HEALTHCHOICES AGREEMENT

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SECTION I: INCORPORATION OF DOCUMENTS

A. Operative Documents

The RFP, which is attached hereto as Appendix 1, and the Proposal, is attached hereto as Appendix 2, are incorporated herein and are made part of this Agreement. With regard to the governance of such documents, it is agreed that:

1. In the event that any of the terms of this Agreement conflict with, or are inconsistent with the terms of the RFP, the terms of this Agreement shall govern;

2. In the event that any of the terms of this Agreement conflict with, or are inconsistent with the terms of the Proposal, the terms of this Agreement shall govern;

3. In the event that any of the terms of the RFP conflict with, or are inconsistent with the terms of the Proposal, the terms of the RFP shall govern.

4. In the event that any of the terms of the Agreement conflict with, or are inconsistent with, the terms of any Appendix or Exhibit to the Agreement, the terms of the Agreement shall govern.

B. Operational Updates and Department Communications

1. Managed Care Operations Memos (MC OPS Memos)

The Department will issue MC OPS Memos via the Pennsylvania HealthChoices Extranet to provide clarifications to requirements pertaining to HealthChoices. PH-MCOs must routinely check the Pennsylvania HealthChoices Extranet. MC OPS Memos and notices are vehicles to clarify operational policies and procedures and are not intended to amend the terms of the Agreement.

2. Pennsylvania HealthChoices Extranet

To access the Pennsylvania HealthChoices Extranet, the PH-MCO must have established connectivity with DHS.

In addition to the MCO-OPS Memos, the Pennsylvania HealthChoices Extranet Systems site contains current information on managed care systems policies and procedures, which include but are not limited to, information on eligibility, enrollment and reimbursement procedures, and encounter data submission requirements. It also contains information on pending changes and systems notices.

SECTION II: DEFINITIONS

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

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

Actuarily 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 42 C.F.R. §438.4(b).

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

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

Actuarially sound rates are developed using sound methods and assumptions, that are reasonably attainable by the MA MCOs in the relevant Agreement year and meet the standards of the Actuarial Standards Board.

Actuary — An individual who meets the qualification standards established by the American Academy of Actuaries for an actuary and follows the practice standards established by the Actuarial Standards Board. In this part, Actuary refers to an individual who is acting on behalf of the State when used in reference to the development and certification of capitation rates.

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

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

Alternate Payment Name — The person to whom benefits are issued on behalf of a Recipient.

Ambulatory Surgical Center — A facility licensed by the Department of Health which provides outpatient surgical treatment. The term does not include individual or group practice offices of private physicians or dentists, unless the offices have a distinct part used solely for outpatient surgical treatment on a regular and organized basis.

Amended Claim — A Provider request to adjust the payment of a previously Adjudicated Claim. A Provider Appeal is not an Amended Claim.

Area Agency on Aging — The single local agency designated by the PDA within each planning and service area to administer the delivery of a comprehensive and coordinated plan of social and other services and activities.

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

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

Behavioral Health Services — Mental health and substance abuse services which are provided by the BH-MCO.

Behavioral Health 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 — A Business Day includes Monday through Friday except for those days recognized as federal holidays or Pennsylvania State holidays.

Capitation — A payment the Department makes periodically to a PH-MCO on behalf of each Member enrolled under the Agreement and based on the actuarially sound 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.

Caregiver – A person employed for compensation by a provider or participant who provides personal assistance services or respite services for the purpose of providing a covered service by a healthcare worker on the staff/under contract.

Case Management Services — Services which will assist individuals in gaining access to necessary medical, social, educational and other services.

Case Payment Name — The person in whose name benefits are issued.

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

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

Certified Nurse Midwife — An individual licensed under the laws within the scope of Chapter 6 of Professions & Occupations, 63 P.S. §§171-176.

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

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

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

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

Client Information System — The Department's database of Recipients. The data base contains demographic and eligibility information for all Recipients.

Community HealthChoices — Community HealthChoices is a new initiative 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 Pennsylvanians who are dually eligible for Medicare and Medicaid (dual eligible).

Community Provider — Private and public service organizations, that are not part of the PH-MCO's Provider Network, with which the PH-MCO coordinates Out-of-Plan Services for their Members.

Complaint —
1. A Complaint regarding an adverse benefit determination: A dispute or objection regarding:

- a denial because the requested service or item is not a covered service;
- the failure of the PH-MCO to provide a service or item in a timely manner, as defined by the Department;
- the failure of the PH-MCO to decide a Complaint or Grievance within the specified time frames;
- a denial of payment by the PH-MCO after a service or item has been delivered because the service or item was provided without authorization by a Provider not enrolled in the MA Program;
- a denial of payment by the PH-MCO after a service or item has been delivered because the service or item provided is not a covered service for the Member; or
- a denial of a Member's request to dispute a financial liability, including cost sharing, copayments, premiums, deductibles, coinsurance, and other Member financial liabilities.

2. A Complaint without an adverse benefit determination: is an expression of dissatisfaction about any matter other than an adverse benefit determination. Complaints may include, but are not limited to, the quality of care of services provided, and aspect of interpersonal relationships such as rudeness of a provider or employee, or failure to respect the enrollee's rights regardless of whether remedial action is requested. Complaint includes an enrollee's right to dispute an extension of time proposed by the MCO to make an authorization decision. These types of complaints do not have a filing timeframe.

This term does not include a Grievance.

Comprehensive Risk Contract — *A* risk contract between the State and an MCO that covers comprehensive services, that is, inpatient hospital services and any of the following services, or any three or more of the following services:

(1) Outpatient hospital services (2) Rural health clinic services (3) Federally Qualified Health Center (FQHC) services (4) Other laboratory and X-ray services (5) Nursing facility (NF) services (6) Early and periodic screening, diagnostic, and treatment (EPSDT) services (7) Family planning services (8) Physician services (9) Home health services.

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

County Assistance Office — The county offices of the Department that administer all benefit programs, including MA, on the local level. Department staff in these offices perform necessary functions such as determining and maintaining Recipient eligibility.

Covered Outpatient Drug — A brand name drug, a generic drug, or an OTC drug which:

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

The term includes biological products and insulin.

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

Daily 834 Eligibility File — An electronic file in a HIPAA compliant 834 format using data from CIS that is transmitted to the PH-MCO on state business days.

Day — Indicates a calendar day unless specifically denoted otherwise. See Business Day.

Deliverables — Those documents, records and reports required to be furnished to the Department for review and/or approval. Deliverables include, but are not limited to: operational policies and procedures, letters of agreement, Provider Agreements, Provider reimbursement methodology, coordination agreements, reports, tracking systems, required files, QM/UM documents, and referral systems.

Denial of Services — Any determination made by the PH-MCO in response to a request for approval which: disapproves the request completely; or approves provision of the requested service(s), but for a lesser amount, scope or duration than requested; or disapproves provision of the requested service(s), but approves provision of an alternative service(s); or reduces, suspends or terminates a previously authorized service. An approval of a requested service which includes a requirement for a Concurrent Review by the PH-MCO during the authorized period does not constitute a Denial of Service.

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

Department — The Department of Human Services of the Commonwealth of Pennsylvania.

Deprivation Qualifying Code — The code specifying the condition which determines a Recipient to be eligible in nonfinancial criteria.

Developmental Disability — A severe, chronic disability of an individual that is:

- Attributable to a mental or physical impairment or combination of mental or physical impairments.

- Manifested before the individual attains age twenty-two (22).

- Likely to continue indefinitely.

- Manifested in substantial functional limitations in three or more of the following areas of life activity:
  - Self care;
  - Receptive and expressive language;
  - Learning;
  - Mobility;
  - Capacity for independent living; and
  - Economic self-sufficiency.

- Reflective of the individual's need for special, interdisciplinary or generic services, supports, or other assistance that is of lifelong or extended duration, except in the cases of infants, toddlers, or preschool children who have substantial developmental delay or specific congenital or acquired conditions with a high probability of resulting in Developmental Disabilities if services are not provided.

Disease Management — An integrated treatment approach that includes the collaboration and coordination of patient care delivery systems and that focuses on measurably improving clinical outcomes for a particular medical condition

through the use of appropriate clinical resources such as preventive care, treatment guidelines, patient counseling, education and outpatient care; and that includes evaluation of the appropriateness of the scope, setting and level of care in relation to clinical outcomes and cost of a particular condition.

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

DHS Fair Hearing — A hearing conducted by the Department's Bureau of Hearings and Appeals.

Drug Efficacy Study Implementation — Drug products that have been classified as less-than-effective by the FDA.

Dual Eligible — An individual who is eligible to receive services through both Medicare and the MA Program.

Durable Medical Equipment — Equipment furnished by a supplier or a home health agency that meets the following conditions: (a) can withstand repeated use (bis primarily and customarily used to serve a medical purpose (c) generally is not useful to an individual in the absence of an disability, illness or injury (d) can be reusable or removable and (e) is appropriate for use in any setting in which normal life activities take place.

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

Early Intervention Program — The provision of specialized services through family-centered intervention for a child, birth to age three (3), who has been determined to have a developmental delay of twenty-five percent (25%) of the child's chronological age or has documented test performance of 1.5 standard deviation below the mean in standardized tests in one or more areas: cognitive development; physical development, including vision and hearing; language and speech development; psycho-social development; or self-help skills or has a diagnosed condition which may result in developmental delay.

Eligibility Period — A period of time during which a consumer is eligible to receive MA benefits. An Eligibility Period is indicated by the eligibility start and end dates on CIS. A blank eligibility end date signifies an Open-ended Eligibility Period.

Eligibility Verification System — An automated system available to MA Providers and other specified organizations for automated verification of MA Recipients' current and past (up to three hundred sixty-five [365] days) MA eligibility, PH-MCO Enrollment, PCP assignment, TPR, 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 Member Issue — A problem of a PH-MCO Member, including problems related to whether an individual is a Member, the resolution of which should occur immediately or before the beginning of the next Business Day in order to prevent a denial or significant delay in care to the Member that could precipitate an Emergency Medical Condition or need for urgent care.

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

Encounter — Any covered health care service provided to a Member, regardless of whether it has an associated Claim.

Encounter Data — A record of any Encounter, including Encounters reimbursed through Capitation, Fee-for-Service, or other methods of compensation regardless of whether payment is due or made.

Enrollee — A Medicaid beneficiary who is currently enrolled in a PH-MCO.

Enrollee Encounter Data — The information relating to the receipt of any item(s) or service(s) by an enrollee under a contract between the State and a PH-MCO that is subject to the requirements of 42 C.F.R. §438.242 and 42 C.F.R. §438.818.

Enrollment — The process by which a Member's coverage by a PH-MCO is initiated.

Enrollment Assistance Program — The program that provides Enrollment Specialists to assist Recipients in selecting a PH-MCO and PCP and in obtaining information regarding HealthChoices Physical, Behavioral Health Services, Community HealthChoices long-term services and supports and service Providers.

Enrollment Specialist — The individual responsible to assist Recipients with selecting a PH-MCO and PCP as well as providing information regarding Physical and Behavioral Health Services and service Providers under the HealthChoices Program.

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

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

Experimental Treatment — A course of treatment, procedure, device or other medical intervention that is not yet recognized by the professional medical community as an effective, safe and proven treatment for the condition for which it is being used.

External Quality Review — A requirement under Section 1902(a)(30)(C) of Title XIX of the Social Security Act, 42 U.S.C. 1396u-2(c)(2) for independent, external review body to perform an annual review of the quality of services furnished by MCOs, including the evaluation of quality outcomes, timeliness and access to services.

Extranet – An Intranet site that can be accessed by authorized internal and external users to enable information exchange securely over the Internet.

Family Planning Services — Services which enable individuals voluntarily to determine family size, to space children and to prevent or reduce the incidence of unplanned pregnancies.

Federally Qualified Health Maintenance Organization (HMO) — An HMO that CMS has determined is a qualified HMO under section 1310(d) of the PHS Act.

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

Fee-for-Service — Payment by the Department to Providers on a per-service basis for health care services provided to Recipients.

Formulary — A Department-approved list of outpatient drugs determined by the PH-MCO's P&T Committee to have a significant, clinically meaningful therapeutic advantage in terms of safety, effectiveness, and cost for the PH-MCO Members.

Fraud —
Any type of intentional deception or misrepresentation, including any act that constitutes fraud under applicable Federal or State law, made by an entity or person with the knowledge that the deception could result in some unauthorized benefit to the entity or person, or some other person in a managed care setting,

committed by any entity, including the PH-MCO, a subcontractor, a Provider, or a Member, among others.

