not take any adverse action against a Provider for assisting a Member in the understanding of or filing of a Complaint or Grievance under the Member Complaint and

Grievance system. Primary Contractors may impose additional requirements on its BH-MCO as are deemed appropriate for effective management.

2) Member Complaint and Grievance System

The Primary Contractor's BH-MCO must develop, implement, and maintain a Complaint and Grievance system which provides for settlement of Member Complaints and Grievances at the most efficient administrative level. The Complaint and Grievance system must conform to the conditions set forth in Appendix H.

a. The Primary Contractor's BH-MCO must provide Members and Parents/custodians of children and adolescents (for CISC, both Parents, if whereabouts are known and county CCYA must receive information) with documents that plainly and clearly outline rights and responsibilities as Members, including the right to file a Complaint or Grievance and/or to request a DHS Fair Hearing. This information must include a toll-free telephone number for Members to facilitate the communication of a Complaint or Grievance.
b. The Primary Contractor and its BH-MCO must ensure that any Subcontractor, with authority to approve and disapprove service requests, complies with the Complaint and Grievance procedures and reporting requirements established by the Primary Contractor or its BH-MCO.
c. Denials of service or coverage must be in writing, notifying the Member or parent/custodian of a child or adolescent of the reason for the denial, alternative treatments available, the right to file a Grievance and/or request a DHS Fair Hearing and the process for doing so.
d. The Primary Contractor's BH-MCO must integrate its Complaint and Grievance system with the QM process in terms of review, corrective action, resolutions, and follow-up.
e. The Primary Contractor's BH-MCO must have a data system in place capable of processing, tracking, and aggregating data to discern trends in Complaints and Grievances.
f. The Primary Contractor's BH-MCO must provide all required Member Complaint and Grievance information to the Enrollment Assistance Program as requested.
g. The Primary Contractor's BH-MCO's Grievance system may not be a prerequisite to or replacement for the Member's right to request a Fair Hearing (in accordance with 42 CFR Part 431, Subpart E) when the Member is adversely affected by an administrative decision rendered by the Primary Contractor's BH-MCO. The Primary Contractor and its BH-MCO must cooperate with and adhere to the Department's procedures and decisions.
h. Complaints or Grievances resulting from any action taken by oversight agencies responsible for fraud, abuse, and prosecution activities must be directed to the respective agency. Oversight agencies include the

Department's Office of Medical Assistance Programs, Bureau of Program Integrity, the Office of the Attorney General's Medicaid Fraud Control Section, the Pennsylvania State Inspector General, and HHS/CMS's Office of Inspector General, and the United States Justice Department.

3) Denial of Services

The Primary Contractor's BH-MCO must have a procedure that allows Members to grieve denials of requests for authorization for services. Individuals responsible for denying services or reviewing Grievances of denials must have the necessary and appropriate clinical training and experience. All denials must be made by a physician or, in some cases, by a licensed psychologist. Denials of inpatient care must be approved by a physician. Qualifications of individuals must be consistent with Appendix AA, and all applicable Commonwealth laws and regulations.

The BH-MCO may not deny or reduce the amount, duration, or scope of a required service solely because of a Member's diagnosis, type of illness or condition. If a service for which the request for authorization is denied is viewed by the prescriber and the Member as an Urgent or Emergency Service, the Primary Contractor's BH-MCO must have a process for expedited review of such Grievances to occur within 24 hours of the request. Any time the Primary Contractor's BH-MCO denies a request for authorization for service, the Primary Contractor's BH-MCO must notify the Member or the parent/custodian of a child or adolescent, in writing. The written notification must include:

a. Specific reasons for the denial with references to the program provisions;
b. A description of alternative services recommended on the basis of placement criteria, e.g., Adult Placement Criteria for Drug and Alcohol services.
c. A description of the Member's right to file a Grievance and/or request a DHS Fair Hearing.

d. Information for the Member describing how to file a Grievance and/or request a DHS Fair Hearing.
e. An offer by the BH-MCO to assist the Member in filing a Grievance and/or DHS Fair Hearing.

4) Provider Complaint System

The Primary Contractor's BH-MCO must develop, implement and maintain a Provider Complaint system which provides for informal mediation and settlement of Provider Complaints at the lowest administrative level and a formal Complaint process when informal resolution is not possible.

The Provider Complaint system must demonstrate a fundamentally fair process for Providers; adequate disclosure to Providers of Provider rights and responsibilities at each step of the process; and sound and justified decisions made at each step.

The Department's Bureau of Hearings and Appeals is not an appropriate forum and shall not be used by Providers to appeal decisions of the Primary Contractor or its BH-MCO.

II-5. REQUIREMENTS

The Primary Contractor is responsible for administering a behavioral health managed care program which meets, at a minimum, the requirements outlined below. The standards allow flexibility in the approach to meeting program objectives, while ensuring the needs of Members are met.

A. General

Participation will be limited to Primary Contractors who are either counties or Multi-County Entities. A County Operated BH-MCO established as an arm or branch of county government is not subject to licensure, so long as the county maintains responsibility for all financial risk. A County Operated BH-MCO established as an arm or branch of county government must be certified by the Commonwealth as a Utilization Management entity under Act 68 if it directly performs Utilization Management functions. In the event a Multi-County Entity submits a single proposal, each county must be separately responsible for financial risk. One county may not assume the financial risk of the other county(ies) covered by the proposal; nor may a remaining county(ies) assume responsibility for the membership of a terminating county.

B. Executive Management

1. The development of the behavioral health managed care program is a broad-based process. The Primary Contractor must have documentation of the participation of consumers, persons in recovery and family members, including Parents of children and adolescents, as well as county drug and alcohol, mental health and intellectual disabilities, children and youth, juvenile justice, and Area Agency on Aging programs and school districts in the development of the behavioral health managed care program. Participation must include the involvement of consumers, persons in recovery, and family members in the selection of a BH-MCO Subcontractor if one is used and development of the proposal in response to the Department's document. Consumers, persons in recovery and family members must also be involved in ongoing program oversight.

2. In the event a county or MCE is the Primary Contractor, the county (separate from the BH-MCO) must establish an administrative structure for management

and program oversight of the behavioral health managed care program. The management structure must include clearly defined and assigned responsibility for monitoring the BH-MCO's fiscal, program/Quality Management and management information systems. The Primary Contractor oversees and is accountable for any functions and responsibilities it delegates to the BH-MCO or any Subcontractor.

3. Subcontractual Relationships and Delegation

For each Subcontract, the Primary Contractor and its BH-MCO must ensure that:

a. The Subcontractor has been evaluated and determined competent to perform the activities to be delegated.

b. The Subcontractor has been engaged pursuant to a written agreement between the Primary Contractor and/or its BH-MCO and the Subcontractor that specifies the activities and reporting responsibilities delegated to the Subcontractor and provides for revoking delegation or imposing other remedies and sanctions if the Subcontractor's performance is inadequate.

c. Performance monitoring will be conducted on an ongoing basis, and the Subcontractor and will be subject it to formal review according to a periodic schedule established by the Department, consistent with industry standards or State MCO laws and regulations.

d. Deficiencies or areas for improvement will be identified, and corrective action is required.

e. The Subcontractor has not been excluded from the participation in any Federal health care program under section 1128 or 1128A of the Social Security Act.

4. Primary Contractors and their BH-MCOs are required to place all HealthChoices Capitation payments in a separate, restricted account(s).

5. The Primary Contractor is required to contract with C/FST services in the counties served or establish such teams if they do not exist.

6. If the Primary Contractor is a county, the Primary Contractor is required to place Reinvestment Funds in a separate restricted account. A plan for expenditures from that account must be prior approved by DHS. Primary Contractors must have prior approval from DHS to carryover Reinvestment Funds from one Agreement period into a subsequent Agreement period; however, DHS approved reinvestment plan funds must continue to be tracked separately. Counties can maintain Reinvestment Funds, for DHS approved

reinvestment plans, up to six months after the time period delineated in their approved reinvestment plan, unless such date is otherwise extended by the Department. This includes reinvestment plans that cover more than one period. After that time, unexpended Reinvestment Funds must be returned to the Department. Any funds remaining in the reinvestment account at the time of Agreement termination must be returned to DHS.

7. The Primary Contractor and or its BH-MCO may combine functions or assign responsibility for a function across multiple departments, as long as it demonstrates the following duties and functions are carried out:

   a. A Chief Executive Officer with clear authority over the entire operation of the BH-MCO.

   b. A Medical Director who is a board-certified psychiatrist licensed in the Commonwealth with at least five years combined experience in mental health and substance abuse services. The responsibilities of the Medical Director include:
      i. development of clinical practice standards, policies, procedures, and performance;
      ii. review and resolution of quality of care problems;
      iii. participation in Complaint and Grievance processes related to service denials and clinical practice;
      iv. development, implementation, and review of the internal Quality Management and Utilization Management programs;
      oversight of the BH-MCO's referral process for specialty and in lieu of and in addition to services;
      v. oversight and management of the BH-MCO's behavioral health rehabilitation and residential services for children and adolescents, in collaboration with the HealthChoices PH-MCO's Medical Directors;
      vi. leadership and direction in the BH-MCO's clinical staff recruitment, credentialing, and privileging activities;
      vii. leadership and direction in the BH-MCO's Prior Authorization and utilization review processes;
      viii. leadership and direction of policies and procedures relating to confidentiality of clinical records; and
      ix. participation in any meetings called by the Department.

   c. A Chief Financial Officer (or governmental equivalent) to oversee the budget and accounting system.

   d. Quality Management

   e. Utilization Management

   f. Management Information Systems

g. Prior Authorization to include:
   i. assessment and substantiation of need for psychiatric and behavioral services provided by a mental health professional;
   ii. assessment and substantiation of need for drug and alcohol treatment services provided by a Drug and Alcohol Addictions Professional.

h. Member Services to communicate with Members, act as Member advocates, and coordinate Members' use of the Complaint and Grievance processes.

i. Provider Services to coordinate communications between the BH-MCO and its Providers.

8. The Primary Contractor's BH-MCO must organize and deliver services in accordance with principles established through the Child and Adolescent Service System Program (CASSP), the Community Support Program (CSP); and DDAP's Principles of Effective Treatment and OMHSAS' Cultural Competency Principles; see Appendices I, J, and CC respectively.

9. The Primary Contractor or its BH-MCO must have written agreements with the county mental health, intellectual disabilities and drug and alcohol authorities assuring availability and access to State Plan Services. Agreements must include provisions for the integration of crisis intervention services and the admission of any Member to a state mental hospital consistent with the established state mental hospital bed allocation assigned to the county as well as provisions for appropriate, coordinated response and dispute resolution processes related to court orders for behavioral health involuntary treatment services.

C. Administration

1. Administrative duties related to the daily operation of the program and interaction with Providers and Members such as those related to Member services, Provider services, Quality Management and Utilization Management, must be conducted in an administrative office in close geographic proximity to the county in which services are provided.

2. The HealthChoices Program, through the EAP, provides Enrollment Specialists to assist Members with enrollment in a PHSS, and to provide Members with information regarding the PH-MCO and BH-MCO programs.

   The EAP is responsible for pre-implementation outreach and education for Members and families to explain the fundamental concepts of managed care and for providing information on benefit packages.

   The Primary Contractor or its BH-MCO must have policies and procedures for

coordination with the EAP. The Primary Contractor or its BH-MCO must have informational materials; e.g., pamphlets and brochures, which can be used by the EAP to assist the Member's access to Behavioral Health Services. Any informational materials developed for this program by the Primary Contractor or its BH-MCO must have the Department's prior, written approval. The Primary Contractor or its BH-MCO will be required to print and provide the EAP with an adequate supply of approved materials on a continual basis.

The Primary Contractor or its BH-MCO must have mechanisms to receive information electronically, as needed, from the EAP regarding the special needs and special services required by Members, identified at the time of enrollment.

3. Training and Professional Development

The Primary Contractor or its BH-MCO must provide an ongoing process of training and professional development for BH-MCO Member services, Service Management, Quality Management and Utilization Management staff. Training topics should include but not be limited to: CSP and CASSP principles and DDAP treatment philosophy, Member rights, Complaint and Grievance process, Provider network access, human services, current clinical practice needs of special populations including persons with co-occurring mental health drug & alcohol conditions, persons with intellectual disabilities, children in substitute care and/or in juvenile probation, persons diagnosed with ASD, school intervention services, and Medical Necessity criteria including the American Society of Addiction Medicine (ASAM).

4. The BH-MCO must monitor the performance and quality of service of any BH Services Provider to which work is delegated to assure conformance with the terms of the Agreement.