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

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

Grievance —
A request to have a PH-MCO or utilization review entity reconsider an adverse benefit determination concerning the Medical Necessity and appropriateness of a health care service. A Grievance may be filed regarding a PH-MCO decision to 1) deny, in whole or in part, payment for a service/item; 2) deny or issue a limited authorization of a requested service/item, including the type or level of service/item; 3) reduce, suspend, or terminate a previously authorized service/item; 4) deny the requested service/item but approve an alternative service/item. 5) deny a request for a BLE.
This term does not include a Complaint.

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

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

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

Health Care Provider — A licensed hospital or health care facility, medical equipment supplier or person who is licensed, certified or otherwise regulated to provide health care services under the laws of the Commonwealth or state(s) in which the entity or person provides services, including a physician, podiatrist, optometrist, psychologist, physical therapist, certified registered nurse practitioner,

registered nurse, clinical nurse specialist, certified registered nurse anesthetist, certified nurse midwife, physician's assistant, chiropractor, dentist, dental hygienist, public health dental hygiene practitioner, pharmacist or an individual accredited or certified to provide behavioral health services.

Health Insuring Organization (HIO) — a county operated entity, that in exchange for capitation payments, covers services for beneficiaries: (1) through payments to, or arrangements with, providers; (2) under a comprehensive risk contract with the State; and (3) meets the following criteria: (i) first became operational prior to January 1, 1986; or (ii) is described in section 9517(c)(3) of the Omnibus Budget Reconciliation Act of 1985 (as amended by section 4734 of the Omnibus Budget Reconciliation Act of 1990 and section 205 of the Medicare Improvements for Patients and Providers Act of 2008).

Health Maintenance Organization — 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, prepaid fee.

HealthChoices Disenrollment — Action taken by the Department to remove a Member's name from the monthly Enrollment Report following the Department's receipt of a determination that the Member is no longer eligible for Enrollment in HealthChoices.

HealthChoices Program — The name of Pennsylvania's 1915(b) waiver program to provide mandatory managed health care to Recipients.

HealthChoices Zone (HC Zone) — A multiple-county area in which the HealthChoices Program has been implemented to provide mandatory managed care to MA Recipients in Pennsylvania.

Home and Community Based Waiver Program — Necessary and cost-effective services, not otherwise furnished under the State's Medicaid Plan, or services already furnished under the State's Medicaid Plan but in expanded amount, duration, or scope which are furnished to an individual in his/her home or community in order to prevent institutionalization.

Hospice Services — A comprehensive set of services described in 1861(dd)(1) of the Social Security Act, identified and coordinated by an interdisciplinary group to provide for the physical, psychosocial, spiritual, and emotional needs of a terminally ill patient and/or family members, as delineated in a specific patient plan of care.

Hospital Outpatient Care — Care in a hospital that usually doesn't require an overnight stay Outpatient hospital services means preventive, diagnostic, therapeutic, rehabilitative, or palliative services that: (1) Are furnished to outpatients; (2) Are furnished by or under the direction of a physician or dentist; and (3) Are furnished by an institution that—(i) Is licensed or formally approved as

a hospital by an officially designated authority for State standard-setting; and (ii) Meets the requirements for participation in Medicare as a hospital; and (4) May be limited by a Medicaid agency in the following manner: the Department may exclude from the definition of “outpatient hospital services” those types of items and services that are not generally furnished by most hospitals in the State.

Immediate Need — A situation in which, in the professional judgment of the dispensing registered pharmacist or prescriber, the dispensing of a 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 PH-MCO may receive additional funds over and above the Capitation rate it was paid for meeting targets specified in the Agreement.

Indian — An individual, defined at 25 U.S.C. §1603(13), §1603 (28), §1679(a), or who has been determined eligible, as an Indian, pursuant to 42 C.F.R. §136.12.

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

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

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

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

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.

Interagency Team for Adults — A multi-system planning team consisting of the individual, family members, legal guardian, advocates, county mental health/intellectual-developmental disability and/or drug and alcohol case managers, PCP, treating specialists, residential or day service Providers and any other participants necessary and appropriate to assess the needs and strengths of the individual, formulate treatment and service goals, approaches and methods, recommend and monitor services and develop discharge plans.

Interagency Team for Individuals Under the Age of Twenty-One (21) — A multi-system planning team comprised of the child, when appropriate, at least one (1) accountable family member, a representative of the County Mental Health and/or Drug and Alcohol Program, the case manager, the prescribing physician or psychologist, and as applicable, the County Children and Youth, Juvenile Probation, Developmental Disability, and Drug and Alcohol agencies, a representative of the school district, BH-MCO, PH-MCO and/or PCP, other agencies that are providing services to the child, and other community resource persons identified by the family.

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

Internal Control Number — The unique number assigned by the Department's MMIS to identify an individual Claim or Encounter.

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

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

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.

Lock-In — Recipients determined to be involved in fraudulent activities or identified as abusing services provided under the MA Program who are restricted to a specific Provider(s) to obtain all of his or her services in an attempt to ensure appropriately managed care.

Long-Term Services and Supports — Services and supports provided to beneficiaries of all ages who have functional limitations and/or chronic illnesses that have the primary purpose of supporting the ability of the beneficiary to live or work in the setting of their choice, which may include the individual's home, a worksite, a provider-owned or controlled residential setting, a nursing facility, or other institutional setting.

Managed Care Organization — An entity that has, or is seeking to qualify for, a comprehensive risk contract under this part, and that is: (1) Federally qualified HMO that meets the advance directives requirements of 42 C.F.R. §489 Subpart I; 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 and (ii) Meets the solvency standards of 42 C.F.R. § 438.116.

Managed Care Program — A managed care delivery system operated by a State as authorized under sections 1915(a), 1915(b), 1932(a), or 1115(a) of the Social Security Act.

Market Share — The percentage of Members enrolled with a particular PH-MCO when compared to the total of Members enrolled in all the PH-MCOs within a HealthChoices Zone.

Master Provider Index — A component of the Department's MMIS which is a central repository of Provider profiles and demographic information that registers and identifies Providers uniquely within the Department of Human Services.

Material Adjustment — An adjustment that, using reasonable actuarial judgment, has a significant impact on the development of the Capitation payment such that its omission or misstatement could impact a determination whether the development of the capitation rate is consistent with generally accepted actuarial principles and practices.

Medicaid Eligibility Determination Automation — Part of the CIS that automates the determination of Medicaid eligibility.

Medical Assistance — The Medical Assistance Program authorized by Title XIX of the federal Social Security Act, 42 U.S.C. §§1396 et seq., and regulations promulgated thereunder, and 62 P.S. §§441.1 et seq. and regulations at 55 Pa. Code Chapters 1101 et seq.

Medical Assistance Transportation Program — A non-emergency medical transportation service provided to eligible persons who need to make trips to and

from a MA reimbursable service for the purpose of receiving treatment, medical evaluation, or purchasing prescription drugs or medical equipment.

Medically Necessary — A service or benefit that is compensable under the MA Program and if it meets any one of the following standards:

- The service, item, procedure or level of care will, or is reasonably expected to, prevent the onset of an illness, condition, injury or disability.

- The service, item, procedure or level of care will, or is reasonably expected to, reduce or ameliorate the physical, mental or developmental effects of an illness, condition, injury or disability.

- The service, item, procedure or level of care will assist the Member to achieve or maintain maximum functional capacity in performing daily activities, taking into account both the functional capacity of the Member and those functional capacities that are appropriate for Members of the same age.

Member — An individual who is enrolled with a PH-MCO under the HealthChoices Program and for whom the PH-MCO has agreed to arrange the provision of PH Services under the provisions of the HealthChoices Program.

Member Record — A record on the Daily 834 Eligibility File or the Monthly 834 Eligibility File that contains information on MA eligibility, managed care coverage, and the category of assistance, which help establish the covered services for which a Recipient is eligible.

Midwifery Practice — Management of the care of essentially healthy women and their healthy neonates (initial twenty-eight [28] day period), including intrapartum, postpartum and gynecological care.

Monthly834 Eligibility File — An electronic file in a HIPAA compliant 834 format using data from CIS that is transmitted to the PH-MCO on a monthly basis.

Network — All contracted or employed Providers in the PH-MCO who are providing covered services to Members.

Network Provider — any provider, group of providers, or entity that has a network provider agreement with a PH-MCO or a Subcontractor, and receives Medicaid funding directly or indirectly to order, refer or render covered services as a result of the state's contract with a PH-MCO. A network provider is not a Subcontractor by virtue of the network provider agreement.

Non-participating Provider — A Health Care Provider, either not enrolled in the Pennsylvania MA Program or not participating in the PH-MCO's Network, which provides medical services or supplies to Members.

Nonrisk Contract — A contract between the State and a PIHP or PAHP under which the contractor (1) Is not at financial risk for changes in utilization or for costs incurred under the contract that do not exceed the upper payment limits specified in 42 C.F.R. §447.362 and (2) May be reimbursed by the State at the end of the contract period on the basis of the incurred costs, subject to the specified limits.

Nursing Facility — A general, county or hospital-based nursing facility, which is licensed by the DOH, enrolled in the MA Program and certified for Medicare participation. The Provider types and specialty codes are as follows:

- General – PT 03, SC 030
- County – PT 03, SC 031
- Hospital-based – PT 03, SC 382
- Certified Rehab Agency – PT 03, SC 040

OMAP Hotlines — Department phone lines designed to address and facilitate resolution of issues encountered by Recipients and their advocates or Providers according to PH-MCO policies and procedures.

Ongoing Medication — A medication that has been previously dispensed to the Member for the treatment of an illness that is chronic in nature or for an illness for which the medication is required for a length of time to complete a course of treatment, until the medication is no longer considered necessary by the physician or prescriber, and that has been used by the Member without a gap in treatment. If a current prescription is for a higher dosage than previously prescribed, the prescription is for an Ongoing Medication at least to the extent of the previous dosage.

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

OPTIONS — The long-term care pre-admission assessment program administered by the PDA.

Other Provider-Preventable Condition — A condition occurring in any health care setting that meets the following criteria:

- Is identified in the State plan,
- Has been found by the State, based upon a review of medical literature by qualified professionals, to be reasonably preventable through the application of procedures supported by evidence-based guidelines,

- Has a negative consequence for the beneficiary,
- Is auditable, and
- Includes, at a minimum, the following:
  - Wrong surgical or other invasive procedure performed on a patient,
  - Surgical or other invasive procedure performed on the wrong body part, or
  - Surgical or other invasive procedure performed on the wrong patient.

Other Related Conditions — A physical disability such as cerebral palsy, epilepsy, spina bifida or similar conditions which occur before the age of twenty-two (22), is likely to continue indefinitely and results in three (3) or more substantial functional limitations.

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

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

- An Emergency Medical Condition that occurs while outside the Member's HealthChoices Zone;

- The health of the Member would be endangered if the Member returned to his or her HealthChoices Zone for needed services;

- The Provider is located outside the Member's HealthChoices Zone, but regularly provides medical services to Members at the request of the PH-MCO; or

- The needed medical services are not available in the Member's HealthChoices Zone.

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

Out-of-Plan Services — Services which are non-plan, non-capitated and are not the responsibility of the PH-MCO under the HealthChoices Program comprehensive benefit package.

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

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 PH-MCO 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 paragraphs (c)(1)(i) through (iii) of 42 C.F.R. §438.6 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.

Patient Centered Medical Home — This model of care includes key components such as: whole person focus on behavioral health and physical health, comprehensive focus on wellness as well as acute and chronic conditions, increased access to care, improved quality of care, team based approach to care management/coordination, and use of electronic health records (EHR) and health information technology to track and improve care.

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

Physical Health Managed Care Organization — A risk bearing entity which has an agreement with the Department to manage the purchase and provision of Physical Health Services under the HealthChoices Program.

PH-MCO Coverage Period — A period of time during which an individual is eligible for MA coverage and enrolled with a PH-MCO and which exists on CIS.

Physical Health Services — Those medical and other related services, provided to Members, for which the PH-MCO has assumed coverage responsibility under this Agreement.

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

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

Potential Enrollee — A Medicaid beneficiary who is subject to mandatory enrollment or may voluntarily elect to enroll in a given MCO, PIHP, or PAHP, but is not yet an enrollee of a specific MCO, PIHP, or PAHP.

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

Premium — An amount to be paid for an insurance policy.

Prepaid Ambulatory Health Plan — An entity that: (1) Provides services to enrollees under contract with the Department, and on the basis of Capitation payments, or other payment arrangements that do not use State plan payment rates; (2) Does not provide or arrange for, and is not otherwise responsible for the provision of any inpatient hospital or institutional services for its enrollees; and (3) Does not have a comprehensive risk contract.

Prepaid Inpatient Health Plan — 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; and (3) Does not have a comprehensive risk contract.

Prepayment Review – Prepayment review is performed after the service or item is provided, but prior to payment being issued. Prepayment review may include the examination of an invoice and related documentation to determine eligibility, benefit packages, or medical necessity of a service or item before payment is made to the provider. Pre-payment review is not synonymous with prior authorization.

Prescription Drugs — Simple or compound substances or mixtures of substances prescribed for the cure, mitigation, or prevention of disease, or for health maintenance that are: (1) Prescribed by a physician or other licensed practitioner of the healing arts within the scope of this professional practice as defined and limited by Federal and State law; (2) Dispensed by licensed pharmacists and licensed authorized practitioners in accordance with the State Medical Practice Act; and (3) Dispensed by the licensed pharmacist or practitioner on a written prescription that is recorded and maintained in the pharmacist's or practitioner's records.

Prevalent – A non-English language determined to be spoken by a significant number or percentage of potential enrollees that are limited English proficient. (42C.F.R. 438.10(a))

Primary Care — All health care services and laboratory services customarily furnished by or through a general practitioner, family physician, internal medicine physician, obstetrician/gynecologist, pediatrician, or other licensed practitioner as authorized by the State Medicaid program, to the extent the furnishing of those services is legally authorized in the State in which the practitioner furnishes them.

Primary Care Practitioner — A specific physician, physician group or a CRNP operating under the scope of his or her licensure, and who is responsible for

supervising, prescribing, and providing primary care services; locating, coordinating and monitoring other medical care and rehabilitative services and maintaining continuity of care on behalf of a Recipient.

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

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

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

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

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

Provider — An individual or entity that is engaged in the delivery of medical or professional services, or ordering or referring for those services, and is legally authorized to do so by the Commonwealth or State in which it delivers the services, including a licensed hospital or healthcare facility, medical equipment supplier, or person who is licensed, certified, or otherwise regulated to provide healthcare services under the laws of the Commonwealth or states in which the entity or person provides services, including a physician, podiatrist, optometrist, psychologist, physical therapist, CRNP, RN, clinical nurse specialist, certified registered nurse anesthetist, certified nurse midwife, physician’s assistant, chiropractor, dentist, dental hygienist, pharmacist, and an individual accredited or certified to provide behavioral health services.

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

Provider Appeal — A request from a Provider for reversal of a determination by the PH-MCO, with regard to:

- Provider credentialing denial by the PH-MCO;

- Claims denied by the PH-MCO for Providers participating in the PH-MCO's Network. This includes payment denied for services already rendered by the Provider to the Member; and

- Provider Agreement termination by the PH-MCO.

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

Provider-Preventable Condition — A condition that meets the definition of a health care-acquired condition or other provider-preventable condition as defined in 42 C.F.R. §447.26(b).

Provider Reimbursement and Operations Management Information System electronic (PROMISe™) — The Department's current MMIS claims processing and management system that supports the FFS and MA Managed Care delivery programs.

Quality Management — An ongoing, objective and systematic process of monitoring, evaluating and improving the quality, appropriateness and effectiveness of care.

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 twelve (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 C.F.R. §438.7(a).

Recipient — A person eligible to receive Physical or Behavioral Health Services under the MA Program of the Commonwealth of Pennsylvania.

Recipient Month — One Member covered by the HealthChoices Program for one (1) calendar month.

Rehabilitative Services — This includes any medical or remedial services recommended by a physician or other licensed practitioner of the healing arts, within the scope of his/her practice under State law, for maximum reduction of physical or mental disability and restoration of a beneficiary to his best possible functional level.

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

Related Party — An entity that is an Affiliate of the PH-MCO or subcontracting PH-MCO and (1) performs some of the PH-MCO or subcontracting PH-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 PH-MCO or subcontracting PH-MCO at a cost of more than $2,500.00 during any year of a HealthChoices Agreement with the Department.

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

Retrospective Review — A review conducted by the PH-MCO, DHS, or DHS vendor or designee to determine whether services were delivered as prescribed and consistent with the PH-MCO's payment policies and procedures in accordance with MA regulations and section V.0.4.p of the Agreement.

Revenue [for the purposes of the Equity requirement calculation] — The total gross Direct Business Premiums, for all Pennsylvania lines of business, reported in Schedule T, "Premiums and other Considerations," of the PID report.

Risk Based Capital — The Total Adjusted Capital figure in Column One from the page titled Five Year Historical Data in the Annual Statement for the most recent year filed with PID, divided by the Authorized Control Level Risk-based Capital figure.

Risk Contract — A contract between the State, an MCO, PIHP, or PAHP under which the contractor: (1) Assumes risk for the cost of the services covered under the contract, and (2) Incurs loss if the cost of furnishing the services exceeds the payments under the contract.

Risk Corridor — A risk sharing mechanism in which the Department and PH-MCOs may share in profits and losses under the Agreement outside of a predetermined threshold amount.

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

Rural Health Clinics (RHCs) - a facility that is engaged primarily in providing services that are typically furnished in outpatient clinics in underserved rural areas.

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

School-Based Health Services — An array of Medically Necessary health services performed by licensed professionals that may include, but are not limited to, immunization, well child care and screening examinations in a School-Based Health Center.

Short Procedure Unit — A unit of a hospital organized for the delivery of ambulatory surgical, diagnostic or medical services.

Social Determinants of Health — The conditions in which people are born, grow, live, work, and age. They are the factors mostly responsible for health inequities – the unfair and avoidable differences in health status seen within and between different geographic locations. There are five major determinant areas:

- Economic stability (poverty, employment, food security, housing stability, transportation);
- Education (high school graduation, enrollment in higher education, language and literacy);
- Social and community context (social cohesion, discrimination, incarceration);
- Health and health care (accessibility and health literacy); and
- Neighborhood and built environment (food deserts, quality of housing, safety).

These factors can impact population health outcomes by establishing a negative social and physical environment and deepening the inequities that certain populations face.

Special Needs Unit — A special dedicated unit within the PH-MCO and the EAP broker's organizational structure established to deal with issues related to Members with Special Needs.

Start Date — The first date on which the PH-MCO is operationally responsible and financially liable for the provision of Medically Necessary services to Members.

Step Therapy — A type of Prior Authorization requirement, sometimes referred to as a fail first requirement, intended as a cost savings that begins drug therapy with

the most cost-effective drug therapy, and progresses to other more costly therapies determined to be Medically Necessary.

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

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

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

Subcontractor — An individual or entity that has a contract a PH-MCO that relates directly or indirectly to the performance of the PH-MCO's obligation under its contract with the Department. A network provider is not a Subcontractor by virtue of the network Provider Agreement with the MCO, PIHP, or PAHP.

Sustained Improvement — Improvement in performance documented through continued measurement of quality indicators after the performance project, study, or quality initiative is complete.

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

Targeted Case Management Program — A case management program for Recipients who are diagnosed with AIDS or symptomatic HIV.

Third Party Liability — An individual entity or program's (e.g. Medicare) other than the PH-MCO financial responsibility for all or part of a Member's health care expenses.

Third Party Resource — Any individual, entity or program that is liable to pay all or part of the medical cost of injury, disease or disability of a Recipient. Examples of TPR include: government insurance programs such as Medicare or CHAMPUS;

private health insurance companies, or carriers; liability or casualty insurance; and court-ordered medical support.

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

Transitional Care Home — A tertiary care center which provides medical and personal care services upon hospital discharge to children who require intensive medical care for an extended period of time to allow for the caregiver to be trained in the care of the child.

Urgent Care Services — Services furnished to an individual who requires services to be furnished within twenty-four (24) hours in order to avoid the likely onset of an emergency medical condition.

Urgent Medical Condition — An illness, injury or severe condition which under reasonable standards of medical practice, should be diagnosed and treated within a twenty-four (24) hour period and if left untreated, could rapidly become a crisis or Emergency Medical Condition. The term also includes services that are necessary to avoid a delay in hospital discharge or hospitalization.

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

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

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

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

Voided Member Record — A Member Record used by the Department to advise the PH-MCO that a certain related Member Record previously submitted by the Department to the PH-MCO should be voided. A Voided Member Record can be

recognized by its illogical sequence of PH-MCO membership start and end dates with the end date preceding the Start Date.

Waste — The overutilization of services or other practices that result in unnecessary costs. Generally not considered caused by criminally negligent actions, but rather misuse of resources.

All Definitions - These definitions are case-insensitive. A defined term used in the Agreement is intended to have the meaning ascribed to such term in the Definition section of the Agreement regardless of capitalization if in the context of the provision the definition is applicable.

AGREEMENT and RFP ACRONYMS

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

AAA — Area Agency on Aging
ACA — Affordable Care Act
AIDS — Acquired Immunodeficiency Syndrome
ASC — Ambulatory Surgical Center
BFM — Bureau of Fiscal Management
BH — Behavioral Health
BHA — Bureau of Hearings and Appeals
BH-MCO — Behavioral Health Managed Care Organization
BLE — Benefit Limit Exception
BMCO — Bureau of Managed Care Operations
BPI — Bureau of Program Integrity
CAHPS — Consumer Assessment of Healthcare Providers and Systems
CAO — County Assistance Office
CBCM — Community Based Care Management
CEO – Chief Executive Officer
CFO — Chief Financial Officer
CHAMPUS — Civilian Health and Medical Program of the Uniformed Services
CHC — Community HealthChoices
CHS — Contract Health Services
CIS — Client Information System
CLIA — Clinical Laboratory Improvement Amendment
CLPPP — Childhood Lead Poisoning Prevention Program
CME — Continuing Medical Education
CMS — Centers for Medicare and Medicaid Services
CNM — Certified Nurse Midwife
COB — Coordination of Benefits
CRNP — Certified Registered Nurse Practitioner
CSP — Community Support Program
DBM – Dental Benefits Manager
DEA — Drug Enforcement Agency
DESI —Drug Efficacy Study Implementation
DHHS — U.S. Department of Health and Human Services
DHS — Department of Human Services
DME — Durable Medical Equipment
DOH — Department of Health (of the Commonwealth of Pennsylvania)
DRA — Deficit Reduction Act
DRG — Diagnosis Related Group
DSH — Disproportionate Share Hospital
DUR — Drug Utilization Review
EAP — Enrollment Assistance Program
ED — Emergency Department
EHR — Electronic Health Record

EMS — Emergency Medical Services
EOB — Explanation of Benefits
EPLS — The Excluded Parties List System
EPSDT — Early and Periodic Screening, Diagnosis and Treatment
EQR — External Quality Review
EQRO — External Quality Review Organization
EVS — Eligibility Verification System
ERISA — Employees Retirement Income Security Act of 1974
FDA — Food and Drug Administration
FFP — Federal Financial Participation
FFS — Fee-for-Service
FQHC — Federally Qualified Health Center
FTE — Full Time Equivalent
FTP — File Transfer Protocol
GA — General Assistance
GAAP — Generally Accepted Accounting Principles
GME — Graduate Medical Education
HBP — Healthy Beginnings Plus
HCAC — Health Care-Acquired Condition
HCRP — High Cost Risk Pool
HCRPAA — High Cost Risk Pool Allocation Amount
HEDIS — Healthcare Effectiveness Data and Information Set
HHS-OIG — U.S. Department of Health and Human Services-Office of Inspector General
HIO — Health Insuring Organization
HIPAA — Health Insurance Portability and Accountability Act
HIPP — Health Insurance Premium Payment
HIV — Human Immunodeficiency Virus
HMO — Health Maintenance Organization
IBNR — Incurred But Not Reported
ICF/ID — Intermediate Care Facility for the Intellectually Disabled
ICF/ORC — Intermediate Care Facility/Other Related Conditions
ICN – Internal Control Number
ICP — Integrated Care Program
IGC — Initial Grievance Committee
IHS — Indian Health Service
IMD – Institution for Mental Diseases
IRM — Information Resource Management
I/T/U — Indian Tribe, Tribal Organization, or Urban Indian Organization
JCAHO — Joint Commission on Accreditation of Healthcare Organizations
JDC — Juvenile Detention Center
LEIE — HHS-OIG List of Excluded Individuals and Entities
LEP — Limited English Proficiency
LTSS — Long-term Services and Supports
MA — Medical Assistance
MAAC — Medical Assistance Advisory Committee