5. The BH-MCO must work in partnership with the designated county/municipal health department, and primary care practitioner as applicable, to ensure that conditions identified in accordance with the Disease Prevention and Control Law of 1955 (35 P.S. § 521.1 et. seq.) are reported (e.g., tuberculosis, hepatitis).

6. Records Retention

a. General

The Primary Contractor, its BH-MCO, Subcontractors and BH Services Providers must agree to maintain books and records relating to the HealthChoices Program services and expenditures, including reports to the Department and source information used in preparation of these reports. These records include but are not limited to financial statements, records relating to quality of care, medical records, and prescription files.

The Primary Contractor, its BH-MCO, Subcontractors and BH Services Providers also must agree to comply with all standards for record keeping specified by the Commonwealth. Operational data and medical record standards are described below.

The Primary Contractor, its BH-MCO, Subcontractors or BH Services Providers must, at their own expense, make all records available for audit, review or evaluation by the Commonwealth, its designated representatives, or federal agencies. Records required for this purpose include, but are not limited to books, records, contracts, computer or other electronic systems of the Primary Contractor, its BH-MCO, Subcontractors and BH Services Providers. Access shall be provided either on-site, during regular business hours, or through the mail. During the contract and record retention period, these records shall be available at the Primary Contractor's chosen location(s), subject to approval of the Department. All mailed records shall be sent to the requesting entity in the form of accurate, legible, paper copies, unless otherwise indicated, within 15 calendar days of such request and at no expense to the requesting entity.

The Primary Contractor, its BH-MCO, Subcontractors and BH Service Providers shall maintain books, records, documents, and other evidence pertaining to all revenues, expenditures and other financial activity pursuant to the Agreement as well as to all required programmatic activity and data pursuant to the Agreement. Records, other than medical records, may be kept in an original paper state or preserved on micro media or electronic format. Medical records shall be maintained in a form acceptable by the Department.

The Department, CMS, the Office of the Inspector General, the Comptroller General, and their designee may, at any time inspect and audit any records or documents of the Primary Contractor, its BH-MCO, Subcontractors or Behavioral Health Services Providers and may, at any time, inspect the premises, physical facilities, and equipment where Medicaid-related activities or work is conducted. The right to audit exists for a 10 year period from the final date of the contract period or from the date of completion of any audit, whichever is later.

b. Digital Records

The Primary Contractor, its BH-MCO, Subcontractors and BH Services Providers shall develop policies and procedures for the transformation of hard-copy originals to digitally stored record-keeping copies. These policies and procedures must be authorized and approved by the Board of Directors and the CEO or President. Staff involved with the generation and authentication and storage of records should be trained and a log of those trained including date, trainer and the individuals trained should be maintained and the training should be provided periodically to staff to

remind them of the process and the importance of engaging the process with fidelity.

An image must be verified as an exact copy of the original paper document and certified as the “record-keeping copy,” by someone other than the originator of the document and at a supervisory level. Once certified, only then can the original paper document be destroyed. Ensuring that the “record-keeping copy” is an exact copy of the original paper document, requires that the following standards, at a minimum be in the policies and procedures developed by BH-MCO providers:

1. The Provider must be able to demonstrate the imaged version is an exact copy of the paper document;
2. The Provider must establish and implement a certification/quality assurance process to ensure the imaged information is an identical replication of the paper document in every way, including identifying the individual authorizing the original and the process. This should include their signature (this includes use of a valid electronic signature);
3. The Provider must retain the scanned image as the “recordkeeping copy” for the required retention period; and
4. As technological advances occur and are put into practice, the Provider must ensure continued accessibility to documents stored using earlier technologies.

c. Operational Data Reports

The Primary Contractor and its BH-MCO must agree to retain the source records for its data reports for a minimum of seven years and must have written policies and procedures for storing this information.

d. Clinical Records

The Primary Contractor or its BH-MCO must have written policies and procedures to maintain the confidentiality of and provide Member and other requesting entities access to the record, consistent with applicable state and federal confidentiality requirements. The Commonwealth must be afforded prompt access to all Members' clinical records whether electronic or paper.

The Primary Contractor or its BH-MCO must have written policies and procedures for the maintenance of clinical records so that those records are documented accurately and in a timely manner, are readily accessible, and permit prompt and systematic retrieval of information.

The Department considers the clinical record as an important component of good patient care, for use in evaluating the quality of care rendered to

Members. Therefore, the Primary Contractor or its BH-MCO must have written standards for clinical record documentation which reflect legibility, accuracy, completeness, and that chronologically reflect the evaluation, appropriateness of treatment, and Medical Necessity within the plan of care for the Member. A complete list of standards to follow is contained in 55 Pa. Code, Chapter 1101.

Clinical records must be legible, signed, dated, preserved, and maintained for a minimum of five years from expiration of the Agreement. Clinical records must be maintained in the original form before conversion to any other form and records in all forms must be readily available for review.

The Department is not required to obtain written approval from a Member before requesting the Member's clinical record from the Primary Contractor or its BH-MCO or any Provider, consistent with state and federal confidentiality requirements.

D. Provider Network/Relations

1. The Primary Contractor and its BH-MCO must provide access to all covered services for Members through a network of qualified professionals and facilities. The Provider's network must have the following features in place and the Primary Contractor and it BH-MCO must submit documentation that the Provider's network has the following features in place at the time it enters into a contract with the Department; on an annual basis; and at any time the Department determines that there has been a significant change in the Primary Contractor's and its BH-MCO's operations that would affect the adequacy of capacity and services, including changes in services, benefits, geographic service area, composition of or payments to the Provider network; or when a new population enrolls in the BH-MCO:

   a. Sufficient Provider capacity and expertise for all covered services, for timely implementation of services, and for reasonable choice by Members of a Provider(s) within each level of care.

   b. Represent the cultural and ethnic diversity of Members and their neighborhoods.

   c. Clinical expertise and Cultural Competency in responding to Members with special needs.

   d. Timely access to covered services and needed specialists including but not limited to the evaluation and treatment of: child and adolescent psychiatric, substance abuse and behavioral disorders; including disorders arising out of psychological and sexual abuse; co-existing psychiatric and substance use disorders; psychiatric or substance use disorders among

older adults (particularly those with co-existing medical conditions); persons with intellectual disabilities with co-existing substance use or mental health disorders; persons with psychiatric or substance use disorders who are also homeless, pregnant or have HIV/AIDS, or persons diagnosed with ASD.

e. Providers must commit to ensuring access to and quality treatment and care for LGBTQI Members as well as racial and ethnic groups by providing a culturally affirmative environment of care.

f. Inclusion of Providers trained and experienced in working with the priority and Special Needs Populations covered under the plan.

g. Evidence of a cooperative relationship between the BH-MCO and its Provider network, for example, inclusion of Providers by the BH-MCO in the development of clinical protocols and Provider profiling.

h. The numbers of Network Providers who are not accepting new Members.

i. The anticipated MA enrollment.

j. The expected utilization of services, taking into consideration the characteristics and health care needs of specific MA populations represented in the BH-MCO.

k. The number and types, in terms of training, experience, and specialization of Providers required to furnish the contracted MA services.

l. The geographic location of Providers and Members considering distance, travel time, the means of transportation ordinarily used by Members, and whether the location provides physical access for Members with disabilities.

2. In order to participate as a Network Provider that a) provides services to, b) orders, prescribes, refers or c) certifies eligibility for services for Members, the Provider must enroll with the Department's MA Program. Provider enrollment shall include identifying information, including the name, specialty, date of birth, Social Security number, national provider identifier, federal taxpayer identification number, and the Department license or certification number of the provider.

3. The Primary Contractor or its BH-MCO must ensure management of the Provider network through agreements which include the following provisions:

a. Maintenance of clinical records which conform to program specific regulations and release of clinical records in conformance with applicable

federal and state confidentiality laws and regulations.

b. Criteria for Provider's clinical privileges, as applicable.

c. Clinical performance standards and data reporting requirements.

d. Financial performance standards and data reporting requirements.

e. Complaint procedures for Providers.

f. Requirements for referral, coordination of treatment planning, and consultation (including participation during Interagency Team meetings) in the diagnosis and treatment of psychiatric, substance abuse and behavioral disorders.

g. Requirements for coordination and continuity of care of Behavioral Health Services with social services; e.g., intellectual disabilities, area agencies on aging, juvenile probation, housing authorities, schools, child welfare, juvenile and county and state criminal justice.

h. Requirements for coordination, credentialing, and continuity of care with PHSS and PCPs or prior approved specialist (in accordance with the Department of Health Technical Advisory #95-1 or most current reference).

i. Procedures for approving demonstration projects for State Plan Service and treatment alternatives/innovations.

j. Compliance with The Child Protective Services Law, 23 Pa.C.S. § 6301-6385.

k. Compliance with The Older Adults Protective Services Law, 35 P.S. § 10225.101 et. seq..

l. Authorization of State Plan Services in accordance with DHS approved Medical Necessity criteria and Prior Authorization procedures.

m. Assurance that Providers delivering State Plan Services to Members via a subcontractual arrangement with a Network Provider, meet the same requirements and standards as a Network Provider.

n. Procedure to provide access to client records for quality of care and access reviews.

o. Prohibition against the use of prone restraints by Child Residential and Day Treatment Providers (both in and out of network).

p. Provide physical access, reasonable accommodations, and accessible equipment for Members with physical or mental disabilities.

4. The Primary Contractor or its BH-MCO must have policies and procedures to monitor that the access standards are met by each Provider in each level of care. The BH-MCO must monitor the network to assure that Providers conform to expected referral and utilization patterns, conditioned upon accepted local and national practice, and deliver services that result in expected treatment outcomes based upon empirical data.

5. The Primary Contractor or its BH-MCO must maintain procedures for response, reporting, and monitoring of significant Member incidents for trend and case analysis. The Primary Contractor or its BH-MCO must make incident records and reports immediately available to the Department upon request.

6. The Primary Contractor or its BH-MCO must maintain procedures for immediate response and appropriate reporting of any suspected or substantiated fraud or abuse to the Department's OMAP, Bureau of Program Integrity.

7. The Primary Contractor or its BH-MCO must notify the Department promptly of any changes to the composition of its Provider network that affect the Primary Contractor or its BH-MCO's ability to make available all State Plan Services or respond to the special needs of a Member or population group in a timely manner.

   a. The Primary Contractor (PC)/BH-MCO shall develop a policy and procedure for considering Provider rate setting for review and approval by OMHSAS. The policy shall include the opportunity of Providers to request a rate increase, summarize information the Provider must submit to justify a rate increase, describe the finance strategies the PC/BH-MCO may use in rate setting such as performance incentives, preferred Provider network, or other strategies. The policy will include a statement that the PC/BH-MCO shall not institute an across the board rate decrease for all Providers or a specific Provider type or group of Providers unless the PC or its BH-MCO has: (i) notified the Department of its intention to impose such an across the board rate decrease at least 45 days prior to the imposition of such a rate decrease; (ii) provided the Department with the justification for instituting such an across the board rate decrease (iii) discussed the proposed action with all affected Providers, and (iv) provided justification that such action will not adversely affect compliance with HealthChoices access and choice requirements.

   b. No payments will be made by the Primary Contractor and/or its BH-MCO for Provider-preventable conditions, as identified in the State Plan and will require that all Providers agree to comply with reporting requirements in 42 CFR § 447.26(d) as a condition of payment from the Primary Contractor. The Primary Contractor and/or its BH-MCO will comply with

such reporting requirements to the extent the Primary Contractor and/or its BH-MCO directly furnishes services.

8. The Primary Contractor or its BH-MCO must maintain a plan of orientation and ongoing training for Network Providers. Training shall include but not be limited to:

   CASSP and CSP principles and DDAP treatment philosophy; priority and Special Needs Population issues such as children in substitute care and/or juvenile probation; Prior Authorization of services; continuity of care; payment procedures; Complaint and Grievance rights and procedures; coordination requirements with PHSS and PCPs; coordination requirements with county behavioral health and human services systems; current clinical best practice and community service resources and advocacy organizations.

9. The Primary Contractor or its BH-MCO must make directories of network Providers for all State Plan Services and BHRS. The Primary Contractor or its BH-MCO must comply with the Department's directions for determining the Providers identified in the directory of BHRS Providers. The Provider directory must be made available on the website of the Primary Contractor or its BH-MCO in a machine-readable file and format as specified by CMS.