MAGI — Modified Adjusted Gross Income
MATP — Medical Assistance Transportation Program
MBE — Minority Business Enterprise
MCO — Managed Care Organization
MEDA — Medicaid Eligibility Determination Automation
MH/ID — Mental Health/Intellectual Disabilities
MIS — Management Information System
MMIS — Medicaid Management Information System
MPI — Master Provider Index
NCPDP — National Council for Prescription Drug Programs
NCQA — National Committee for Quality Assurance
NPDB — National Practitioner Data Bank
NPI — National Provider Identifier
NPPES — National Plan and the Provider Enumeration System
OBRA — Omnibus Budget Reconciliation Act
OCDEL — Office of Child Development and Early Learning
OCYF — Office of Children, Youth and Families
ODP — Office of Developmental Programs
OIP — Other Insurance Paid
OLTL — Office of Long Term Living
OMAP — Office of Medical Assistance Programs
OMHSAS — Office of Mental Health and Substance Abuse Services
OPPC — Other Provider-Preventable Condition
ORC — Other Related Conditions.
OTC — Over-the-Counter
OUD-COE — Opioid Use Disorder Centers of Excellence
P&T — Pharmacy & Therapeutics
PAHP — Prepaid Ambulatory Health Plan
PARP — Prior Authorization Review Panel.
PBM — Pharmacy Benefit Manager
PCP — Primary Care Practitioner
PCCM — Primary Care Case Manager
PCMH — Patient Centered Medical Home
PDA — Pennsylvania Department of Aging
PDL — Preferred Drug List
PERT — Program Evaluation and Review Technique
PH — Physical Health
PHDHP — Public Health Dental Hygiene Practitioners
PH-MCO — Physical Health Managed Care Organization
PHS — Public Health Service
PID — Pennsylvania Insurance Department
PIHP — Prepaid Inpatient Health Plan
PIP — Physician Incentive Plan
PIPs — Performance Improvement Projects
PMPM — Per Member, Per Month
POSNet — Pennsylvania Open Systems Network

PPC — Provider Preventable Condition
PPR — Prepayment Review
PPS — Prospective Payment System
PROMISe™ — Provider Reimbursement (and) Operations Management Information System electronic (format)
PSMI — Persistent Serious Mental Illness
PT — Provider Type
QA — Quality Assurance
QARI — Quality Assurance Reform Initiative
QM — Quality Management
QMC — Quality Management Committee
QM/UM — Quality Management and Utilization Management
RBUC — Reported But Unpaid Claim
RFP — Request for Proposal
RHC — Rural Health Centers/Clinics
RPAA — Risk Pool Allocation Amount
RTF — Residential Treatment Facility
SAM — System for Award Management
SAP — Statutory Accounting Principles
SNU — Special Needs Unit
SPU — Short Procedure Unit
SSADMF — Social Security Administration's Death Master File
SSI — Supplemental Security Income
SUD — Substance Use Disorder
TANF — Temporary Assistance for Needy Families
TCM — Targeted Case Management
TPL — Third Party Liability
TPR — Third Party Resources
TTY — Text Telephone Typewriter
UM — Utilization Management
URCAP — Utilization Review Criteria Assessment Process
VBM – Vision Benefit Manager
VBP — Value Base Purchasing
WBE — Women's Business Enterprise
WIC — Women, Infants and Children (Program)

SECTION III: RELATIONSHIP OF PARTIES

A. Basic Relationship

The PH-MCO, its employees, servants, agents, and representatives shall not be considered and shall not hold themselves out as the employees, servants, agents or representatives of the Department or the Commonwealth of Pennsylvania. The PH-MCO, its employees, servants, agents and representatives do not have the authority to bind the Department or the Commonwealth of Pennsylvania and they shall not make any claim or demand for any right or privilege applicable to an officer or employee of the Department or the Commonwealth of Pennsylvania, unless such right or privilege is expressly delegated to the PH-MCO herein. The PH-MCO shall be responsible for maintaining for its employees, and for requiring of its agents and representatives, malpractice, workers' compensation and unemployment compensation insurance in such amounts as required by law.

The PH-MCO is responsible for all taxes and withholdings of its employees. In the event that any employee or representative of the PH-MCO is deemed an employee of the Department by any taxing authority or other governmental agency, the PH-MCO will indemnify the Department for any taxes, penalties or interest imposed upon the Department by such taxing authority or other governmental agency.

B. Nature of Agreement

The PH-MCO must arrange for the provision of medical and related services to Members through qualified Providers in accordance with this Agreement. In administering the HealthChoices Program, the PH-MCO must comply fully with this Agreement, including but not limited to, the operational and financial standards, as well as any functions expressly delegated to the PH-MCO herein.

The Secretary for DHS will determine the number of MCOs operating in the HealthChoices Program and may, during the term of this Agreement, enter into agreements with additional qualified MCOs who meet all established agreement, licensing and readiness review requirements.

SECTION IV: APPLICABLE LAWS AND REGULATIONS

A. Certification and Licensing

During the term of this Agreement, the PH-MCO must require that each of its Network Providers complies with all certification and licensing laws and regulations applicable to the profession or entity. The PH-MCO may not

employ or enter into a contractual relationship with a Health Care Provider who is precluded from participation in the MA Program or other federal health care program and is required to screen all Health Care Providers (both individual and entities), at the time of hire or contracting; and thereafter, on an ongoing monthly basis to determine if they have been excluded from participation in federal health care programs.

B. Specific to MA Program

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

In compliance with ARRA 5006(a), the PH-MCO is prohibited from imposing enrollment fees, premiums, cost sharing, or similar charges on Indians served by an Indian health care provider; Indian Health Service (IHS); an Indian Tribe, Tribal Organization, or Urban Indian Organization (I/T/U) or through referral under contract health services (CHS).

Any cost sharing imposed by the PH-MCO on enrollees is in accordance with Medicaid fee for service requirements at 42 C.F.R. 447.50-447.82 and the Social Security Act §§1916(a)(2)(D) and (b)(2)(D).

C. General Laws and Regulations

1. The PH-MCO must comply with Titles VI and VII of the Civil Rights Act of 1964, 42 U.S.C. §§2000d et seq. and 2000e et seq.; Title IX of the Education Amendments of 1972, 20 U.S.C. §§1681 et seq.; Section 504 of the Rehabilitation Act of 1973, 29 U.S.C. §§701 et seq.; the Age Discrimination Act of 1975, 42 U.S.C. §§6101 et seq.; the Americans with Disabilities Act, 42 U.S.C. §§12101 et seq.; Section 1557 of the Patient Protection and Affordable Care Act (ACA), [42 C.F.R. 438.3(f)(1); 42 C.F.R. 438.100(d)]; the Health Insurance Portability and Accountability Act of 1996 (HIPAA); the Health Information Technology for Economic and Clinical Health

(HITECH) Act; the HIPAA Privacy Rule and the HIPAA Security Rule, 45 C.F.R.. Parts 160, 162, and 164 (HIPAA Regulations); the Pennsylvania Human Relations Act of 1955, 71 P.S. §§941 et seq.; Article XXI of the Insurance Company Law of 1921, as amended, 40 P.S. §§991.2102 et seq.; and Drug and Alcohol Use and Dependency Coverage Act 106 of 1989, 40 P.S. §§908-1 et seq.

The PH-MCO must comply with Commonwealth requirements and regulations pertaining to reporting and patient rights under any contract involving research, developmental, experimental or demonstration work with respect to any discovery or invention which arises or is developed in the course of or under such contract, and requirements and regulations pertaining to copyrights and rights in data.

Contracts, subcontracts, and subgrants of amounts in excess of $100,000 shall contain a provision, which requires compliance with all applicable standards, orders or requirements issued under section 306 of the Clean Air Act (42 USC 7606), section 508 of the Clean Water Act (33 USC 1368) and Executive Order 1178.

Contracts shall recognize mandatory standards and policies relating to energy efficiency, which are contained in the State energy conservation plan issued in compliance with the Energy Policy and Conservation Act (Pub. L. 94-163).

All contracts shall be in compliance with Equal Employment Opportunity (EEO) provisions.

All contracts in excess of $2,000 shall be in compliance with the Copeland Anti-Kickback Act and the Davis-Bacon Act.

All contracts in excess of $2,000 for construction and $2,500 employing mechanics or laborers, shall abide by and be in compliance with the Contract Work Hours and Safety Standards.

The PH-MCO must be in compliance with the Byrd Anti-Lobbying Amendment.

2. The PH-MCO must comply with the Commonwealth's Contract Compliance Regulations that are set forth at 16 Pa. Code 49.101 and on file with the PH-MCO.

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

The PH-MCO must comply with applicable Federal and State laws that pertain to Member rights and protections. The PH-MCO must require that its staff and Providers take those rights and protections into account when furnishing services to Members.

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

   If the PH-MCO elects not to provide, reimburse for, or provide coverage of, a counseling or referral service because of an objection on moral or religious grounds, the PH-MCO must furnish information about the services not covered in accordance with the provisions of 42 C.F.R. §438.102(b)

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

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

5. The PH-MCO must maintain the highest standards of integrity in the performance of this Agreement and must take no action in violation of state or federal laws, regulations, or other requirements that govern contracting with the Commonwealth.

6. Nothing in this Agreement shall be construed to permit or require the Department to pay for any services or items which are not or have ceased to be compensable under the laws, rules and regulations governing the MA Program at the time such services are provided.

7. The PH-MCO must comply with all applicable Federal regulations, including 42 C.F.R. §§438.726 and 438.730 describing conditions under which CMS may deny payments for new enrollees.

8. The PH-MCO must comply with all applicable Federal regulations pertaining to provider screening and enrollment, including but not limited to 42 C.F.R. §§455.414 and 455.432.

9. The PH-MCO is required under 42 C.F.R. §455.436 to check the exclusion status of the provider, persons with an ownership or control interest in the provider, and agents, and managing employees of the provider on the U.S. Department of Health and Human Services-Office of Inspector General's (HHS-OIG) List of Excluded Individuals and Entities (LEIE), the System for Award Management (SAM), the Social Security Administration's Death Master File (SSADMF), the National Plan and the Provider Enumeration System upon enrollment and re-enrollment; and check the LEIE and SAM no less frequently than monthly. The PH-MCO is required to check the SSADMF at the time of initial enrollment and re-enrollment as well as providers, owners, agents, and managing employees against the LEIE and SAM on a monthly basis.

D. Limitation on the Department's Obligations

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

E. Health Care Legislation, Regulations, Policies and Procedures

The PH-MCO will comply with future changes in federal and state law, federal and state regulations, and Department requirements and procedures related to changes in the MA Program.

F. Health Information Technology and the American Recovery and Reinvestment Act of 2009 (ARRA)

The PH-MCO will comply with future changes in federal and state law, federal and state regulations, and Department requirements and procedures related to changes in the MA Program resulting from the Department's Health Information Technology (HIT) initiatives or requirements under the State Medicaid Health IT Plan (SMHP) as approved by CMS. This includes, but is not limited to, requirements under Public Law 111-5, known as the American Recovery and Reinvestment Act of 2009, and specifically:

- 42 U.S.C. §1396b(t)

as amended and as it meets the requirements of 42 U.S.C. §1395w-4(o) and Title XIII, section 13001, known as HITECH of Public Law 111-5, known as the American Recovery and Reinvestment Act of 2009.

Should the Department provide funding to the PH-MCO to support the HIT initiative or to meet the requirements under the SMHP as approved by CMS,

the PH-MCO shall at a minimum and with approval from the Department use these funds to:

- Pursue initiatives that encourage the adoption of certified Electronic Health Record technology to promote health care quality and the exchange of health care information;
- Track the meaningful use of certified Electronic Health Record technology by providers;
- Provide oversight of the initiative including, but not limited to, attesting to qualifications of providers to participate in the initiative, tracking meaningful use attestations, and other reporting mechanisms as necessary.

SECTION V: PROGRAM REQUIREMENTS

A. In-Plan Services

The PH-MCO must ensure that all services provided are Medically Necessary.

The MCO may but is not required to impose copayments, but only for those services, items, and pharmacy services that have a copayment in the MA FFS delivery system and subject to the exemptions in the MA FFS delivery system. If the MCO imposes copayments, the amount of the copayments may not exceed the amounts imposed in the MA FFS delivery system. Network Providers and other Providers that may render services under the Agreement may not deny a covered service because a Member is unable to pay the copayment amount, but the Provider may continue to attempt to collect the copayment amount.

1. Amount, Duration and Scope

At a minimum, the PH-MCO must provide In-Plan Services 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. This includes quantitative and non-quantitative treatment limits (QTL) (NQTL) as indicated in state statutes and regulations, the Medicaid state plan and other state policies and procedures. The PH-MCO must provide services that are sufficient in amount, duration, or scope to reasonably be expected to achieve the purpose for which the services are furnished. If services or eligible consumers are added to the Pennsylvania MA Program or the HealthChoices Program, or if covered services or eligible consumers are expanded or eliminated, implementation by the PH-MCO must be on the same day as the Department’s, unless the PH-

MCO is notified by the Department of an alternative implementation date.

The PH-MCO may not arbitrarily deny or reduce the amount, duration or scope of a Medically Necessary service solely because of the Member's diagnosis, type of illness or condition.

Pursuant to 42 C.F.R. §438.3(e)(2)(i) – (iii), the PH-MCO may cover services or settings for enrollees that are in lieu of those covered under the Medicaid State Plan if:

• The State determines that the alternative service or setting is a medically appropriate substitute for the covered service or setting under the Medicaid State Plan.

• The State determines that the alternative service or setting is a cost effective substitute for the covered service or setting under the Medicaid State Plan.