   The Primary Contractor or its BH-MCO must make available a paper Provider directory upon request, within five business days, and must utilize a web-based Provider directory. The Primary Contractor or its BH-MCO must establish a process to ensure the accuracy of electronically posted content, including a method to monitor and update changes in Provider information. The Primary Contractors or its BH-MCO must update the paper Provider directory at least monthly and electronic Provider directories must be updated no later than 30 calendar days after the Primary Contractor or its BH-MCO receives updated Provider information.

   The Provider directory must provide the following information as required in 42 CFR § 438.10(h) about its Network Providers:

   - Provider's name as well as any group affiliation
   - Street address(es)
   - Telephone number(s)
   - Website URL, as appropriate
   - Specialty, as appropriate
   - Whether the provider will accept new enrollees
   - The Provider's cultural and linguistic capabilities, including languages (including American Sign Language) offered by the Provider or a skilled medical interpreter at the Provider's office and whether the Provider has completed cultural competency training.
   - Whether the Provider's office/facility has accommodations for people with physical disabilities, including offices, exam room(s) and equipment.

10. Primary Contractor and/or its BH-MCO must provide information required in 42 CFR § 438.10 to enrollees electronically, and the information:

- Must be in a format that is readily accessible.
- Must be placed in a location on the website that is prominent and readily accessible.
- Must be provided in an electronic form which can be electronically retained and printed.
- Is consistent with content and language requirements.
- Must notify the enrollee that the information is available in paper form without charge upon request.

E. Provider Enrollment - Credentialing/Recredentialing

1. In maintaining the Provider network, the Primary Contractor or its BH-MCO must establish written credentialing and recredentialing policies and procedures. Primary Contractor or its BH-MCOs must adhere to credentialing requirements under the Pennsylvania Department of Health regulations, 28 Pa. Code §§ 9.761 and 9.762 for all State Plan Services Provider types as well as for Providers of in lieu of and in addition to services in the BH-MCO Provider network Provider types interested in participating as a Provider within the network must obtain credentialing from the Primary Contractor or its BH-MCO (who will ensure the service is within the Provider's scope of practice) and approval from a county who wishes to offer the service. Credentialing policies and procedures must include, but not be limited to, the following criteria:

   a. Applicable license or certification as required by Pennsylvania law, including the Department's license or certification number of the Provider.

   b. Verification of enrollment in good standing with Medicaid (Providers of in lieu of and in addition to services, Out-of-Network Providers and Non-participating Providers must be enrolled in the MA program).

   c. Verification of an active MA Provider Agreements.

   d. Evidence of malpractice/liability insurance.

   e. Disclosure of any past or pending lawsuits/litigations.

   f. Board certification or eligibility, as applicable.

2. Except as provided by 42 CFR 438.12(b), the Primary Contractor or its BH-MCO may not discriminate for the participation, reimbursement or

indemnification of any Provider who is acting within the scope of his or her license or certification under applicable State law, solely on the basis of that license or certification. If the Primary Contractor or its BH-MCO declines to include individual or groups or Providers in its network, it must give the affected Providers written notice of the reason for its decision.

3. The Provider credentialing policies and procedures must not discriminate against Providers that serve high risk populations or specialize in conditions that require costly treatment.

   a. A Primary Contractor or its BH-MCO may not prohibit, or otherwise restrict a health care professional acting within the lawful scope of practice, from advising or advocating on behalf of a Member who is his or her patient, for the following:
      i. any information the Member needs in order to decide among all relevant treatment options;
      ii. for the risk, benefit and consequences of treatment and non-treatment;
      iii. for the Member's right to participate in decisions regarding his or her health care, including the right to refuse treatment, and to express preferences about future treatment decisions; or
      iv. for Member's health status, medical care or treatment options, including any alternative treatment that may be self-administered.

4. The Primary Contractor, its BH-MCO or Subcontractors may not employ or contract with Providers excluded from participation in federal health care programs under either Section 1128 or Section 1128A of the Social Security Act.

5. A Primary Contractor or its BH-MCO shall have a process in place, approved by the Department, for consulting with the counties served regarding Providers to be enrolled in the network and those recredentialed.

6. Any Provider that has been terminated from the Medicare program or from another State's Medicaid program will be terminated from participation in the HC BH Medical Assistance program.

F. Service Access

1. The Provider network must provide face-to-face treatment intervention for all Members within one hour for emergencies, within 24 hours for Urgent situations, and within seven days for routine appointments and for specialty referrals. Upon the initial face-to-face intervention, the implementation of treatment services must adhere to the prescribed treatment plan, including the Start Date and frequency of treatment services. Prior Authorization of emergency inpatient and emergency outpatient services is not permitted.

The Primary Contractor or its BH-MCO must have a notification process in place with Providers for the referral of a Member to another Provider, if a selected Provider is not able to schedule the referred Member within the access standard.

2. The Primary Contractor and its BH-MCO must maintain a Provider network for all Members which is geographically accessible to Members. All levels of care must be accessible in a timely manner. Members must have a choice of at least two Providers for all state plan services except crisis intervention services. A minimum of one provider must be available for crisis intervention services (telephone and mobile).

   For ambulatory services to which the Member travels, the Providers must be:
   a. Within 30 minutes travel time in Urban areas.

   b. Within 60 minutes travel time in Rural areas.

   For inpatient and residential services at least one of the two Providers must be:
   a. Within 30 minutes travel time in Urban areas.

   b. Within 60 minutes travel time in Rural areas.

   Access standards including requirements for time and distance and minimum number of providers are subject to change in accordance to CMS requirements.

   The Primary Contractor and its BH-MCO must comply with additional access standards for Network Providers if CMS determines that it will promote the objectives of the Medicaid program for a level of care to be subject to an access standard.

   Network Providers are not required to be located within the county covered by the Agreement. Adherence to the travel time requirements may be facilitated by the Primary Contractor or its BH-MCO's inclusion of out-of-county BH Services Providers in its network.
   The Primary Contractor or its BH-MCO must obtain DHS approval for network exception requests to cover situations in which the Primary Contractor or its BH-MCO determines that a Member is in need of a specialized State Plan Service and a Network Provider is not available within the travel timeframes. The network exception request must provide for the appropriate delivery of services and the availability of local supports for the Member. The Department will review and approve network exception requests based on the number of Network Providers in that specialty practicing in the service area.

3. The Primary Contractor's BH-MCO must have a service authorization system that includes verification of eligibility and a coordinated, expedited decision-

making process in accordance with Appendix T for admission, continued stay and discharge for all State Plan Services. The Primary Contractor or its BH-MCO's service authorization system must include procedures for informing Providers and Members of authorization decisions.

4. The Primary Contractor or its BH-MCO must have written policies and procedures which comply with MA Bulletin 99-03-13 and Appendix V, to authorize care and transition Members to Network Providers for Members who are in care at the time of the Agreement implementation. Policies and procedures must specifically address priority and Special Needs Populations. Protocols for authorization, denial of authorization, and transfer to alternative facilities or Providers must also be included. Where disruption of services would have a significant negative impact on the Member, the Primary Contractor and its BH-MCO must have provisions for the authorization and payment of services delivered by Out-of-Network Providers. A transition monitoring plan must be developed to ensure that procedures and protocols governing transition into service are being followed and that transition problems are identified and corrected. The transition plan should also address the Primary Contractor or its BH-MCO staff recruitment and training prior to start-up and supervisory support during initial implementation. Planning must also address Network Provider credentialing, contracting and training; the Primary Contractor or its BH-MCO telephone capacity related to both Member services and Service Management functions; and MIS backup.

5. The Primary Contractor or its BH-MCO must have procedures for accessing Out-of-Network, but State Plan Services in emergency or unique situations including services for children and adolescents in substitute care.

6. The Primary Contractor and its BH-MCO must have procedures to assure continuity of care for Members affected by either Provider termination or loss of the Member's MA eligibility when Medical Necessity continues at the same or other level of care.

7. If 5% or more of the MA recipients in a County Assistance Office or a district office within the county speak a language other than English as a first language, the Primary Contractor or its BH-MCO must make available in that language all information that is disseminated to English speaking Members. This information includes, but is not limited to, Member handbooks, hard copy Provider directories, education and outreach materials, marketing materials, website access and digital materials available on the BH-MCO’s website, written notifications, etc. All materials that are essential to service delivery, including at a minimum, provider directories, enrollee handbooks, appeal and Grievance notices, and denial and termination notices, must include taglines in the prevalent non-English language(s) explaining the availability of written translation or oral interpretation to understand the information provided and the toll-free and TTY/TYD telephone number of the Primary Contractor or its

BH-MCO's member/customer service unit. Interpreter services must be available, as practical and necessary, by toll-free telephone or in person to ensure Members are able to communicate with the Primary Contractor or its BH-MCO and Providers and receive covered benefits in a timely manner. The Primary Contractor must have policies and procedures for ensuring language assistance services for people who have limited proficiency in English.

In addition, the Primary Contractor and its BH-MCO must comply with the ADA (42 U.S.C. §§ 12101 et. seq.) concerning the availability of appropriate alternative methods of communication for Members who are visually impaired, deaf or hard of hearing. Such appropriate alternative methods include, but are not limited to, Braille, audio tapes, large print, compact disc, DVD and/or electronic communication. The Primary Contractor or its BH-MCO must provide Text Telephone Typewriter (TTY) and/or Pennsylvania Telecommunication Relay Services for communicating with Members who are deaf or hard of hearing and comply with the ADA concerning access for Members with physical disabilities. These services must be made available upon request to the Member at no cost, in an appropriate manner that takes into consideration the special needs of the Member with disabilities or limited English proficiency.
The Primary Contractor or its BH-MCO must comply with 45 CFR §92.8. The term "significant publications and significant communications" referenced in 45 CFR §92.8(f) and 45 CFR §92.8(g) includes written notices requiring a response from an individual and notices to an individual, such as those pertaining to rights or benefits.

The information required for prevalent non-English speakers, as outlined above, must include at a minimum, Member handbooks, Provider directories, education and outreach materials, marketing materials, appeal and grievance notices, and denial and termination notices. The Primary Contractor or its BH-MCO must make oral interpretation available in all languages, and written translations in each prevalent non-English language as identified above, as well as Large Print as necessary, at no cost to the Member. Large print means printed in a font size no smaller than 18 points.

All written materials must use easily understood language in a font size no smaller than 12 point. All written materials must include taglines in the prevalent non-English languages as identified above, as well as in large print, explaining the availability of written translation or oral interpretation to understand the information provided, explaining how to request auxiliary aids and services and the provision of materials in alternative formats, and the toll-free and TTY/TDY telephone number of the Primary Contractor or its BH-MCO's member/customer service unit. The Primary Contractor or its BH-MCO must provide written materials in alternative formats upon request of the Member at no cost.

8. The Primary Contractor or its BH-MCO is expected to refer any Member in

need of any routine and specialized medical and/or social service not provided by the BH-MCO to an appropriate agency/organization.

9. The Primary Contractor or its BH-MCO and its Provider network are required reporters for suspected instances of child abuse pursuant to 23 Pa.C.S. § 6311.

10. The Primary Contractor or its BH-MCO must assure that Members are provided reasonable access to Behavioral Health Services provided by FQHC, wherever FQHC Behavioral Health Services are available, within travel of 30 minutes (Urban) and 60 minutes (Rural).

11. In all agreements with health care professionals, the Primary Contractor or its BH-MCOs must comply with the requirements specified in 42 CFR 438.12 and 438.214 which includes selection and retention of Providers, credentialing and recredentialing requirement and nondiscrimination.

G. Utilization Management and Quality Management (UM/QM)

1. General

The Primary Contractor or its BH-MCO must adhere to Department of Health Regulation 28 Pa. Code Chapter 9, Subchapter G. The Primary Contractor or its BH-MCO must have written policies and procedures to monitor use of services by its Members and to assure the quality, accessibility, and timely delivery of care being provided by its network. Such policies and procedures must:

a. Conform to state Medicaid plan QM requirements.

b. Assure a UM/QM committee meets on a regular basis.

c. Provide for regular UM/QM reporting to the Primary Contractor or its BH-MCO management and its Provider network (including profiling of Provider utilization patterns) as well as reports of joint UM/QM activities/studies conducted with the PHSS.

d. Provide opportunity for consumer (including representation for consumers in Special Needs Populations), persons in recovery and family (including Parents/custodians of children and adolescents) participation in program monitoring.

2. Utilization Management (UM)

The Primary Contractor or its BH-MCO must have Department approved written UM policies and procedures that include protocols for prior approval (in accordance with Appendix AA), determination of Medical Necessity, Concurrent Review, Denial of Services, hospital discharge planning, Provider

profiling, and Retrospective Review of claims. As part of its UM function, the Primary Contractor or its BH-MCO must have processes to identify over, under, and type of service utilization problems and undertake corrective action.

UM practices should focus on the evaluation of the necessity, level of care, appropriateness, and effectiveness of Behavioral Health Services, procedures, and use of facilities.

The Primary Contractor must have criteria and review procedures. Mental health review criteria must be compatible with guidelines provided in Appendix T. Drug and alcohol reviews for adults must be conducted in accordance with criteria compatible with the ASAM criteria.

The Primary Contractor or it's BH-MCO must conduct drug and alcohol reviews for children and adolescents in accordance with criteria compatible with those of ASAM.

The Primary Contractor or it's BH-MCO must use the guidelines of Appendix S, *Medical Necessity Guidelines for Applied Behavioral Analysis (ABA) Using Behavioral Specialist Consultant (BSC)-Autism Spectrum Disorder (ASD) and Therapeutic Staff Support (TSS) Services for Children and Adolescents with Autism Spectrum Disorder,* when reviewing requests for prior authorization of ABA using BSC-ASD services and TSS services for children and adolescents under age 21 with ASD including the documentation that must be submitted for the BH-MCOs to determine the medical necessity of ABA using BSC-ASD services and TSS services.

The Primary Contractor will distribute the review and UM criteria to all Providers in its Provider network and to any new Provider who signs a Provider Agreement with the Primary Contractor. The Primary Contractor must also provide the criteria to Members, upon request.

3. Quality Management

   a. The Primary Contractor or its BH-MCO agrees to implement a Quality Management program that includes a Continuous Quality Improvement (CQI) process. The Primary Contractor or its BH-MCO agrees to fully comply with the Department's Quality Management and Utilization Management standards. The Primary Contractor or its BH-MCO must ensure that compensation to individuals or entities that conduct Utilization Management activities is not structured so as to provide incentives for the individual or entity to deny, limit, or discontinue medically necessary services to any Member. In the event that CMS specifies performance measures and topics for performance improvement projects to be required by the Department in their contracts with the Primary Contractor, its BH-MCO and its

Subcontractors must agree to cooperate fully in implementing these performance measures and projects.

b. Performance Improvement Projects

The Primary Contractor or its BH-MCO is required to conduct performance improvement projects that are designed to achieve, through ongoing measurements and intervention, significant improvement, sustained over time, in clinical care and non-clinical care areas that are expected to have a favorable effect on health outcomes and Member satisfaction. The performance improvement projects must involve the following:

i. Measurement of performance using objective quality indicators.
ii. Implementation of system interventions to achieve improvement in quality.
iii. Evaluation and initiation of activities for increasing or sustaining improvement.

Each performance improvement project must be completed in a reasonable time period so as to generally allow information on the success of performance improvement projects, in the aggregate, to produce new information on quality of care every year. The Primary Contractor is required to report the status and results of each project to the Department, as requested.

The BH-MCO must have a written QM plan that complies with 42 CFR Part 438, Subpart E and includes quality assessment and performance improvement processes designed to monitor, assure, and improve the quality of care delivered over a range of clinical and health service delivery areas. The continuous quality improvement process places emphasis on but need not be limited to, high volume and high-risk services and treatment and behavioral health rehabilitation services for children and adolescents, and care furnished to Members with special health care needs.

As a part of the QM plan, the BH-MCO should address, at a minimum, the effectiveness of the services received by Members, the quality and effectiveness of internal processes, and the quality of the Provider network. Among those areas to be considered in service delivery are access to services, the appropriateness of service manager authorizations, the authorization appeal process, adverse incidents, and the quality of service manager planning. Internal processes include but are not limited to telephone responsiveness; overall utilization patterns and trends; treatment outcomes; and Complaint, Grievance and fair hearing tracking processes. Provider monitoring includes but is not limited to utilization patterns, treatment outcomes, cooperation, and Member satisfaction. The QM plan shall also include mechanisms to incorporate recommended enhancements resulting from the

Department's monitoring and external evaluations and audits.

4. Confidentiality

The Primary Contractor or its BH-MCO must have written policies and procedures which comply with federal and state law and regulations for maintaining the confidentiality of data, including clinical records/Member information.

5. Member Satisfaction

The Primary Contractor, its BH-MCO or Subcontractor must have systems and procedures to routinely assess Member satisfaction. These systems and procedures should include but not be limited to the use of ongoing consumer/family satisfaction teams (C/FST) (in accordance with Appendix L).

The Primary Contractor or its BH-MCO shall contract with existing C/FST, or establish such teams if they do not exist, to conduct satisfaction surveys for Members. The Subcontract shall ensure technical support of the C/FST for report writing and conducting interviews and include funds for travel expenses and staff development of the C/FST. The Department will approve the C/FST Subcontracts established.

An annual report must be submitted to the Department on the activities and findings of the C/FST and Member satisfaction survey. Members and their families, including Parents of children and adolescents who are seriously emotionally disturbed and/or who abuse substances, or have been diagnosed with ASD, are to participate on the consumer/family satisfaction teams and in the design and implementation of the survey process. Such participation is to include: serving on C/FST, the review of C/FST and annual survey findings, and the determination of quality improvements to be undertaken based on the findings. The Primary Contractor and its BH-MCO should also have mechanisms which ensure that Member comments concerning Provider performance can be tracked in aggregate and be used as a component of Provider profiling. In addition, the Primary Contractor and its BH-MCO must cooperate in Member satisfaction assessments which may be performed by the Department, independent of the Primary Contractor's or its BH-MCO's internal process.

6. Provider Satisfaction

The Primary Contractor, either directly or via its BH-MCO or Subcontractor, must have systems and procedures to assess Provider satisfaction with network management. The systems and procedures must include, but not be limited to, an annual Provider satisfaction survey. Areas of the survey must include claims processing, Provider relations, credentialing, Prior Authorization, Service Management and Quality Management.

7. Department Review

The Primary Contractor, its BH-MCO and BH Services Providers must agree to make available to the Department and/or its authorized agents, on a periodic basis, clinical and other records for review of quality of care and access issues.

8. Performance-Based Contracting

Each performance improvement project must be completed in a reasonable time period so as to generally allow information on the success of performance improvement projects, in the aggregate, to produce new information on quality of care every year.

9. External Independent Assessment

On at least an annual basis, the Primary Contractor or its BH-MCO must provide necessary documentation in order to comply with independent external quality review organization (EQRO) activities. The review shall include:

a. Validation of the Primary Contractor's quality improvement projects.

b. Validation of the Primary Contractor's performance measures.

The Primary Contractor or its BH-MCO must provide, as necessary, a review of its compliance with state structural and operational standards. Information included in the EQRO must be derived from an assessment of compliance with standards that occurred within the last three years.

10. Pay for Performance - BH-MCO and PH-MCO Integrated Care Plan

The Department implemented a Pay for Performance program for integration and coordination of behavioral health and physical health services in accordance with Appendix E – Pay for Performance – Integrated Care Plan Program.

H. Advanced Directives

The Primary Contractor and its BH-MCO must have written policies and procedures for Advanced Directives that include the following: a description of State law; the process for notifying the Member of any changes in applicable State law as soon as possible, but no later than 90 days after the effective date of the change; any limitation the Primary Contractor or its BH-MCO has regarding implementation of Advanced Directives as a matter of conscience; the process for Members to file a Complaint

concerning noncompliance with the Advanced Directive requirements with the BH-MCO and DOH; and how to request written information on Advance Directive policies. The Primary Contractor and its BH-MCO must educate staff concerning its policies and procedures on Advanced Directives. The policies and procedures must include that the Primary Contractor and its BH-MCO may not condition the provision of care or otherwise discriminate against a Member based on whether or not the Member has executed an Advanced Directive.

II-6. PROGRAM OUTCOMES AND DELIVERABLES

A. Outcome Reporting

To measure the program's performance in the areas of access to care, outcomes, and satisfaction, the Primary Contractor and its BH-MCO must comply with the Department's program performance reporting requirements as delineated in Appendix K. The Primary Contractor or its BH-MCO must establish all coordination agreements and procedures necessary to collect the required data elements from the Providers, Members, etc.

The Primary Contractor or its BH-MCO must provide quarterly reports summarizing the findings, and actions taken in response to the findings of the consumer/family satisfaction teams as well as an annual report summarizing the findings and follow-up actions taken pursuant to the annual Member satisfaction survey conducted pursuant to Appendix L.

The Primary Contractor or its BH-MCO must have a plan in place to review the DDAP CIS data for accuracy and completeness and a plan to work with their Providers to that end.

B. Deliverables

Deliverables submitted by the Primary Contractor include, but are not limited to:

1)	Member Services	Marketing materials; Member handbooks; educational materials; Complaint and Grievance policies and procedures; Prior Authorization and access policies and procedures; listing of Providers.
2)	Administration	Letters of agreement; Provider contracts/Subcontracts; Provider Complaint system procedures; Provider network; staff development plan; Provider directory; Provider enrollment procedures; reimbursement methodology and rates; billing instructions and forms; encounter/referral form; coordination agreements; Complaint and Grievance data; clinical records; work space for evaluation teams; procedures and monitoring mechanisms for adhering to confidentiality laws and

regulations.

3) Quality Management /Utilization Management

QM plan; reports of QM activities; procedures for sharing independently developed QM/UM information related to pharmacy services; UM criteria and review procedures; clinical records and Member information; and corrective action plan(s).

4) Data

Descriptions of management reports; QM/UM data; monthly performance reports; person-level encounter; fiscal reports; aggregate encounter; Complaint and Grievance reports; performance outcome management reports, including the consumer registry and quarterly status; transition monitoring and monitoring reports.

5) Behavioral Health Rehabilitation Services for Children and Adolescents

Procedures for informing Members and Providers about services available concerning BHRS; procedures for evaluating Provider compliance with BHRS requirements; procedures for ensuring timely provision of services on an emergency or Urgent basis.

6) Other

Organization chart listing key staff/functions; management information system; management and financial data system; identification and location of service sites; plan for coordination with county mental health and drug and alcohol authorities, as applicable; coordination agreement including procedures for clinical dispute resolution between the PH-MCO and BH-MCO; DUR policies and procedures; incident reports and trend analyses.

II-7. FINANCIAL AND REPORTING REQUIREMENTS

A. Financial Standards

To measure the program's capacity to assume and manage risk as well as meet fiscal requirements related to account management and claims processing, the Primary Contractor and its BH-MCO must provide the Department with financial reports as required or upon request. It must also cooperate with any Department or external, independent assessment of performance under the Agreement, including any federally required cost-effectiveness review or other audit.

1) General

The Insurance Department (ID) regulates the financial stability of licensed BH-MCOs in Pennsylvania. Any licensed BH-MCO, therefore, must comply with applicable Insurance Department standards in addition to standards described in this document.

2) Risk Protection for High Cost Cases

The Department seeks to minimize risks that valid claims, submitted to BH MCOs by Providers, for costs incurred by a Member above a certain monetary threshold, might not be paid. Each Primary Contractor must have a risk protection arrangement in place until the Agreement expires. This risk protection arrangement must include individual stop loss reinsurance that covers, at a minimum, eighty percent (80%) of inpatient costs incurred by one Member during one year in excess of $75,000. The Department may alter or waive the reinsurance requirement if the Primary Contractor submits an alternative risk protection arrangement that the Department determines is acceptable.

The Department reserves the right to institute a different reinsurance threshold amount, to be determined by the Department if, upon review of financial and encounter data or other information, fiscal concerns arise that such a change in reinsurance threshold is deemed warranted by DHS. A review will occur annually, so that any change in reinsurance thresholds can be imposed or withdrawn as the financial situation of the Primary Contractor warrants a change.

The Primary Contractor must submit its plan for risk protection for high cost cases 60 days prior to the beginning of each Agreement period. The Department will determine the acceptability of the reinsurance or alternate risk protection arrangement.

The Primary Contractor may not change or discontinue the risk protection arrangement without prior approval from DHS. The Primary Contractor must notify DHS 45 days prior to any change in the risk protection arrangement. The Department reserves the right to review such risk protection arrangements and require changes based on the Department's assessment of the Primary Contractor's overall financial condition.