• The enrollee is not required by the PH-MCO to use the alternative service or setting.

• The approved in lieu of services are authorized and identified in the PH-MCO contract.

• The approved in lieu of services are offered to enrollees at the option of the PH-MCO.

2. In-Home and Community Services

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

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

The PH-MCO must include in its Provider Network any Home Health Agency that offers in-home nursing services, home health aide services, or personal care services for Members under the age of 21 that is enrolled in Pennsylvania Medical Assistance and is willing to comply with all of the PH-MCO's quality and non-quality contract standards, utilization management standards and accept PH-MCO rates that are consistent with reimbursement rates paid to similar In-Network Providers.

The PH-MCO must submit to the Department for prior review and written approval any Home Health Agency requests for entrance to the Network that it intends to deny based upon quality of care, program integrity or other relevant concerns.

The PH-MCO must implement a Public Health Dental Hygiene Practitioner (PHDHP) program or a dental hygienist program under the direct supervision of a dentist. The hygienists must spend the majority of their time face-to-face performing direct patient preventive care in the community.

3. Program Exceptions

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

4. Expanded Services

The PH-MCO may provide expanded services subject to advance written approval by the Department. These must be services that are generally considered to have a direct relationship to the maintenance or enhancement of a Member's health status, and may include various seminars and educational programs promoting healthy living or illness prevention, memberships in health clubs and facilities promoting physical fitness and expanded eyeglass or eye care benefits. These services must be generally available to all Members and must be made available at all appropriate Network Providers. Such services cannot be tied to specific Member performance; however, the Department may grant exceptions when

it believes that such performance will produce significant health improvements for Members. Previously approved services will continue to remain in effect under this Agreement, unless the PH-MCO is notified, in writing, by the Department, to discontinue the expanded service.

In order for information about expanded services to be included in any Member information provided by the PH-MCO, the PH-MCO must make the expanded services available for a minimum of one full year or until the Member information is revised, whichever is later. Upon sixty (60) days advance notice to the Department, the PH-MCO may modify or eliminate any expanded service. Such services as modified or eliminated shall supersede those specified in the Proposal. The PH-MCO must send written notice to Members and affected Providers at least thirty (30) days prior to the effective date of the change in covered services and must simultaneously amend all written materials describing its covered services or Provider Network. A change in covered services includes any reduction in services or a substantial change to the Provider Network.

5. Referrals

The PH-MCO must establish and maintain a referral process to effectively utilize and manage the care of its Members. The PH-MCO may require a referral for any medical services, which cannot be provided by the PCP except where specifically provided for in this Agreement.

6. Self-Referral/Direct Access

The PH-MCO may not require referrals from a PCP for certain services. A Member may self-refer for vision, dental care, obstetrical and gynecological (OB/GYN) services, providing the Member obtains the services within the Provider Network. A Member may access chiropractic services in accordance with the process set forth in MA Bulletin 99-10-12, and physical therapy services in accordance with the amended Physical Therapy Act (63 P.S. §§1301 et seq.)
The PH-MCO may not use either the referral process or Prior Authorization to manage the utilization of Family Planning Services. The PH-MCO may not restrict the right of a Member to choose a Health Care Provider for Family Planning Services and must make such services available without regard to marital status, age, sex or parenthood. Members may access at a minimum, health education and counseling necessary to make an informed choice about contraceptive methods, pregnancy testing and counseling, breast cancer screening services, basic contraceptive supplies such as oral

birth control pills, diaphragms, foams, creams, jellies, condoms (male and female), Norplant, injectables, intrauterine devices, and other family planning procedures as described in Exhibit F, Family Planning Services Procedures. The PH-MCO must pay for Out-of-Network Services.

The PH-MCO must provide Members with direct access to OB/GYN services and must have a system in place that does not erect barriers to care for pregnant women and does not involve a time-consuming authorization process or unnecessary travel.

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

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

7. Behavioral Health Services

The PH-MCO is not responsible to provide services as set forth in the agreements between the Department and the BH-MCOs in effect at the same time as this Agreement, as outlined in Exhibit U, Behavioral Health Services.

8. Pharmacy Services

The PH-MCO must comply with the Department's outpatient drug services standards and requirements described in Exhibit BBB, Outpatient Drug Services.

9. EPSDT Services

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

The PH-MCO must also adhere to specific Department regulations at 55 Pa. Code Chapters 3700 and 3800 as they relate to EPSDT

examination for individuals under the age of 21 and entering substitute care or a child residential facility placement.

10. Emergency Services

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

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

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

For emergency services rendered by a licensed emergency medical services agency, as defined in 35 Pa.C.S. § 8103, that has the ability to transport patients or is providing and billing for emergency services under an agreement with an emergency medical services agency that has that ability, the managed care plan may not deny a claim for payment solely because the enrollee did not require transport or refused to be transported.

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

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

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

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

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

- A representative of the PH-MCO instructs the Member to seek emergency services.

The PH-MCO may not:

- Limit what constitutes an Emergency Medical Condition with reference to the definition of "Emergency Medical Condition, Emergency Services, and Post Stabilization Services" on the basis of lists of diagnoses or symptoms.

- Refuse to cover emergency services based on the emergency room provider, hospital, or fiscal agent not notifying the Member's Primary Care Practitioner, PH-MCO, or applicable state entity of the Member's screening and treatment within ten (10) calendar days of presentation for emergency services.

- Hold a Member who has an Emergency Medical Condition liable for payment of subsequent screening and treatment needed to diagnose the specific condition or stabilize the patient.

- Deny a claim for payment for emergency services rendered by a licensed emergency medical services agency, as defined in 35 Pa.C.S. § 8103, that has the ability to transport patients or is providing and billing for emergency services under an agreement with an emergency medical services agency that has that ability, solely because the enrollee did not require transport or refused to be transported.

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

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

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

11. Post-Stabilization Services

The PH-MCO must cover Post-Stabilization Services, as defined in 42 C.F.R. §438.114.

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

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

a. The Post-Stabilization Services were administered to maintain the Member's stabilized condition within one hour of Provider's request to the PH-MCO for pre-approval of further Post-Stabilization Services.

b. The Post-Stabilization Services were not pre-approved by the PH-MCO because the PH-MCO did not respond to the Provider's request for pre-approval of these Post-Stabilization Services within one (1) hour of the request.

c. The Post-Stabilization Services were not pre-approved by the PH-MCO because the Provider could not reach the PH-MCO request pre-approval for the Post-Stabilization Services.

d. The PH-MCO and the treating physician cannot reach an agreement concerning the Member's care and a PH-MCO physician is not available for consultation. In this situation, the MCO must give the treating physician the opportunity to consult with a PH-MCO physician and the treating physician may continue with care of the patient until a PH-MCO physician is reached or one of the criteria applicable to termination of PH-MCO's financial responsibility described below is met.

The PH-MCO's financial responsibility for Post-Stabilization Services it has not pre-approved ends when:

a. A Network physician with privileges at the treating hospital assumes responsibility for the Member's care;

b. A Network physician assumes responsibility for the Member's care through transfer;

c. The PH-MCO and the treating physician reach an agreement concerning the Member's care; or

d. The Member is discharged.

12. Examinations to Determine Abuse or Neglect

a. Upon notification by the County Children and Youth Agency system, the PH-MCO must provide Members under evaluation as possible victims of child abuse or neglect and who present for physical examinations for determination of abuse or neglect, with such services. These services must be performed by trained examiners in a timely manner according to the Child Protective Services Law, 23 Pa. C.S. §§6301 et seq. and Department regulations.

b. The PH-MCO must ensure that emergency department staff and physicians know the procedures for reporting suspected abuse and neglect in addition to performing exams for Members under the care of the county Children and Youth Agency consistent with their obligations mandated in 18 Pa.C.S.A. §5106 and all other applicable statutes. This includes reporting to Adult Protective Services any suspected

abuse or neglect of Members over the age of 18. These requirements must be included in all applicable Provider Agreements.

c. Should a PCP determine that a mental health assessment is needed, the PCP must inform the Member or the County Children and Youth Agency representative how to access these mental health services and coordinate access to these services, when necessary.

13. Hospice Services

The PH-MCO must provide hospice care and use certified hospice Providers in accordance with the provisions outlined at 42 C.F.R. 418.1 et seq.

Recipients who are enrolled in the Department's Hospice Program and were not previously enrolled in the HealthChoices Program will not be enrolled in HealthChoices. However, if a PH-MCO Member is determined eligible for the Department's Hospice Program after being enrolled in the PH-MCO, the Member will remain the responsibility of the PH-MCO and will not be disenrolled from HealthChoices.

14. Organ Transplants

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

15. Transportation

The PH-MCO must provide for all Medically Necessary emergency ambulance transportation and all Medically Necessary non-emergency ambulance transportation.

Any non-emergency transportation (excluding Medically Necessary non-emergency ambulance transportation) for Members to and from MA compensable services must be arranged through the MATP. A complete description of MATP responsibilities can be found in Exhibit L, Medical Assistance Transportation Program.

16. Waiver Services/State Plan Amendments

a. HIV/AIDS Targeted Case Management (TCM) Program

The PH-MCO must provide for TCM services for persons with AIDS or symptomatic HIV, including access to needed medical and social services using the existing TCM program standards of practice followed by the Department or comparable standards approved by the Department. In addition, individuals within the PH-MCO who provide the TCM services must meet the same qualifications as those under the Department's TCM Program.

b. Healthy Beginnings Plus (HBP) Program

The PH-MCO must provide services that meet or exceed HBP standards in effect as defined in current or future MA Bulletins that govern the HBP Program. The PH-MCO must also continue the coordinated prenatal activities of the HBP Program by utilizing enrolled HBP Providers or developing comparable resources. Such comparable programs will be subject to review and approval by the Department. The PH-MCO must provide a full description of its plan to provide prenatal care for pregnant women and infants in fulfillment of the HBP Program objectives for review and advance written approval by the Department. This plan must include comprehensive postpartum care.

Since the HBP program focuses on community based services provided by licensed and non-licensed providers who see recipients face-to-face in outpatient provider offices or community settings, the PH-MCO's prenatal program must have the majority of its pregnant Members seen face-to-face in the community setting. Majority is defined as greater than fifty percent (50%) of unique pregnant women as reported in the Operations 15 Comprehensive Care Management report. This will be accomplished by contractual relationships within the PH-MCO's Provider Network, PH-MCO employees, or delegated vendor relationship.

The HBP Program also requires that high risk pregnant women should be adequately treated for substance use disorder (SUD). The PH-MCO will contract with high volume obstetrical hospitals and health systems that perform more than 900 Medicaid deliveries to establish highly coordinated

health homes for pregnant Members with SUD. These health homes will be focused on identifying, initiating treatment, and referring pregnant Members for comprehensive drug and alcohol counseling services. If the PH-MCO is unsuccessful in contracting with any of the high volume obstetrical hospitals or health systems, it must document its efforts to negotiate with the provider for review by the Department.

17. Nursing Facility Services

The PH-MCO is responsible for payment for nursing home care (including hospital reserve or bed hold days).

A PH-MCO may not deny or otherwise limit Medically Necessary services, such as home health services, on the grounds that the Member needs, but is not receiving, a higher level of care.
The PH-MCO must abide by the decision of the Functional Eligibility Determination process determination letter related to the need for Nursing Facility services.

The Department will not enroll Recipients who are placed into a Nursing Facility and who were not previously enrolled in the HealthChoices Physical Health Program or individuals who enter a Nursing Facility and are then determined eligible for MA in the HealthChoices Physical Health Program. If an individual leaves the Nursing Facility to reside in the HealthChoices Physical Health Zone covered by this Agreement and is then determined eligible for Enrollment into the HealthChoices Physical Health Program, the individual will be enrolled in the HealthChoices Physical Health Program.

18. Benefit Limits and Benefit Limit Exceptions (BLEs)

The PH-MCO has the option to impose the same benefit limits or lesser benefit limits as the Department. For those services that are covered in a Member's benefit package only with an approved BLE, the PH-MCO must use the same criteria as the Department or may use criteria that are less restrictive for its review of BLE requests.

The PH-MCO must establish and maintain written policies and procedures for its BLE process. The PH-MCO must receive advance written approval from the Department of these policies and procedures. The policies and procedures must comply with guidance issued by the Department. The PH-MCO's submission of revised policies and procedures for review and approval by the Department shall not act to void any existing policies and procedures which have

been prior approved by the Department for operation in a HC Zone. Unless otherwise required by law, the PH-MCO may continue to operate under such existing policies and procedures until such time as the Department approves the new or revised version thereof. The Department may periodically request ad hoc information related to PH-MCO operations surrounding these BLE requests.

If the PH-MCO imposes benefit limits, the PH-MCO must issue notices to its members and notify network providers at least thirty (30) days in advance of the changes. The member notices must receive advance Department approval prior to being sent to Members.