3) Insolvency Arrangement/Secondary Liability

Each Primary Contractor must submit its plan 60 days prior to the beginning of each Agreement period to provide for payment to Providers by a secondarily liable party after a default in payment to Providers resulting from bankruptcy or insolvency. The secondarily liable party must insure payment to Providers for all services performed by the BH-MCO's Providers through the last day for which DHS paid a Capitation premium to the Primary Contractor. The insolvency arrangement must be at a minimum, the

equivalent of two months' worth of paid claims, when determinable, or two months of expected Capitation revenue, in the absence of claims history. The requirement may be met by submitting one or more of the following arrangements:

a. insolvency insurance;
b. an irrevocable, unconditional and automatically renewable letter of credit for the benefit of DHS, or the county or Multi-County Entity, as applicable, to be determined on a case-by-case basis, which is in place for the entire term of the Agreement;
c. a guarantee from an entity, acceptable to the Department, with sufficient financial strength and credit worthiness to assume the payment obligations of the Primary Contractor in the event of a default in payment resulting from bankruptcy or insolvency; or
d. other arrangements, satisfactory to the Department, that are sufficient to ensure payment to Providers in the event of a default in payment resulting from bankruptcy or insolvency.

The financial instrument(s) submitted for consideration must clearly reflect that the instrument(s) is to be attached only in the event of a bankruptcy or insolvency. DHS must approve all such arrangements prior to the signing of the Agreement. Such approval will include approval of the financial strength of the secondarily liable parties and approval of all legal forms for secondary liability.

The Primary Contractor is required to submit its insolvency arrangement to DHS annually. Any proposed changes must be submitted to DHS for approval at least 45 days prior to any change becoming effective.

The Department, at its discretion, reserves the right to temporarily waive this requirement, in full or in part, if the insolvency requirement is being met by funds held in an approved Risk and Contingency account. The Department will provide written notification of any temporary waiver.

4) Equity and Other Requirements

The following section applies only if the Primary Contractor is a County or Multi-County Entity operated BH-MCO:

a. The Primary Contractor is required to meet and maintain minimum equity requirements throughout the life of the Agreement. The purpose of the standard is to assure payment of the Primary Contractor's BH-MCO's obligations to Providers and to assure performance by the BH-MCO of its obligations under the Agreement.

   The Primary Contractor is required to submit a quarterly report (refer to Appendix P, Report #17) that states whether or not it is in compliance

with the equity requirements. If not in compliance with the requirements of this section, the Primary Contractor will supply a report that provides an analysis of its fiscal health and steps that management plans to take, if any, to improve its fiscal health and to meet the equity requirements under this Agreement.

Each Primary Contractor must maintain minimum equity equal to the greater of $250,000 or 5% of annual HealthChoices Capitation revenue net of the Gross Receipts Tax, HIPF and MCO Assessment obligations paid or accrued as of the end of each reporting quarter. Annual HealthChoices Capitation revenue refers to amounts paid or accrued by DHS to the Primary Contractor, as shown on Report #17. During the first year after implementation, the equity may be phased in over the first four quarters of the Agreement. The phase-in requirement is 2% at the end of the first quarter; 3% at the end of the second quarter; 4% at the end of the third quarter and 5% at the end of the fourth quarter.

No later than 45 days prior to the effective date of this Agreement, the Primary Contractor must provide documentation that the equity requirement is being met, or will be met, by the effective date of the Agreement. The Primary Contractor must provide DHS with a Statement of Revenues and Expenses, balance sheet, and a Statement of Cash Flows, not later than 45 days after the end of each month (See Appendix P, Reports #13, 14, and 15). Statements must be consistent with Generally Accepted Accounting Principles (GAAP). These financial statements must include only information applicable to this Agreement. Each quarter, the balance sheet that provides information as of the last day of a calendar quarter must be accompanied by a certification, by an independent actuary, of the liabilities shown on the balance sheet (See Appendix P, Report #13).

Equity requirements will be determined at the end of each quarter, based on the contract-specific balance sheet. Assets held to meet the minimum equity requirements must be in a form accepted by the ID as an "admitted asset." Assets held to meet the equity requirements must be maintained in a Restricted Reserve Account up to a maximum of 105% of the equity requirement as calculated on quarterly Report #17. This account must be established by applicable municipal ordinance or similar authority and will maintain funds for the exclusive use as a reserve under the Agreement. Withdrawals from this account will be made only with express written approval by DHS. Copies of the bank statements verifying deposits must be mailed monthly directly from the banking institution to the Department. The amounts held in the Restricted Reserve Account as of the last day of the calendar quarter will be compared to the minimum equity requirement amounts in order to determine compliance with this standard.

Within 15 days of identification of equity funds in excess of 105% of the requirement as shown on quarterly Report #17, funds must be:

- moved to funds designated for reinvestment; or
- moved to a Risk and Contingency account, up to the allowable DHS-calculated limit, after receiving written approval from the Department; or
- used to provide State Plan Services and administrative functions required by this document, due to fluctuations in enrollment, revenue or utilization which have caused costs to exceed available Capitation payments; or
- be returned to the Department.

The Department, at its discretion, reserves the right to temporarily waive this requirement, in full or in part, if the equity requirement is being met by the funds held in an approved Restrictive Reserve account. The Department will provide written notification of any temporary waiver.

If the Primary Contractor fails to comply with the requirements of this section, the Department may take any or all of the following actions:

- discuss fiscal situation with the Primary Contractor's management;
- require the Primary Contractor to submit and implement a corrective action plan to address fiscal problems;
- suspend enrollment of some or all Members into the Primary Contractor's BH-MCO;
- terminate the Agreement effective the last day of the calendar month after the Department notifies the Primary Contractor of termination.

b. The Primary Contractor shall account for its HealthChoices transactions in an Enterprise Fund.

c. Except as otherwise approved by the Department, the Primary Contractor may not use State and Federal funds allocated to the County MH and D&A programs pursuant to the 1966 MH/MR Act and the 1972 Drug and Alcohol Act (71 P.S. § 1690.101 et. seq.) to pay for HealthChoices Program costs.

5) Equity and Other Requirements

The following requirements apply if the Primary Contractor is a county or a Multi-County Entity and the Primary Contractor contracts with a Private Sector BH-MCO and one of the following conditions applies:

- the cost of the BH-MCO contract is at least 80% of the revenue the county

receives from DHS under this Agreement; or

- the contract between the Primary Contractor and the BH-MCO provides that the BH-MCO contractor is substantially at risk to provide services without financial recourse to the county.

a) The requirements of Sections 2), 3), and 4)a. above also apply to the Private Sector BH-MCO contractor if the contract between the Primary Contractor and the Private Sector BH-MCO requires that the Private Sector BH-MCO meet and maintain the risk protection, equity and insolvency arrangement requirements stated in Sections 2), 3), and 4)a.

b) The Primary Contractor shall account for its HealthChoices transactions in a Special Revenue Fund.

c) Except as otherwise approved by the Department, the Primary Contractor may not use State and Federal funds allocated to the County MH and D&A programs pursuant to the 1966 MH/MR Act and the 1972 Drug and Alcohol Act (71 P.S. § 1690.101 et. seq.) to pay for HealthChoices Program costs.

6) Equity and Other Requirements

The following requirements apply if the Primary Contractor is a Private Sector BH-MCO:

1. The requirements of Sections 2) and 3)

b) Equity Requirements – Private Sector BH-MCO

In addition to the Primary Contractor's responsibility to meet requirements of the Insurance Department, the Primary Contractor is required to meet and maintain minimum equity requirements throughout the life of the Agreement. The purpose of the standards is to assure payment of the Primary Contractor's obligations to Providers and to assure performance by the Primary Contractor of its obligations under the Agreement.

Each Primary Contractor must maintain minimum SAP-based equity equal to the greater of $250,000 or 5% of annual HealthChoices Capitation revenue net of the Gross Receipts Tax, HIPF, and MCO Assessment obligations paid or accrued as of the end of each reporting quarter. Annual HealthChoices Capitation revenue refers to amounts paid by DHS to the Primary Contractor.

The Primary Contractor's equity as of the last day of the most recent Calendar quarter will be determined in accordance with SAP-based equity, as reported to the Insurance Department, and compared to the minimum equity requirement amounts in order to determine compliance with this standard.

The Primary Contractor will be required to submit a quarterly report (refer to Appendix P, Report #17) that states whether or not it is in compliance with the equity requirements. If equity is not in compliance with the requirements of this section, the Primary Contractor will supply a report that provides an analysis of its fiscal health and steps that management plans to take, if any, to improve its fiscal health and to meet the equity requirements of its Agreement.

If the Primary Contractor fails to comply with the requirements of this section, the Department may take any or all of the following actions:

- Discuss fiscal situation with Primary Contractor management;
- Require the Primary Contractor to submit and implement a corrective action plan to address fiscal problems;
- Suspend enrollment of some or all recipients into the Primary Contractor's HC-BH Program;
- Terminate the Agreement effective the last day of the calendar month after the Department notifies the Primary Contractor of termination.

7) The Primary Contractor must maintain revenues paid by the Department under the Agreement in a contract-specific bank account or accounts. These accounts will not contain funds unrelated to the Agreement. The Primary Contractor may prudently invest funds in the account and retain any interest or dividend for use in funding the costs of the Agreement.

8) The Primary Contractor must maintain separate fiscal accountability for Medicaid funding under the Waiver apart from mental health and substance abuse programs funded by state, county, and/or other federal program moneys, or any other lines of business. The Primary Contractor must maintain procedures for accurately recording, tracking and monitoring HealthChoices revenues and expenses separately from other lines of business, and by county, if the Primary Contractor has an Agreement in more than one (1) HealthChoices county.

9) DHS' obligation to make payments is limited to the Capitation payments provided by the Agreement. If DHS is obligated as a result of litigation to pay a Provider for a service rendered under the Agreement, the Primary Contractor will have an obligation to DHS in the same amount. DHS may offset an obligation it has to the Primary Contractor by this amount, or DHS may demand payment from the Primary Contractor.

10) Limitation of Liability

In accordance with 42 CFR 434.20, the Primary Contractor must assure that Members will not be liable for the Primary Contractor or its BH-MCO's debts

if the Primary Contractor or its BH-MCO becomes insolvent.

The Primary Contractor and its BH-MCO must also include in all of its Provider Agreements a continuation of benefits clause, which states that the Provider agrees that in the event of the BH-MCO's insolvency or other cessation of operations, the Provider will continue to provide benefits to the BH-MCO Members through the period for which the premium has been paid, including Members in an inpatient facility.

11) Behavioral Health Service Cost Accruals

The Primary Contractor must have actuarial services available to provide rate and other support services needed under the Agreement. The Primary Contractor must provide DHS with an actuarial certification of liabilities quarterly, if a county-operated BH-MCO, and at least annually, if a licensed, risk-bearing entity. As part of its accounting and budgeting function, the Primary Contractor or its BH-MCO must establish an actuarially sound process for estimating and tracking incurred but not reported claims (IBNRs). The Primary Contractor or its BH-MCO must reserve funds by major categories of service (e.g., inpatient; outpatient) to cover both IBNRs and received but unpaid claims (RBUCs). As part of its reserving methodology, the Primary Contractor or its BH-MCO should conduct annual reviews and reconciliations to assess its reserving methodology and make adjustments as necessary.

12) Financial Performance

The Department will monitor the financial performance of the Primary Contractor, its BH-MCO and its major Subcontractors. Monitoring will include, but not be limited to, financial viability, profit, and appropriateness of medical and administrative expenditures.

13) Reporting Penalty

If the Primary Contractor fails to provide any report, audit, or file that is specified by the Agreement by the applicable due date, or if the Primary Contractor provides any report, audit, or file specified by the Agreement that does not meet established criteria, a subsequent payment to the Primary Contractor may be reduced by the Department. The reduction shall equal the number of days that elapse between the due date or any extension due date granted by the Department, and the day that the Department receives a report, audit, or file that meets established criteria, multiplied by the average PMPM Capitation rate that applies to the first month of the Agreement period. If the Primary Contractor provides a report, audit, or file on or before the due date, and if the Department notified the Primary Contractor after the 15th calendar day after the due date that the report, audit, or file does not meet established criteria, no reduction in payment will apply to the 16th day after the due date through

the date that the Department notified the Primary Contractor.

See Appendix R, Encounter Data Submission Requirements and Liquidated Damages for Noncompliance, for sanctions related to noncompliance.

14) The Primary Contractor and its BH-MCO must not pay any amount for which funds may not be used under the federal Assisted Suicide Funding Restriction Act of 1997 (P.L. 105-12, 111 Stat. 23 (April 30, 1997)), including payments for items or services furnished for the purpose of causing, the death of any individual, such as by assisted suicide, euthanasia or mercy killing. The Primary Contractor and its BH-MCO must not pay for any item or service for road bridges, stadiums, or any other item or service not provided for under this Agreement.

B. Capitation Payment

The following requirements apply to the final Capitation rate and the receipt of Capitation payments under the contract:

(1) The final Capitation rate for each Primary Contractor must be:

(i) Specifically identified in the review and approval by CMS of the rate certification package.