The time frames for notices of decisions for prior authorization set forth at Section V.B.2 and V.B.3. apply to requests for BLEs. If the PH-MCO denies a BLE request, the PH-MCO must issue a written denial notice, using the appropriate template available in Docushare.

If the Member is currently receiving a service or item that is subject to a benefit limit and the request for a BLE is denied, and the recipient files a complaint, grievance or request for a Fair Hearing that is postmarked or hand-delivered within 10 days of the date of the notice, the PH-MCO must continue to provide the service until a decision is made.

Recipients with approved BLE's are in a course of treatment. As such, the requirements for Continuity of Care for Course of Treatment Services Not Requiring Prior Authorization for Adults Age 21 and Older and Children Under the Age of 21, set forth in MA Bulletin 99-03-13, Attachment D, apply. PH-MCOs are required to honor all approved BLE requests issued by the Fee-for-Service (FFS) program, another PH-MCO, or a CHC-MCO. The FFS delivery system and CHC-MCOs will also honor all approved BLE requests issued by PH-MCOs.

19. Environmental Lead Testing

The PH-MCO must provide for necessary comprehensive environmental lead investigations as part of covered blood lead treatment services. The PH-MCO must contract with the necessary number of MA-enrolled Comprehensive Lead Investigation Providers to ensure access to this service in all HealthChoices zones in which the PH-MCO operates. The PH-MCO will ensure that results of environmental lead investigations are shared with the referring provider and the Member (or Member's guardian).

20. Opioid Use Disorder/Substance Abuse Disorder Management

The PH-MCO must implement and maintain an opioid use disorder/substance abuse disorder (OUD/SUD) strategy for its members with OUD/SUD. The OUD/SUD strategy must address how the PH-MCO will manage their members with OUD/SUD and include initiatives similar to those described in the following links:

- Dowell D, Haegerich TM, Chou R. CDC Guideline for Prescribing Opioids for Chronic Pain — United States, 2016. MMWR Recomm Rep 2016; 65(No. RR-1):1–49. DOI: http://dx.doi.org/10.15585/mmwr.rr6501e1

  The Pennsylvania Guidelines on the Use of Opioids to Treat Chronic Noncancer Pain. Accessed January 31, 2017, https://www.health.pa.gov/topics/Documents/Opioids/Non-cancer%20Pain%20Guidelines%20Final.pdf

At a minimum, the OUD/SUD strategy must include care management initiatives, alternative treatment modalities such as pain management, strategies to address opioid related harm reduction, tapering strategies and medication assisted treatment (MAT). In addition, the PH-MCO must coordinate and collaborate with the Opioid Use Disorder Centers of Excellence for its member with OUD/SUD.

B. Prior Authorization of Services

1. General Prior Authorization Requirements

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

previously approved policies and procedures. Unless otherwise required by law, the PH-MCO may continue to operate under such existing policies and procedures until such time as the PARP approves the new or revised version.

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

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

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

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

The PH-MCO may waive the Prior Authorization requirements for services which are required by the Department to be Prior Authorized.

2. Time Frames for Notice of Decisions

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

b. If the requested information is provided within fourteen (14) days, the PH-MCO must make the decision to approve or deny the service, and notify the Member orally, within two (2) Business Days of receipt of the additional information. The PH-MCO must mail written notice of the decision to the Member, the Member's PCP, and the prescribing Provider within two (2) Business Days after the decision is made.

c. If the requested information is not received within fourteen (14) days, the PH-MCO must make the decision to approve or deny the service based upon the available information and notify the Member orally within two (2) Business Days after the additional information was to have been received. The PH-MCO must mail written notice of the decision to the Member, the Member's PCP, and the prescribing Provider within two (2) Business Days after the decision is made.

d. In all cases, the PH-MCO must make the decision to approve or deny a covered service or item and the Member must receive written notification of the decision no later than twenty-one (21) days from the date the PH-MCO received the request, or the service or item is automatically approved. To satisfy the twenty-one (21) day time period, the PH-MCO may mail written notice to the Member, the Member's PCP, and the prescribing Provider on or before the eighteenth (18th) day from the date the request is received. If the notice is not mailed by the eighteenth (18th) day

after the request is received, the PH-MCO must hand deliver the notice to the Member, or the request is automatically approved.

e. If the Member is currently receiving a requested service and the PH-MCO decides to deny the Prior Authorization request, the PH-MCO must mail the written notice of denial at least (10) days prior to the effective date of the denial of authorization for continued services. If probable Member fraud has been verified, the period of advance notice is shortened to five (5) days. The PH-MCO is not required to provide advance notice when it has factual information on the following:

- confirmation of the death of a Member;
- receipt of a clear written statement signed by a Member that she or he no longer wishes services or gives information that requires termination or reduction of services and indicates that she or he understands that termination must be the result of supplying that information;
- the Member has been admitted to an institution where she or he is ineligible under the PH-MCO for further services;
- the Member's whereabouts are unknown and the post office returns mail directed to him or her indicating no forwarding address;
- the PH-MCO established the fact that the Member has been accepted for MA by another State; or
- a change in the level of medical care is prescribed by the Member's physician.

3. Prior Authorization of Outpatient Drug Services

The PH-MCO must comply with the requirements of Exhibit BBB specific to Prior Authorization of Outpatient Drug Services.

C. Continuity of Care

The PH-MCO must comply with the procedures outlined in MA Bulletin #99-96-01, Continuity of Prior Authorized Services Between FFS and Managed Care Plans and Between Managed Care Plans for Individuals Under Twenty-One (21), and MA Bulletin 99-03-13 Continuity of Care for Recipients Transferring Between and Among Fee-for-Service and Managed Care Organizations to provide for continuity of Prior Authorized Services.

The PH-MCO must comply with Section 2117 of Article XXI of the Insurance Company Law of 1921, as amended, 40 P.S. §991.2117, regarding continuity of care requirements and 28 Pa. Code §9.684 and 31 Pa. Code §154.15. The PH-MCO must comply with the procedures outlined in MA Bulletin 99-03-13, Continuity of Care for Recipients Transferring Between and Among Fee-for-Service and Managed Care Organizations, to ensure continuity of Prior Authorized Services for individuals age twenty-one (21) and older and continuity of non-prior authorized services for all Members.

The PH-MCO must implement a transition of care policy consistent with the above requirements and compliant with 42 C.F.R. 438.62 (b) (1) (2) (3).

The PH-MCO Special Needs Unit must have a resource account email box in place for receipt of transition of care documentation to ensure timely access to all medically necessary services. The Special Needs Unit Coordinator and multiple staff must have access to this resource account.

D. Coordination of Care

The PH-MCO must coordinate care for its Members. The PH-MCO must provide for seamless and continuous coordination of care across a continuum of services for the Member with a focus on improving health care outcomes. The continuum of services may include the In-Plan comprehensive service package, out-of-plan services, and non-MA covered services provided by other community resources such as:

- Nursing Facility Care
- Intermediate Care Facility for the Intellectually Disabled/Other Related Conditions
- Residential Treatment Facility
- Acute Psychiatric Facilities
- Extended and Extended Acute Psychiatric Facilities
- Non-Hospital Residential Detoxification, Rehabilitation, and Half-Way House Facilities for Drug/Alcohol Dependence/ Addiction
- Opioid Use Disorder Centers of Excellence
- Aging Well PA/Level of Care Assessment and Pre-admission Screening Requirements

- Juvenile Detention Centers
- Children in Substitute Care Transition
- Adoption Assistance for Children and Adolescents
- Services to Dual Eligibles Under the Age of Twenty-one
- Transitional Care Homes
- Medical Foster Care Services
- Early Intervention Services (note the PH-MCO must refer for Early Intervention Services any of its Members who are children from birth to age three (3) who are living in residential facilities. “Children living in residential facilities” describes children who are in a 24-hour living setting in which care is provided for one or more children.)
- The OBRA waiver, a home-and-community-based waiver program for individuals who have a severe developmental physical disability requiring an Intermediate Care Facility/Other Related Conditions (ICF/ORC) level of care
- Intellectual Disabilities Services (note the PH-MCO is responsible to ensure a family with a child who has or is at risk of a developmental delay is referred to the County Intellectual Disabilities office for a determination of eligibility for home and community-based services, including children living in residential facilities as described above.)
- Home-and Community-Based Waiver for Persons with Intellectual Disabilities
- Children in Residential Facilities
- Home-and Community-Based Waiver for Persons with Autism

The PH-MCO must provide the necessary related services for Members in facilities as described in Exhibit O, Description of Facilities and Related Services. Out-of-Plan Services are described

in Exhibit P, Out-of-Plan Services. Recipient coverage rules are outlined in Exhibit BB, PH-MCO Recipient Coverage Document.

1. Coordination of Care/Letters of Agreement

The PH-MCO must coordinate the comprehensive in-plan package with entities providing Out-of-Plan Services. To facilitate the efficient administration of the Medical Assistance Program, to enhance the treatment of Members who need Out-of-Plan services and to clearly define the roles of the entities involved in the coordination of services, the PH-MCO must enter into coordination of care letters of agreement with County Children and Youth Agencies (CCYAs), Juvenile Probation Offices (refer to Sample Model Agreement, Exhibit Q), and BH-MCOs (refer to Exhibit R, Coordination with BH-MCOs). In Addition, the PH-MCO must make a good faith effort to enter into coordination of care letters of agreement with school districts and other public, governmental, county, and community-based service providers.

Should the PH-MCO be unable to enter into coordination of care letters of agreement as required under this Agreement, the PH-MCO must submit written justification to the Department. Justification must include all the steps taken by the PH-MCO to secure coordination of care letters of agreement, or must demonstrate an existing, ongoing, and cooperative relationship with the entity. The Department will determine whether to waive strict compliance with this requirement.

All written coordination documents developed and maintained by the PH-MCO must have advance written approval by the Department and must be reviewed and, if necessary, revised at least annually by the PH-MCO. Coordination documents must be available for review by the Department upon request.

The PH-MCO must obtain the Department's prior written approval of all written coordination documents entered into between a service provider and the PH-MCO. These coordination documents must contain, but should not be limited to, the provisions outlined in Exhibit S, Written Coordination Agreements Between PH-MCO and Service Providers, and must be submitted for final Department review and approval at least thirty (30) days prior to the operational date of Agreement. Under no circumstances may these coordination documents contain a definition of Medically Necessary other than the definition found in this Agreement.

2. PH-MCO and BH-MCO Coordination

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

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

a. Information exchange including the BH utilization data provided by the Department to control avoidable hospital admissions, readmissions and emergency department usage for Members with PSMI and/or substance abuse disorders.

b. Development of specific coordination mechanisms to assess and, where appropriate, reduce the use of psychotropic medications prescribed for children, especially those in substitute care.

The PH-MCO will comply with the requirements regarding coordination of care, which are set forth in Section V.D, Coordination of Care, including those pertaining to behavioral health.

a. The PH-MCO will, and the Department will require BH-MCOs to agree, to submit to a binding independent arbitration process in the event of a dispute between the PH-MCO and a BH-MCO concerning their respective obligations under this Agreement and the Behavioral HealthChoices agreement. The mutual agreement of the PH-MCO and a BH-MCO to such an arbitration process must be evidenced by and included in the written agreement between the PH-MCO and the BH-MCO.

b. Exhibit BBB contains additional requirements specific to Outpatient Drug Services.

3. Disability Advocacy Program

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

E. PH-MCO Responsibility for Reportable Conditions

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

F. Member Enrollment and Disenrollment

1. General

The PH-MCO is prohibited from restricting its Members from changing PH-MCOs for any reason. The MA Consumer has the right to initiate a change in PH-MCOs at any time.

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

The Department will disenroll Members from a PH-MCO when there is a change in residence which places the Member outside the HC Zone(s) covered by this Agreement, as indicated on the individual county file maintained by the Department's Office of Income Maintenance.

The Department has implemented a process to enroll Members transferring from one HC Zone to another with the same PH-MCO, provided that the PH-MCO operates in both HC Zones.

2. PH-MCO Outreach Materials

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

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

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

b. The PH-MCO must comply with the Enrollment procedures established by the Department in order to ensure that, before the individual is enrolled with the PH-MCO, the individual is provided accurate oral and written information sufficient to make an informed decision on whether to enroll.

c. The PH-MCO must not directly or indirectly conduct door-to-door, telephone, email, texting, or other cold-call marketing activities.

d. The PH-MCO must ensure that all outreach plans, procedures and materials are accurate and do not mislead, confuse or defraud either the Recipient or the Department. Refer to Exhibit X, HealthChoices MCO Guidelines for Advertising, Sponsorships, and Outreach.