(ii) The final Capitation rates must be based only upon services covered under the State Plan and additional services deemed by the Department to be necessary to comply with the requirements of subpart K of §438.900 (applying parity standards from the Mental Health Parity and Addiction Equity Act), and represent a payment amount that is adequate to allow the Primary Contractor to efficiently deliver covered services to Medicaid-eligible individuals in a manner compliant with contractual requirements.

(2) Capitation payments may only be made by the Department and retained by the Primary Contractor for Medicaid eligible enrollees.

C. Acceptance of Department Capitation Payments

The Department's payment to a Primary Contractor is capitated for all State Plan Services. The obligation of the Department to make payments is limited to Capitation payments. The Department shall make Capitation payments to the Primary Contractor on a monthly basis in the following manner:

On the first day of each month, the Department will identify Members, whose enrollment in the BH-MCO is effective the previous month, as indicated in CIS. By the 15th day of the month, the Department shall make a Capitation payment to the Primary Contractor, for each Member enrolled in the BH-MCO, that constitutes payment in full for any and all covered services provided to the

Member for the first day of the previous month that the Member is enrolled in the BH-MCO and for each subsequent day, through and including the last day of the previous month. This payment will be limited to those days for which the Department has not previously made payment to the Primary Contractor. The Department, however, at its sole discretion, reserves the right to:

1. delay all Capitation payments that would otherwise be made in the months of May and June, until July of the same year.
2. make a Capitation payment by the 15th of the month, for those months specified by the Department and upon notice to the Primary Contractor by the Department, for each Member enrolled in the BH-MCO, that constitutes payment in full for any and all covered services provided to the Member for the first day of the current month that the Member is enrolled in the BH-MCO and for each subsequent day, through and including the last day of the month. This payment will be limited to those days for which the Department has not previously made payment to the Primary Contractor.

For Members whose enrollment is effective at any time after the first day of the month, Capitation will be prorated and paid at a later date.

Appendix V, the HealthChoices Behavioral Health Recipient Coverage Document, provides for adjustments to the Department's obligation to make Capitation payments. Appendix V is subject to revision by the Department in its sole discretion and without the need to amend the Agreement.

The Capitation payment will be equal to the amount awarded the Primary Contractor through the rate setting process. Monthly Capitation rates will be changed to equivalent per diem amounts for the purpose of payments.

The Agreement will provide for rates for SSI Members who have Medicare Part A benefits that are distinct from rates for SSI Members who do not have Medicare Part A benefits. If the Department's TPL file is updated to indicate Medicare Part A coverage within four months prior to the current month for a Member at an SSI without Medicare rate, the Department will adjust the payment to reflect the rate cell appropriate to the Members, provided the TPL file indicates Part A coverage as of the first day of coverage by the Primary Contractor for this Member during the program month for which payment was made. If the Department's TPL file is updated to adjust or delete indication of Medicare Part A coverage within four months of a payment to the Primary Contractor for a Member at an SSI with Medicare or Healthy Horizons rate, the Department will adjust the payment to reflect the rate cell appropriate to the Member, provided the TPL file does not indicate Part A coverage as of the first day of coverage by the Primary Contractor for this Member during the program month for which payment was made. The Department will provide information to the Primary Contractor on this type of payment

adjustment on an electronic file. The Primary Contractor will utilize this information to adjust its payments to Providers and instruct its Providers to bill Medicare.

The Department will recover Capitation payments made for the Members who were later determined to be ineligible or deceased. (See Appendix V, HealthChoices BH Recipient Coverage Document.)

The Primary Contractor must agree to accept Capitation payments in this manner and must have written policies and procedures for receiving, reconciling and processing Capitation payments.

By executing this Agreement, the Primary Contractor has reviewed the rates set forth in Appendix 3, Rates, and accepts the rates.

1. Payments for Members that are patients in an IMD

a) The Department will make a monthly capitation payment for a Member receiving inpatient or residential treatment services in an IMD so long as the facility is a hospital or a residential facility providing psychiatric or substance use disorder treatment.

i. IMDs providing substance use disorder treatment: Capitation payment will be made for stays in an IMD providing substance use disorder treatment .

ii. IMDs providing psychiatric treatment:
- For individuals under 21 years of age or 65 years of age or older, capitation payment will be made.
- For individuals 21-64 years of age, the Primary Contractor can retain the capitation payment only if the length of stay in the IMD is for a short term stay of no more than 15 cumulative days during the period of the monthly capitation payment and the provision of inpatient psychiatric treatment in an IMD must meet the requirements for *in lieu of* services in 42 CFR § 438.3(e)(2)(i) through (iii). For stays longer than 15 cumulative days, the entire capitation payment for the month will be recouped by the Department.

b) For purposes of rate setting, the Department will use the utilization of services provided to an enrollee under 42 CFR § 438.6 when developing the inpatient psychiatric or substance use disorder component of the capitation rate but must price utilization at the cost of the same services through Providers included under the State Plan.

c) The Primary Contractor, and/or its BH-MCO, will comply with the Department's request for information regarding individuals in an IMD on a

monthly basis, or as requested.

2. Automated Clearing House

The Department will make Capitation payments through the Automated Clearing House (ACH) Network. Within 10 days of the contract award, the Primary Contractor must submit or have already submitted its ACH information within its user profile in the Commonwealth's procurement system (PA Supplier Portal). At the time of submitting ACH information, the Primary Contractor will also be able to enroll to receive remittance advice via electronic addenda.

It is the responsibility of the Primary Contractor to ensure that the ACH information contained in SRM is accurate and complete. Failure to maintain accurate and complete information may result in delays in payments.

D. Physician Incentive Arrangements

The Primary Contractor may operate a physician incentive plan only in accordance with Federal requirements for physician incentive plans and must provide reports to CMS or the Department upon request. The Primary Contractor contracts must provide for compliance with the requirements set forth in §§ 422.208 and 422.210 of 42 CFR, Chapter 438. In applying the provisions of § 422.208 and § 422.210 of 42 CFR, references to ''MA organization,'' ''CMS,'' and ''Medicare beneficiaries'' must be read as references to the Primary Contractor ''State,'' and ''Medicaid beneficiaries,'' respectively.

E. Claims Payment and Processing

1) Payments to Providers

The Department believes that one of the advantages of a behavioral health managed care system is that it permits Primary Contractors and their BH-MCOs to enter into creative payment arrangements intended to encourage and reward effective Utilization Management and quality of care. The Department therefore intends to give Primary Contractors and BH-MCOs as much freedom as possible to negotiate mutually acceptable payment rates. However, regardless of the specific arrangements made with Providers, the Primary Contractor and BH-MCOs must agree to make timely payments to both contracted and non-participating Providers, subject to the conditions described below. The Primary Contractor and its BH-MCO must also agree to abide by special reimbursement provisions for FQHCs described below.

The Primary Contractor agrees to negotiate and pay rates to IHCPs, FQHCs, and RHCs comparable to other Providers who provide comparable services in the Primary Contractor's Provider network. The Primary Contractor cannot pay annual cost settlement or prospective payment. If the Primary Contractor

does not negotiate a rate with an IHCP, the Primary Contractor must pay the IHCP a rate that is not less than the level and amount of payment that it would have made for the services to a participating provider which is not an IHCP. The BH-MCO may require that an FQHC comply with Case Management procedures that apply to other entities that provide similar benefits or services.;

The Primary Contractor must provide Members access to FQHCs and RHCs within the Provider Network. The Primary Contractor must pay FQHC and RHC rates no less than Fee-for-Service Prospective Payment System (PPS) rate(s), as determined by the Department. The Primary Contractor must include in its Provider Network every FQHC and RHC that is willing to accept PPS rates as payment in full.

The Primary Contractor and its BH-MCO shall not be obligated to pay Providers of authorized Behavioral Health Services unless bills for such services are submitted within 180 days from the date of service.

BH-MCOs may include a requirement in its Provider Agreements and Subcontracts that require that submission of Claims or Encounter records to be submitted within 180 days, or less, from the date of services. Claims adjudicated by a third-party vendor must be provided to the BH-MCOs by the end of the month following the month of adjudication.

The Primary Contractor and its BH-MCO shall follow state law on invoicing requirements on uniform claims, including the CMS 1500 and UB92, and HIPAA regulations for electronic billing via the 837 I and 837 P.

When an IHCP is not enrolled in the MA Program as an FQHC it may receive its applicable encounter rate published annually in the Federal Register by the Indian Health Service, or in the absence of a published encounter rate, the amount it would receive if the services were provided under the Department's MA FFS program.

2) The Department will not make payments to a Network Provider, for services covered under the Agreement between the Department and the Primary Contractor except when these payments are specifically required to be made by the Department in Title XIX of the Act, in 42 CFR Chapter IV, or when the Department makes direct payments to Network Providers for graduate medical education, costs approved under the State Plan.

3) The Primary Contractor and its BH-MCO shall adjudicate 90% of all Clean Claims within 30 days, 100% of Clean Claims within 45 days, and 100% of all claims within 90 days. The Primary Contractor shall provide the Department with a monthly report that supplies summary information on claims processed. This reporting requirement applies to claims processed by the Primary Contractor, its BH-MCO, or a Subcontractor, as well as capitation payments

to Providers or Subcontractors of Behavioral Health Services. The specific report contents and claims processing timeliness standards are detailed in the HealthChoices Behavioral Health Financial Reporting Requirements (See Appendix P, Report #8).

F. Retroactive Eligibility Period

The Primary Contractor and its BH-MCO will not be responsible for any payments owed to Providers for services that were rendered prior to a Member's effective date of enrollment.

G. (Member) Copays

The Primary Contractor and its BH-MCO are not allowed to impose co-pays for services.

H. Financial Responsibility for Dual Eligibles

The Commonwealth enters into a Coordination of Benefits Agreement with Medicare for the Medical Assistance populations. Consistent with 42 C.F.R. §438.3(t), the Primary Contractor or its BH-MCO must enter into individual Coordination of Benefits Agreements with Medicare for members dually eligible for Medicaid and Medicare and participate in the automated claims crossover process.

The Primary Contractor must ensure that a Member who is eligible for both Medicaid and Medicare benefits has the right to access a Medicare product or service from the Medicare Provider of his/her choice, regardless of whether that Provider is enrolled in the BH-MCO network. BH-MCOs may establish policies and procedures for their networks that maximize opportunities for consumers to have a choice of Medicare Providers.

The Primary Contractor and its BH-MCO must pay Medicare deductibles and coinsurance amounts relating to any Medicare-covered service for qualified Medicare beneficiaries up to the contracted BH-MCO rate for the service billed by Network Providers. The Primary Contractor, its BH-MCO and Providers are prohibited from balance billing Members for Medicare deductibles or coinsurance. If the service is a covered Medicare service, the Primary Contractor is responsible to pay any Medicare coinsurance and deductible amount, whether or not the Medicare Provider is included in the BH-MCOs Provider Network, and whether or not the Medicare Provider has complied with the authorization requirements of the Contractor. Since Medicaid payment of Medicare deductible and coinsurance amounts may be made only to Medicaid participating Providers, Medicare Providers seeking payment must be enrolled in Medicaid.

If no contracted BH-MCO rate exists or if the Provider of the service is an Out-of-Network Provider, the Primary Contractor must pay deductibles and coinsurance up to the applicable Medical Assistance fee schedule amount for the service.

For Medicare services that are not covered by either MA or the BH-MCO, the Primary Contractor must pay cost-sharing to the extent that the payment made under Medicare for the service and the payment made by the BH-MCO do not exceed 80% of the Medicare-approved amount.

In the event that Medicare does not cover a service, the Primary Contractor's BH-MCO may require Prior Authorization as a condition of payment for the service.

I. Risk and Contingency Funds (Does not apply to a Private Sector BH-MCO as the Primary Contractor)

1) The Primary Contractor shall submit a written request to the Department prior to designating funds as Risk and Contingency Funds. The request must include why funds should be designated as Risk and Contingency Funds instead of reinvested.

2) The amount approved by the Department must be placed in a risk and contingency account within 30 days of receiving a written approval letter from the Department.

3) The Primary Contractor is permitted to utilize without approval from the Department its Risk and Contingency Funds to make payments to its BH-MCO or Subcontractors if there is a delay of more than 31 days in a Capitation Payment from the Department. The Primary Contractor must return any funds used to its risk and contingency account within 60 days of their withdrawal from the risk and contingency account.