3. PH-MCO Outreach Activities

The PH-MCO must comply with the following:

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

The PH-MCO is also prohibited from subcontracting with an outside entity to engage in outreach activities associated with any form of Enrollment to eligible or potential Recipients. The PH-MCO must not engage in outreach activities associated with Enrollments, which include but are not limited to, the following locations and activities:

- CAOs
- Providers' offices
- Malls/Commercial or retail establishments
- Hospitals
- Check cashing establishments
- Door-to-door visitations
- Telemarketing
- Community Centers
- Churches
- Direct Mail

b. The PH-MCO, either individually or as a joint effort with other PH-MCOs in the HealthChoices Zone, may use but not be limited to commonly accepted media methods for the advertisement of quality initiatives, educational outreach, and health-related materials and activities.

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

The PH-MCO must obtain from the Department advance written approval of any advertising placed in mass media for any reason by the PH-MCO.

c. The PH-MCO may participate in or sponsor health fairs or community events. The Department may set limits on

contributions and/or payments made to non-profit groups in connection with health fairs or community events and requires advance written approval for contributions and/or payments of $2,000.00 or more. The Department will consider such participation or sponsorship when a written request is submitted thirty (30) calendar days in advance of the event, thus allowing the Department reasonable time to review the request and provide timely advance written approval. All contributions/payments are subject to financial audit by the Department.

d. The PH-MCO may offer items of little or no intrinsic value (i.e., trinkets with promotional PH-MCO logos)at health fairs or other approved community events. Such items must be made available to the general public, not to exceed $5.00 in retail value and must not be connected in any way to PH-MCO Enrollment activity. All such items are subject to advance written approval by the Department.

e. The PH-MCO may offer Members health-related services in excess of those required by the Department and is permitted to feature such expanded services in approved outreach materials. All such expanded services are subject to advance written approval by the Department and must meet the requirements of Section V.A.4., Expanded Services.

f. The PH-MCO may offer Members consumer incentives only if they are directly related to improving health outcomes. The incentive cannot be used to influence a Member to receive any item or service from a particular Provider, practitioner or supplier. In addition, the incentive cannot exceed the total cost of the service being provided. The PH-MCO must receive advance written approval from the Department prior to offering a Member incentive.

g. Unless approved by the Department, PH-MCOs are not permitted to directly provide products of value unless they are health related and are prescribed by a licensed Provider.

h. PH-MCOs may not offer Member coupons for products of value.

i. The Department may review any and all outreach activities and advertising materials and procedures used by the PH-MCO, including all outreach activities, advertising materials, and corporate initiatives that are likely to reach MA Recipients.

In addition to any other sanctions, the Department may impose monetary or restricted Enrollment sanctions should the PH-MCO be found to be using unapproved outreach materials or engaging in unapproved outreach practices. The Department may suspend all outreach activities and the completion of applications for new Members. Such suspensions may be imposed for a period of up to sixty (60) days from notification by the Department to the PH-MCO citing the violation.

j. The PH-MCO is prohibited from distributing, directly or through any agent or independent contractor, outreach materials that contain false or misleading information.

k. The PH-MCO must not, under any conditions use the Department's CIS to identify and market to Recipients participating in the MA FFS Program or enrolled in another PH-MCO. The PH-MCO must not share or sell Recipient lists with other organizations for any purpose, with the limited permissible exception of sharing Member information with affiliated entities and/or Subcontractors under Department-approved arrangements to fulfill the requirements of this Agreement.

l. The PH-MCO must submit a plan for advertising, sponsorship, and outreach procedures to the Department for advance written approval in accordance with the guidelines outlined in Exhibit X, HealthChoices PH-MCO Guidelines for Advertising, Sponsorships, and Outreach.

4. Limited English Proficiency (LEP) Requirements

During the Enrollment Process, the PH-MCO and/or the Department’s Enrollment Specialists must seek to identify Members who speak a language other than English as their first language.

Upon a Member’s request, the PH-MCO must provide, at no cost to Members, oral interpretation services in the requested language or sign language interpreter services to meet the needs of the Members. These services must also include all services dictated by federal requirements for translation services designated to the PH-MCO providers if the provider is unable or unwilling to provide these services.

The PH-MCO must make all vital documents disseminated to English speaking Members available in alternative languages, upon request

of a Member. Documents may be deemed vital if related to the access to programs and services and may include informational material. Vital documents include but are not limited to Complaint and grievance notices, adverse benefit determinations and termination notices, and Provider Directories and Member Handbooks. The PH-MCO must include appropriate instructions on all materials about how to access, or receive assistance with accessing, desired materials in an alternate language. This information must also be posted on the PH-MCO's web site.

The notice of nondiscrimination and the taglines must be posted on physical locations where PH-MCO, contractors, and entities interact with the public.

5. Alternate Format Requirements

The PH-MCO must provide alternative methods of communication for Members who are visually or hearing impaired, including Braille, audio tapes, large print (minimum 18 point font), compact disc, DVD, computer diskette, and/or electronic communication. The PH-MCO must, upon request from the Member, make all written materials disseminated to Members accessible to visually impaired Members. The PH-MCO must provide TTY and/or Pennsylvania Telecommunication Relay Service for communicating with Members who are deaf or hearing impaired, upon request.
The PH-MCO must include appropriate instructions on all materials about how to access, or receive assistance with accessing, desired materials in an alternate format.

- These materials must be in a format that is readily accessible
- The information must be placed in a location on the PH-MCOs website that is prominent and readily accessible
- The information must be provided in an electronic form which can be electronically retained and printed
- The information is consistent with content and language requirements
- The PH-MCO must notify the enrollee that the information is available in paper form without charge upon request
- The PH-MCO must provide, upon request, the information in paper form within 5 business days

6. PH-MCO Enrollment Procedures

The PH-MCO must have in effect written administrative policies and procedures for newly enrolled Members. The PH-MCO must also provide written policies and procedures for coordinating Enrollment information with the Department's EAP broker. The PH-MCO must receive advance written approval from the Department regarding these policies and procedures. The PH-MCO's submission of new or revised policies and procedures for review and approval by the Department shall not act to void any existing policies and procedures which have been prior approved by the Department for operation in a HealthChoices Zone. Unless otherwise required by law, the PH-MCO may continue to operate under such existing policies and procedures until such time as the Department approves the new or revised version thereof.

The PH-MCO must enroll any eligible Recipient who selects or is assigned to the PH-MCO in accordance with the Enrollment/Disenrollment dating rules that are determined and provided by the Department on the Pennsylvania HealthChoices Extranet site and in Exhibit Z, Automatic Assignment, regardless of the Recipient's race, color, creed, religion, age, sex, national origin, ancestry, marital status, sexual orientation, gender identity, income status, program membership, Grievance status, MA category status, health status, pre-existing condition, physical or mental disability or anticipated need for health care.

7. Enrollment of Newborns

The PH-MCO must have written administrative policies and procedures to enroll and provide all Medically Necessary services to newborn infants of Members, effective from the time of birth, without delay, in accordance with Section V.F.12, Services for New Members, and Exhibit BB, PH-MCO Recipient Coverage Document. The PH-MCO must receive advance written approval from the Department regarding these policies and procedures.

The PH-MCO must notify the Department if there are errors or inconsistencies in the newborn's MA or PH-MCO eligibility dates per the established procedures found on the Pennsylvania HealthChoices Extranet.

For pregnant members, the PH-MCO must make every effort to identify what PCP/pediatrician the mother chooses to use for the newborn prior to the birth, so that this chosen Provider can be assigned to the newborn on the date of birth.

The PH-MCO is not responsible for the payment of newborn metabolic screenings.

8. Transitioning Members Between PH-MCOs

It may be necessary to transition a Member between PH-MCOs. Members with Special Needs should be assisted by the SNU(s) to facilitate a seamless transition. The PH-MCO must follow the Department's established procedures as outlined in Exhibit BB of this Agreement, MCO Recipient Coverage Document.

9. Change in Status

The PH-MCO must report the following to the Department on a weekly Enrollment/Disenrollment/Alert file: pregnancy (not on CIS), death (not on CIS), newborn (not on CIS) and return mail alerts in accordance with Section VIII.B.5, Alerts.

The PH-MCO must report Member status changes to the appropriate CAO using the CAO Notification Form within ten (10) Business Days of their becoming known. These changes include phone number, address, pregnancy, death and family addition/deletion. A detailed explanation of how the information was verified must also be included on the form.

10. Membership Files

a. Monthly File

The Department will provide an 834 Monthly Eligibility File to each PH-MCO on the next to the last Saturday of each month. The file contains the MA Eligibility Period, PH-MCO coverage, BH-MCO coverage and other Recipient demographic information. It will contain only the most current record for each HealthChoices Recipient where the Member is both MA and Managed Care eligible at some point in the following month. The PH-MCO must reconcile this membership file against its internal membership data and notify the Department of any discrepancies within thirty (30) Business Days.

Recipients not included on this file with an indication of prospective coverage will not be the responsibility of the PH-MCO unless a subsequent 834 Daily Eligibility File indicates otherwise. Those with an indication of future month coverage

will not be the responsibility of the PH-MCO if an 834 Daily Eligibility File received by the PH-MCO prior to the beginning of the future month indicates otherwise.

b. Daily File

The Department will provide the PH-MCO with an 834 Daily Eligibility File that contains one record for each HealthChoices Recipient where data for that Recipient has changed that day. The file contains add, termination and change records, but does not contain BH-related information. The file contains demographic changes, eligibility changes, Enrollment changes, Members enrolled through the automatic assignment process, and TPL information. The PH-MCO must process this file within 24 hours of receipt.

The PH-MCO must reconcile this file against its internal membership information and notify the Department of any discrepancies within thirty (30) Business Days.

11. Enrollment and Disenrollment Updates

a. Weekly Enrollment/Disenrollment/Alert Reconciliation File

The Department will provide a weekly file containing information on Members voluntarily enrolled or disenrolled and dispositions of alerts previously submitted by the PH-MCO. The PH-MCO must use this file to reconcile alerts submitted to the Department.

b. Disenrollment Effective Dates

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

c. Discharge/Transition Planning

When any Member is disenrolled from the PH-MCO because of:

- Admission to or length of stay in a facility,

- A waiver program eligibility which makes the Member exempt from the HealthChoices Program, or

- A child's placement in substitute care outside the HealthChoices Zone(s) covered by this Agreement,

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

If the Recipient chooses a different PH-MCO, the gaining PH-MCO must participate in the discharge/transition planning upon notification that the Recipient has chosen its PH-MCO.

12. Services for New Members

The PH-MCO must make available the full scope of benefits to which a Member is entitled from the effective Enrollment date provided by the Department.

The PH-MCO must make a best effort to conduct an initial screening of each member's needs, within 90 days of the effective date of enrollment for all new members, including subsequent attempts if the initial attempt to contact the member is unsuccessful. The PH-MCO must share with DHS or any other MCO serving the member the results of any identification and assessment of that member's needs to prevent duplication of those activities. The PH-MCO will collaborate with the Department to develop, adopt and disseminate a Social Determinants of Health assessment tool.

The PH-MCO must use pertinent demographic information about the Recipient, i.e., Special Needs data collected through the EAP or directly indicated to the PH-MCO by the Recipient after Enrollment, upon the new Member's effective Enrollment date in the PH-MCO. If a Special Need is indicated, the PH-MCO must place a Special Needs indicator on the Member's record and must outreach to that Member to identify their Special Need or circumstance. The PH-MCO must assure that the Member's needs are adequately

addressed including the assignment of a Special Needs or Care Management case manager as appropriate.

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

13. New Member Orientation

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

- Orienting new Members to their benefits (e.g., prenatal care, dental care, and specialty care),
- Educational and preventative care programs that include an emphasis on health promotion, wellness and healthy lifestyles and practices,
- Education of members on how they can report suspected fraud, waste and abuse,
- The proper use of the PH-MCO identification card and the Department's ACCESS Card,
- The role of the PCP,
- What to do in an emergency or urgent medical situation,
- How to utilize services in other circumstances,
- How to request information from the PH-MCO
- How to register a Complaint, file a Grievance or request a DHS Fair Hearing, and
- Information on the existence and function of the SNU and how to contact it, if necessary.

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

The PH-MCO is prohibited from contacting a potential Member who is identified on the Daily Membership File with an automatic assignment indicator (either an "A" auto assigned or "M" Member

assigned) until five (5) Business Days before the effective date of the Member's Enrollment unless it is the PH-MCO's responsibility under this Agreement; or at the request of the Department.

14. PH-MCO Identification Cards

The PH-MCO must issue its own identification card to Members. The Department also issues an identification card, called an ACCESS Card, to each Recipient, which the Member is required to use when accessing services. Providers must use this card to access the Department's EVS and to verify the Member's eligibility. The ACCESS Card will allow the Provider the capacity to access the most current eligibility information without contacting the PH-MCO directly.