4) With prior written approval from the Department, the Primary Contractor may use Risk and Contingency Funds for the following purposes:

   a. To provide State Plan Services and administrative functions required by this document, due to fluctuations in enrollment, revenue and utilization which have caused costs to exceed available Capitation Payments;

   b. To meet the Primary Contractor's insolvency arrangement plan under Part II-7 A. of this document. Those Risk and Contingency Funds held for insolvency protection purposes will be restricted and only available in the event of a bankruptcy or insolvency; or for 3) above; or

   c. To meet the Primary Contractor's reinvestment plan.

5) Risk and Contingency (R&C) Funds shall at no time exceed the equivalent of 45 days' worth of paid claims, as determined by the Department, unless the Primary Contractor is holding funds in its risk and contingency account in order to meet the Department's insolvency arrangement requirements in Part II-7 A.

as follows:

a. If Risk and Contingency Funds are being used to fully meet the Department's insolvency arrangement requirement (equal to 60 days' worth of paid claims), the Department will inform the Primary Contractor of how many days of paid claims the Primary Contractor must maintain, which may include up to 90 days' worth of paid claims.

b. If Risk and Contingency Funds are being used to partially meet the Department's insolvency arrangement requirement (less than 60 days' worth of paid claims), the Department will inform the Primary Contractor of how many days of paid claims the Primary Contractor must maintain, which may include up to 75 days' worth of paid claims.

c. If Risk and Contingency Funds are being used to fully or partially meet the Department's insolvency arrangement requirement, the Department will inform the Primary Contractor of how many days of paid claims the Primary Contractor must maintain which may include up to 75 or 90 days' worth of paid claims. The Risk and Contingency Fund would then need to be funded, at a minimum, at the amount agreed upon by the Department, at all times.

d. In the event a Primary Contractor is meeting the insolvency arrangement requirement via Risk and Contingency Funds and changes the method in which the insolvency arrangement requirement is met, the days' worth of paid claims permitted to be maintained as Risk and Contingency Funds must change accordingly.

   Funds designated in a reinvestment plan submitted to the Department will not be included in the calculation of the 45, 75 or 90 days' worth of paid claims, as applicable. If the Risk and Contingency Funds exceed the equivalent of 45, 75 or 90 days' worth of paid claims, as applicable, at the end of any Agreement period, the Primary Contractor shall return the excess portion to the Department within 15 days of written notification from the Department.

6) The Risk and Contingency Funds shall be held in a bank account that is separate from any other HealthChoices bank accounts. Copies of the bank statements must be mailed monthly to the Department.

7) The Risk and Contingency Funds shall be reported as a separate line item on the monthly financial report and audited balance sheet submitted for the annual Agreement audit, including a statement of cash flow.

8) Within 14 months from the termination of the Agreement, any Risk and Contingency Funds remaining in the Primary Contractor's HealthChoices Special Revenue or Enterprise Fund for the HealthChoices Behavioral

Health Program shall be returned to the Department.

9) In the event that the Department enters into another agreement with the Primary Contractor for the provision of HealthChoices Behavioral Health Services subsequent to a current Agreement's termination, the Department reserves the right, in its sole discretion, to allow the Primary Contractor to retain all, or a portion thereof, of Risk and Contingency Funds otherwise owed to the Department.

10) The Department reserves the right to revise the Risk and Contingency Fund requirements at its discretion. Any revisions will be implemented in compliance with timelines defined in the Agreement.

J. Return of Funds

Sections 1) and 2) below do not apply to a Private Sector BH-MCO as the Primary Contractor)

1) The Primary Contractor must return any unexpended Reinvestment Funds to the Department within six months from the time period approved for such expenditure unless such date is otherwise extended by the Department.

2) In the event that the Agreement with the Department ends and is not renewed, all funds, except for those in DHS approved reinvestment plans, or Reinvestment Funds in a plan submitted to DHS but which DHS has not taken a positive or negative action, remaining in the Primary Contractor's Special Revenue Fund or Enterprise Fund, or held by any Subcontractor, inclusive of Risk and Contingency Funds, not expended for HC-BH transactions, must be returned to the Department within 14 months from the expiration of the Agreement.

K. In-Network Services

The Primary Contractor or its BH-MCO will be responsible for making timely payment for medically necessary, State Plan Services.

1) In-Network Providers

The Primary Contractor or its BH-MCO will be responsible for making timely payment for medically necessary, State Plan Services rendered by in-network Providers when:

a. Services were rendered to treat a psychiatric or drug/alcohol emergency other than in a hospital emergency room; or

b. Medically necessary involuntary treatment services were rendered pursuant to a court order; or

c. Services were rendered under the terms of the BH-MCO's contract with the Provider; or

d. Services were prior authorized.

Under these terms, the Primary Contractor will not be financially liable for services rendered in a hospital emergency room other than for emergency room evaluations for voluntary or involuntary commitments pursuant to the Mental Health Procedures Act of 1976 which will be the responsibility of the BH-MCO.

2) Out-of-Network Providers

The Primary Contractor or its BH-MCO will be responsible for making timely payments to Out-of-Network Providers for medically necessary, State Plan Services when:

a. Services were rendered to treat a psychiatric or drug/alcohol emergency other than in a hospital emergency room; or

b. Medically necessary involuntary treatment services were rendered pursuant to a court order; or

c. Services were prior authorized by the BH-MCO; or

d. Medically necessary services were rendered during an emergency placement by the child welfare agency.

Under these terms, the Primary Contractor will not be financially liable for services rendered in a hospital emergency room other than for voluntary or involuntary commitments pursuant to the 1976 Mental Health Procedures Act which will be the responsibility of the BH-MCO. The BH-MCO must assure that Out-of-Network Providers coordinate with respect to payment. The BH-MCO must assure that cost to Members is no greater than it would be if services were provided within the Provider network.

An Out-of-Network Provider, which is an enrolled MA Provider and which is billing the BH-MCO for covered HealthChoices State Plan Services, shall not balance bill the Member.

However, if the BH-MCO is referring a Member to an Out-of-Network Provider, the BH-MCO must pay deductibles and co-insurance up to the applicable Medical Assistance fee schedule amount for the service. In these circumstances, the Member cannot be subject to balance billing by the Provider.

The Primary Contractor and its BH-MCO must permit a Member who is an Indian as defined at 25 USC §§ 1603(13), 1603(28), or 1679(a), or who has been determined eligible as an Indian under 42 CFR § 136.12, to obtain

services from out-of-network IHCPs from whom the Member would otherwise be eligible to receive such services. The Primary Contractor and its BH-MCO must permit an out-of-network IHCP to refer a Member who is an Indian to a Network Provider.

3) Liability During an Active Provider Complaint

The Primary Contractor or its BH-MCO will not be liable to pay claims to Providers if the validity of the claim is being challenged by the BH-MCO through a Complaint process or appeal, unless the BH-MCO is obligated to pay the claim or a portion of the claim through its contract with the Provider.

L. Third Party Liability (TPL)

The Primary Contractor must comply with the TPL procedures defined by Section 1902(a)(25) of the Social Security Act, 42 U.S.C.A. § 1396 (a)(25) and implemented by the Department. Under the Agreement, the Third-Party Liability responsibilities of the Department will be allocated between the parties as indicated below.

1) Cost Avoidance Activities

a. The Primary Contractor/ BH-MCO has primary responsibility for cost avoidance through the Coordination of Benefits (COB) relative to federal and private health insurance-type resources including, but not limited to, Medicare, private health insurance, Employees Retirement Income Security Act of 1974 (ERISA), 29 U.S.C.A. § 1396a(a)(25) plans, and workers compensation. Except as provided in subparagraph 2, the Primary Contractor/ BH-MCO must attempt to avoid initial payment of claims, whenever possible, where federal or private health insurance-type resources are available. All cost-avoided funds must be reported to the Department via encounter data submissions and financial report 11. The use of the appropriate HIPAA 837 Loop(s) for Medicare, and Other Insurance Paid (OIP) shall indicate that TPL has been pursued and the amount which has been cost-avoided. The Primary Contractor shall not be held responsible for any TPL errors in the Department's EVS or the Department's TPL file.

b. The Primary Contractor or its BH-MCO agrees to pay, and to require that its Subcontractors pay, all Clean Claims for prenatal or preventive pediatric care including EPSDT services to children, and services to children having medical coverage under a Title IV-D child support order to the extent the Primary Contractor/BH-MCO is notified by the Department of such support orders or to the extent they become aware of such orders, and then seek reimbursement from liable third parties. The Primary Contractor or its BH-MCO shall communicate and encourage Providers to bill other primary insurance first, prior to submitting the claim to Medicaid. The

Primary Contractor or its BH-MCO recognizes that cost avoidance of these claims is prohibited.

c. The Primary Contractor or its BH-MCO may not deny or delay approval of otherwise covered treatment or services based upon Third Party Liability considerations. The Primary Contractor or its BH-MCO may neither unreasonably delay payment nor deny payment of claims unless the probable existence of Third-Party Liability is established at the time the claim is adjudicated.

2) Post-Payment Recoveries

a. Post-payment recoveries are categorized by (a) health-related insurance resources and (b) other resources. Health-related insurance resources are ERISA health benefit plans, Blue Cross/Blue Shield subscriber contracts, Medicare, private health insurance, workers compensation, and health insurance contracts. The term “other resources” means all other resources and includes, but is not limited to, recoveries from personal injury claims, liability insurance, first-party automobile medical insurance and accident indemnity insurance.

b. The Department's Division of TPL retains the sole and exclusive right to investigate, pursue, collect, and retain all "other resources" as defined in paragraph 2)a. above. The Department is assigned the Primary Contractor’s subrogation rights to collect the “other resources” covered by this provision. Any correspondence or inquiry forwarded to the Primary Contractor or its BH-MCO (by an attorney, Provider of service, insurance carrier, etc.) relating to a personal injury accident or trauma-related medical service, or which in any way indicates that there is, or may be, legal involvement regarding the recipient and the services which were provided, must be immediately forwarded to the Department's Division of TPL. The Primary Contractor or its BH-MCO may neither unreasonably delay payment nor deny payment of claims because they involved an injury stemming from an accident such as a motor vehicle accident, where the services are otherwise covered. Those funds recovered by the Commonwealth under the scope of these "other resources" shall be retained by the Commonwealth.

c. Due to potential time constraints involving cases subject to litigation, the Department must ensure that it identifies these cases and establishes its claim before a settlement has been negotiated. Should the Department fail to identify and establish a claim prior to settlement due to the Primary Contractor's/BH-MCO’s untimely submission of notice of legal involvement where the Primary Contractor/BH MCO has received such notice, the amount of the Department's actual loss of recovery shall be assessed against the Primary Contractor/BH-MCO The Department's actual loss of

recovery shall not include the attorney's fees or other costs, which would not have been retained by the Department.

d. The Primary Contractor or its BH-MCO has the sole and exclusive responsibility and right to pursue, collect and retain all health-related insurance resources for a period of 12 months from the date of payment. Notification of intent to pursue, collect and retain health-related claims not recovered by the Primary Contractor within the 12 months from the date of payment will become the sole and exclusive right of the Department to pursue, collect and retain. The Primary Contractor is responsible to notify the Department of all cases recovered within the 12 month period.

e. Should the Department lose recovery rights to any claim due to late or untimely filing of a claim with the liable third party, and the untimeliness in billing that specific claim is directly related to untimely submission of encounter data, additional records under special request, or inappropriate denial of claims for accidents or emergency care in casualty related situations, the amount of the unrecoverable claim shall be assessed against the Primary Contractor/BH-MCO.

f. Encounter data that is not submitted to the Department in accordance with the data requirements and/or timeframes identified in this Agreement can possibly result in a loss of revenue to the Department. Strict compliance with these requirements and timeframes shall therefore be enforced by the Department and could result in the assessment of liquidated damages against the Primary Contractor.

g. The Primary Contractor or its BH-MCO is responsible for pursuing, collecting, and retaining recoveries of 1) a claim involving Workers' Compensation, 2) health-related insurance resources where the liable party has improperly denied payment based upon either lack of a medically necessary determination or lack of coverage. The Primary Contractor or its BH-MCO is encouraged to develop and implement cost-effective procedures to identify and pursue cases that are susceptible to collection through either legal action or traditional subrogation and collection procedures.

3) HIPP Program

The HIPP Program pays for employment-related health insurance for Members when it is determined to be cost effective. The cost effectiveness determination involves the review of group health insurance benefits offered by employers to their employees to determine if the anticipated expenditures in MA payments are likely to be greater than the cost of paying the premiums under a group plan for those services. The Department shall not purchase Medigap policies for equally eligible

Members in the HealthChoices zone.

4) Requests for Additional Data

The Primary Contractor/BH-MCO must provide, at the Department's request, such information not included in the encounter data submissions that may be necessary for the administration of TPL activity. The Primary Contractor/ BH-MCO shall use its best efforts to provide this information within 15 calendar days of the Department's request. There are certain Urgent requests involving cases for minors that require information within 48 hours. Such information may include, but is not limited to, individual medical records for the express purpose of determining TPL for the services rendered. Confidentiality of the information shall be maintained as required by federal and state regulations.

5) Accessibility to TPL Data

The Department shall provide the Primary Contractor with accessibility to data maintained on the TPL file.

6) Third Party Resource Identification

Third party resources identified by the Primary Contractor and/or its BH-MCO, which do not appear on the Department's TPL database, must be supplied to the Department's TPL Division by the Primary Contractor and or its BH-MCO. In addition to newly identified resources, coverage for other household members, addition of coverage type, changes to existing resources, including termination of coverage and changes to coverage dates, must also be supplied to the Department's TPL Division. The method of reporting shall be via electronic process or manual submission or by any alternative method approved by the Department. TPL resource information must be submitted within two weeks of its receipt by the Primary Contractor and/or its BH-MCO. A manual document is only to be submitted for "negated" TPL resources or to send resource referrals older than five years from the Department's processing date. For electronic submissions, the Primary Contractor must follow the required report format, data elements, and specifications supplied by the Department. For manual submissions, the Primary Contractor must use an exact replica of the TPL resource referral form supplied by the Department. As the office responsible for the maintenance and quality assurance of the records stored on the TPL database, the Department's TPL Division will use these submissions for subsequent updates to the system.

The Primary Contractor shall use the Department's EVS and secured services on the internet (previously known as POSNET) to assure detailed information is provided for insurance carriers when a resource is received that does not have a unique carrier code.

7) Damage Liability

Liability for damages is identified in this section due to the large dollar value of many claims which are potentially recoverable by the Department's Division of TPL.

8) Estate Recovery

Section 1412 of the Human Services Code, 62 P.S. 1412, requires the Department to recover MA costs paid on behalf of certain deceased individuals. Individuals age 55 and older who were receiving MA benefits for any of the following services are affected:

a. Public or private nursing facility services;

b. Residential care at home or in a community setting; or

c. Any hospital care and prescription drug services provided while receiving nursing facility services or residential care at home or in a community setting.

The applicable MA costs are recovered from the assets of the individual's probate estate. The Department's Division of TPL is solely responsible for administering the Estate Recovery Program.

M. Performance Management Information System and Reporting

1) General

The requirement that the Primary Contractor and its BH-MCO provide the requested data is a result of the terms and conditions established by CMS. CMS specified that the state define a minimum data set and require all Primary Contractors and their BH-MCOs to submit the data.

To measure the Primary Contractor and its BH-MCO's accomplishments in the areas of access to care, behavioral health outcomes, quality of life, and Member satisfaction, the Primary Contractor and its BH-MCO must provide the Department with uniform service utilization, Quality Management, and Member satisfaction/Complaint/Grievance data on a regular basis. The Primary Contractor and its BH-MCO also must cooperate with the Department in carrying out data validation steps. The Department intends to use this information as part of a collaborative effort with the Primary Contractor and its BH-MCOs to effect continuous quality improvement.

This data will include components specified by the Department and also problem areas targeted by the continuous quality improvement program, both of which may change from time to time.
The Primary Contractor and its BH-MCO will manage the program in compliance with the Department's standards and requirements and will

provide data reports to support this management.

The Primary Contractor must, at its expense, arrange for a background check for each of its employees, as well as for the employees of its Subcontractors, who will have access to Commonwealth Information Technology (IT) facilities, either through on site or remote access. Background checks are to be conducted via Obtain a Criminal History Check procedure found at http://www.psp.state.pa.us/portal/server.pt/community/psp/4451/how_to/452779. The background check must be conducted prior to initial access by an IT employee and annually thereafter.

Before the Commonwealth will permit an IT Employee access to Commonwealth facilities, the Primary Contractor must provide written confirmation to the office designated by the agency that the background check has been conducted. If, at any time, it is discovered that an IT Employee has a criminal record that includes a felony or misdemeanor involving terroristic threats, violence, use of a lethal weapon, or breach of trust/fiduciary responsibility; or which raises concerns about building, system, or personal security, or is otherwise job-related, the Primary Contractor shall not assign that employee to any Commonwealth facilities, shall remove any access privileges already given to the employee, and shall not permit that employee remote access to Commonwealth facilities or systems, unless the agency consents, in writing, prior to the access being provided. The agency may withhold its consent at its sole discretion. Failure of the Primary Contractor to comply with the terms of this paragraph may result in default of the Primary Contractor under its Agreement with the Commonwealth.

The Department's detailed report formats are available on the Department's websites.

It is the Department's right to request medical records directly from BH-MCO's and BH Services Providers for issues related to quality of care, behavioral health outcome measures, TPL, and fraud and abuse.

2) Management Information System

The Department requires an automated MIS. There are numerous components required for the complete system. They are service authorization, Member Complaint and Grievance, Provider Complaint, Provider profiling, claims processing including TPL identification, Member enrollment, financial reporting, Utilization Management, encounter data, performance outcomes, Quality Management, and suspected/substantiated fraud and abuse. Of these components, service authorization, Provider profiling, claims processing (including TPL) encounter data and Member enrollment must be integrated.

The Primary Contractor and its BH-MCO's MIS must have the capability to

electronically transfer data files with the Department and the EAP broker. The Primary Contractor and its BH-MCO must use a secure FTP connection that is compatible with the Department's product.

The Primary Contractor and its BH-MCO must comply with all applicable business and technical standards available on the DHS Internet site at the following link: http://www.dhs.pa.gov/provider/busandtechstandards/index.htm. This includes compliance with the standards for connectivity to the Commonwealth's network. The Primary Contractor and its BH-MCO's MIS must be compatible with the Department's MIS. The Primary Contractor and its BH-MCO must also comply with the Department's SeGovernment Data Exchange Standards. In addition, the Primary Contractor and its BH-MCO must comply with any changes made to the Commonwealth's Business and Technical Standards. Whenever possible, the Department will provide advance notice of at least 60 days prior to the implementation of changes. For more complex changes, every effort will be made to provide additional notice.

The Primary Contractor or its BH-MCO must maintain an automated Provider directory that meets the requirements of Section II-5.D.9. Upon request, the Primary Contractor or its BH-MCO is required to provide this directory to the Department via secure email or other portable storage device.

The MIS must include mechanisms to incorporate recommended enhancements resulting from the Department's monitoring and external evaluations and audits.

3) Encounter and Alternative Payment Arrangements Data

The Department requires the Primary Contractor or its BH-MCO to submit a separate record, or "pseudo claim," each time a Member has an encounter with a Provider. This includes encounters with Providers which are reimbursed on a Fee-for-Service or Alternative Payment Arrangement basis. An encounter is a service provided to a Member. This would include, but not be limited to, a professional contact between a Member and a Provider and will result in more than one encounter if more than one service is rendered. For services provided by BH-MCO contractors and Subcontractors, it is the responsibility of the Primary Contractor or its BH-MCO to take appropriate action to provide the Department with accurate and complete encounter data. The Department's point of contact for encounter data will be the Primary Contractor or its BH-MCO and not other Subcontractors or Providers.

The Department requires the Primary Contractor or its BH-MCO to submit a separate Alternative Payment Arrangement record for each advance payment made to a contractor or Provider responsible for all or part of a Member's behavioral health care. If the payment is an Alternative Payment Arrangement reimbursement, a separate record is required to report the

amount paid on behalf of each Member. It is the responsibility of the BH-MCO to take appropriate action to provide the Department with accurate and complete data for payments made by BH-MCO to its contractors and Providers; the Department's point of contact for Alternative Payment Arrangement data will be the Primary Contractor or its BH-MCO and not other Subcontractors or Providers.

The Department will validate the accuracy of data on the encounter and Alternative Payment Arrangement data files. Validation criteria are included for each data element in the Requirements and Specifications Manual for Encounter Data/Alternative Payment Arrangement Data and in the Encounter and Complaint and Grievance Reporting Manuals.

a. 837 Transaction.

The 837 Transaction must include, at a minimum, the data elements listed in the HIPAA Implementation Guides and PROMISe Companion Guides.

b. Encounter Data.

The encounter data submittal must include, at a minimum, the data elements/reports listed in the Encounter Data and Complaint and Grievance Reporting Manuals.

c. Data Format.

The Primary Contractor and its BH-MCO must agree to submit Encounter and Alternative Payment Arrangement data electronically to the Department through PROMISe using the FTP. Data file content must conform to the requirements specified in the HIPAA Implementation Guides and PROMISe Companion Guides and the Aggregate Encounter and Complaint and Grievance Reporting Manuals.

d. Timing of Data Submittal

An encounter must be submitted and pass PROMISe edits on or before the last calendar day of the third month after the Primary Contractor paid/adjudicated the encounter.

Acceptable Alternative Payment Arrangement (formerly known as subcapitation) data must be submitted and found acceptable to the Department within 30 days after the period or case for which the payment applies.

The Primary Contractor must adhere to the file size specifications provided by the Department. A file submission schedule will be

developed and provided to the Primary Contractor.

e. Member Medical Information

When requested, the Primary Contractor or its BH-MCO must provide a Member's medical records within 15 days of the Department's request.

f. Data Validation

The Primary Contractor and its BH-MCO must agree to assist the Department in its validation of utilization data by making available medical records and its claims data. The validation may be completed by Department staff and independent, external review organizations.

N. Audits

All costs incurred under the Agreement are subject to audit by the Department or its designee for final approval and acceptability, in accordance with industry standards, applicable accounting principles, and Federal and State regulations and policy. Additional information on auditing is contained in Appendix W and the HealthChoices Financial Reporting Requirements (Appendix P). The Primary Contractor is responsible to comply with audit requirements as specified in the HealthChoices Audit Clause (Appendix W).

O. Restitution

The Primary Contractor must report to the Department within 60 days when it has identified overpayment of Capitation payments or other payments in excess of the amount specified in the Agreement. The Primary Contractor shall make full and prompt restitution to the Department, as directed by the Department, for overpayments received in excess of amounts due to the Primary Contractor under this Agreement whether such overpayment is discovered by the Primary Contractor, the Department, or other third party.

P. Claims Processing and MIS

The Primary Contractor or its BH-MCO must have a comprehensive automated MIS that is capable of meeting the requirements listed below and throughout this document. The Primary Contractor or its BH-MCO MIS must comply with the requirements listed in the latest version of the MIS and System Performance Review Standards. The Department will provide data support for the Primary Contractor and its BH-MCO as listed in Appendix O and described in the "Managed Care Data Support Overview for Behavioral Health".

- The Membership management system must have the capability to receive, update and maintain the BH-MCO's Membership files consistent with information provided by the Department.

- The claims processing system must have the capability to process claims consistent with timeliness and accuracy requirements identified in this document. Claims history must be maintained with sufficient detail to meet all Department reporting and encounter requirements.

- The Provider file management system must have the capability to store information on each Provider sufficient to meet the Department's reporting requirements.

- The Primary Contractor or its BH-MCO must have sufficient telecommunication, including electronic mail, capabilities to meet the requirements of this document.

- The Primary Contractor or its BH-MCO must have the capability to electronically transfer data files with the Department.

- The Primary Contractor or its BH-MCO must be compliant with the Health Insurance Portability and Accountability Act (HIPAA) of 1996, Administrative Simplification Rule for the eight electronic transactions and for the code sets used in these transactions.

- Primary Contractor or its BH-MCO must have a procedure for maintaining recipient enrollment and eligibility data, including a procedure for reconciliation of data discrepancies between their eligibility database and the Department's EVS, CIS and daily and monthly eligibility file transfers. The BH-MCO must process and load the daily files in their entirety within twenty-four (24) hours of receipt.

  The BH-MCO must reconcile all components of the files against its internal membership information and notify the Department within thirty (30) in order to resolve problems.

  The Primary Contractor or its BH-MCO's information system shall be subject to review and approval by the Department at any time.

Q. Data Support

The Department will make files available to the Primary Contractor or its BH-MCO on a routine basis that will allow them to effectively meet their obligation to provide services and record information consistent with Agreement requirements (See Appendix O). The Department expects to provide daily and monthly eligibility files, TPL monthly files, monthly payment reconciliation and summary payment files, MCO Provider Error File, ARM 568 File, MA Provider File, Procedure Code, Diagnosis Code Files and quarterly DDAP CIS files.