15. Member Handbook

The PH-MCO must provide a Member handbook, or other written materials, with information on Member rights and protections and how to access services, in the appropriate language or alternate format to Members within five (5) Business Days of a Member's effective date of Enrollment. The PH-MCO may provide the Member handbook in formats other than hard copy. If this option is exercised, the PH-MCO must inform Members what formats are available and how to access each format. The PH-MCO must maintain documentation verifying that the Member handbook is reviewed for accuracy at least once a year, and that all necessary modifications have been made. The PH-MCO must notify all Members on an annual basis of any changes made, and the formats and methods available to access the handbook. Upon request, the PH-MCO must provide a hard copy version of the Member handbook to the Member. The PH-MCO is required to provide adult enrollees with written information on advance directives policies and include description of applicable state law. The PH-MCO is required to reflect changes in state law in its written advance directives information as soon as possible, but no later than 90 days after the effective date of the change.

a. Member Handbook Requirements

i. The PH-MCO must provide that the Member handbook is written at no higher than a sixth-grade reading level and includes, at a minimum, the information outlined in the PH-MCO Member Handbook Template as issued by DHS.

ii. The PH-MCO must notify members at least thirty (30) days in advance of the effective date of a significant change in the member handbook.

iii. The PH-MCOs must have written policies guaranteeing each enrollee's right to be treated with respect and with due consideration for his or her dignity and privacy.

iv. The PH-MCOs must have written policies guaranteeing each enrollee's right to receive information on available treatment options and alternatives, presented in a manner appropriate to the enrollee's condition and ability to understand.

v. The PH-MCOs must have written policies guaranteeing each enrollee's right to participate in decisions regarding his or her health care, including the right to refuse treatment.

vi. The PH-MCOs must have written policies guaranteeing each enrollee's right to be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience or retaliation.

vii. The PH-MCOs must have written policies guaranteeing each enrollee's right to request and receive a copy of his or her medical records, and to request that they be amended or corrected.

viii. The PH-MCOs must ensure that each enrollee is free to exercise his or her rights without the PH-MCO or its network providers treating the enrollee adversely.

b. Department Approval

The PH-MCO must submit Member handbook to the Department for advance written approval prior to distribution to Members. The PH-MCO must make modifications in the language contained in the Member handbook if ordered by the Department so as to comply with the requirements described in Section V.F.15.a., Member Handbook Requirements, above.

16. Provider Directories

The PH-MCO must make available directories for all types of Network Providers, including, but not limited to: PCPs, hospitals, specialists, Providers of ancillary services, Nursing Facilities, etc.

The PH-MCO must utilize a web-based Provider directory. The PH-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 PH-MCO must perform monthly reviews of the web-based Provider directory, subject to random monitoring by the Department to ensure complete and accurate entries.

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

- Correct PROMIS*e*™ Provider ID
- All Providers in the PH-MCO's Network
- The location where the PCP will see Members, as well as whether the PCP has evening and/or weekend hours
- Wheel chair accessibility of Provider sites
- Language indicators including non-English language spoken by current Providers in the Member's service area.
- Must be in machine readable format

A PH-MCO will not be certified as "ready" without the completion of the electronic Provider directory component as determined and provided by the Department on the Pennsylvania HealthChoices Extranet site.

The PH-MCO must notify its Members annually of their right to request and obtain Provider directories. Upon request, the PH-MCO must provide its Members with directories for PCPs, dentists, specialists, hospitals, and Providers of ancillary services, which include, at a minimum, the information listed in Exhibit FF of this Agreement, PCP, Dentists, Specialists and Providers of Ancillary

Services Directories. Upon request from the Member, the PH-MCO may print the most recent electronic version from their Provider file and mail it to the Member.

The PH-MCO must submit PCP, specialist, and Provider of ancillary services directories to the Department for advance written approval before distribution to its Members if there are significant format changes to the directory. The PH-MCO also must make modifications to its Provider directories if ordered by the Department.

17. Member Disenrollment

The PH-MCO may not request Disenrollment of a Member because of an adverse change in the Member's health status, or because of the Member's utilization of medical services, diminished mental capacity, or uncooperative or disruptive behavior resulting from his or her Special Needs. The PH-MCO may not reassign or remove Members involuntarily from Network Providers who are willing and able to serve the Member.

G. Member Services

1. General

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

- Explaining the operation of the PH-MCO and assisting Members in the selection of a PCP.

- Assisting Members with making appointments and obtaining services, including interpreter services, as needed.

- Assisting with arranging transportation for Members through the MATP. See Section V.A.15., Transportation and Exhibit L, Medical Assistance Transportation Program.

- Receiving, identifying and resolving Emergency Member Issues.

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

The PH-MCO must forward all calls received by the Member services area in which the caller requests the Special Needs Unit to the SNU. In the event the call is received beyond the hours of availability of the SNU, The PH-MCO's SNU must allow the Member to leave a message. The SNU must return the call as soon as possible but no longer than two (2) business days from the receipt of the call.

2. PH-MCO Internal Member Dedicated Hotline

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

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

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

- Provides for a dedicated phone line for its Members.

- Provide for necessary translation and interpreter assistance for LEP Members.

- Be staffed by individuals trained in:
  - Cultural Competency;
  - addressing the needs of special populations;

- the availability of and the functions of the SNU;
- the services which the PH-MCO is required to make available to all Members; and
- the availability of social services within the community.

- Be staffed with representatives familiar with accessing medical transportation.

- Be staffed with adequate service representatives to ensure an abandonment rate of less than or equal to five percent (5%) of the total calls.

- Be staffed with adequate service representatives to ensure that at least 85% of all calls are answered within thirty (30) seconds.

- Provide for TTY and/or Pennsylvania Telecommunication Relay Service availability for Members who are Deaf or hard of hearing.

3. Education and Outreach/Health Education Advisory Committee

The PH-MCO must develop and implement effective Member education and outreach programs that may include health education programs focusing on the leading causes of hospitalization and emergency room use, and health initiatives that target Members with Special Needs, including but not limited to: HIV/AIDS, Intellectual/Developmental Disabilities, Dual Eligibles, etc.

The PH-MCO must establish and maintain a Health Education Advisory Committee that includes Members and Providers of the community to advise on the health education needs of HealthChoices Members. Representation on this Committee must include, but not be limited to, women, minorities, persons with Special Needs and at least one (1) person with expertise on the medical needs of children with Special Needs. Provider representation includes physical health, behavioral health, and dental health Providers. The PH-MCO must provide the Department annually with the membership (including designation) and meeting schedule of the Health Education Advisory Committee.

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

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

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

4. Informational Materials

The PH-MCO must distribute Member newsletters at least three times each year to each Member household. The PH-MCO must obtain advance written approval from the Department of all Member newsletters, and will be required to add information provided by the Department related to Departmental initiatives. The PH-MCO must post the Department-approved Member newsletters in an easily accessible location on the PH-MCO's website. The PH-MCO must notify all Members of the availability and methods to access each Member newsletter. Upon request, the PH-MCO must provide a hard copy version of the member newsletter(s) to the Member.

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

The PH-MCO must provide, all written materials for potential enrollees and enrollees using a font size no smaller than 12 point.

If the PH-MCO uses any of the terms included in Exhibit AA in a written communication with a potential Member or a Member, the PH-MCO's use of the term must be consistent with the definition included in Exhibit AA.

H. Additional Addressee

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

I. Member Complaint, Grievance and DHS Fair Hearing Process

1. Member Complaint, Grievance and DHS Fair Hearing Process

The PH-MCO must develop, implement, and maintain a Complaint and Grievance process that provides for settlement of Members' Complaints and Grievances and the processing of requests for DHS Fair Hearings as outlined in Exhibit GG, Complaint, Grievance, and DHS Fair Hearing Processes. The PH-MCO must use the required templates to inform Members regarding decisions and the process. Templates GG(1) through GG(20) are available in Docushare.

The PH-MCO must have written policies and procedures approved by the Department, for resolving Member Complaints and for processing Grievances and DHS Fair Hearing requests, that meet the requirements established by the Department and the provisions of 40 P.S. §991.2101 et seq. (known as Act 68), Pennsylvania DOH regulations (28 Pa. Code Chapter 9), PID regulations (31 Pa. Code CHs. 154 and 301) and 42 C.F.R. §431.200 et seq. The PH-MCO must also comply with 55 Pa. Code Chapter 275 regarding DHS Fair Hearing Requests and 42 C.F.R. §438.406(b).

The PH-MCO's submission of new or revised policies and procedures for review and approval by the Department shall not act to void any existing policies and procedures which have been prior approved by the Department. Unless otherwise required by law, the PH-MCO may continue to operate under such existing policies and procedures until such time as the Department approves the new or revised version.

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

PH-MCO must adhere to the mechanisms and time-frames for reporting member complaints and grievances to the Department in the manner The Department has determined.

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

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

The PH-MCO must abide by the final decision of BHA for those cases when a Member has requested a DHS Fair Hearing, unless requesting reconsideration by the Secretary of the Department. Only the Member may appeal to Commonwealth Court. The decisions of the Secretary and the Court are binding on the PH-MCO.

2. DHS Fair Hearing Process for Members

During all phases of the PH-MCO Grievance process, and in instances involving Complaints related to adverse benefit determinations, the Member has the right to request a Fair Hearing with the Department. The PH-MCO must comply with the DHS Fair Hearing Process requirements defined in Exhibit GG of this Agreement, Complaint, Grievance and DHS Fair Hearing Processes.

A request for a DHS Fair Hearing does not prevent a Member from also utilizing the PH-MCO's Complaint or Grievance process. If a Member requests both an external appeal/review and a DHS Fair Hearing, and if the decisions rendered are in conflict with one another, the PH-MCO must abide by the decision most favorable to the Member. In the event of a dispute or uncertainty regarding which decision is most favorable to the Member, the PH-MCO will submit the matter to DHS' Grievance and Appeals Coordinator for review and resolution.

J. OMAP Hotlines

The PH-MCO will cooperate with the functions of OMAP's Hotlines, which are intended to address clinically-related systems issues encountered by Recipients and their advocates or Providers.

K. Provider Dispute Resolution System

The PH-MCO must develop, implement, and maintain a Provider Dispute Resolution Process, which provides for informal resolution of Provider Disputes at the lowest level and a formal process for Provider Appeals. The

resolution of all issues regarding the interpretation of Department-approved Provider Agreements must be handled between the two (2) entities and shall not involve the Department; therefore, these are not within the scope of the Department's BHA. Additionally, the Department's BHA or its designee is not an appropriate forum for Provider Disputes/Appeals with the PH-MCO.

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

The PH-MCO's submission of new or revised policies and procedures for review and approval by the Department shall not act to void any existing policies and procedures which have been prior approved by the Department. Unless otherwise required by law, the PH-MCO may continue to operate under such existing policies and procedures until such time as the Department approves the new or revised version thereof.

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

- Informal and formal processes for settlement of Provider Disputes;
- Acceptance and usage of the Department's definition of Provider Appeals and Provider Disputes;
- Timeframes for submission and resolution of Provider Disputes/Provider Appeals;
- Processes to ensure equitability for all Providers;
- Mechanisms and time-frames for reporting Provider Appeal decisions to PH-MCO administration, QM, Provider Relations and the Department; and
- Establishment of a PH-MCO Committee to process formal Provider Disputes/Provider Appeals which must provide:
  - At least one-fourth (1/4th) of the membership of the Committee must be composed of Health Care Providers/peers;
  - Committee members who have the authority, training, and expertise to address and resolve Provider Dispute/Provider Appeal issues;
  - Access to data necessary to assist committee members in making decisions; and

– Documentation of meetings and decisions of the Committee.

L. Certification of Authority and County Operational Authority

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

The PH-MCO must also maintain operating authority in each county covered by this Agreement. The PH-MCO must provide to the Department a copy of the DOH correspondence granting operating authority in each county covered by this Agreement upon request.

M. Executive Management

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

- A full-time Administrator with authority over the entire operation of the PH-MCO.

- A full-time HealthChoices Program Manager to oversee the operation of the Agreement, if different than the Administrator.

- A full-time Medical Director who is a current Pennsylvania-licensed physician. The Medical Director must be actively involved in all major clinical program components of the PH-MCO and directly participates in the oversight of the SNU, QM Department and UM Department. The Medical Director and his/her staff/consultant physicians must devote sufficient time to the PH-MCO to provide timely medical decisions, including after-hours consultation, as needed.

- A full-time Pharmacy Director who is a current Pennsylvania-licensed pharmacist. The Pharmacy Director oversees the outpatient drug management and serves on the PH-MCO P&T Committee.

- A Dental Director who is a current Pennsylvania-licensed Doctor of Dental Medicine or Doctor of Dental Surgery. The Dental Director may be a consultant or employee but must be available at a minimum of 30 hours per week. The Dental Director must be actively involved in all program components related to dental services including, but not limited to, dental provider recruitment strategy, assessment of dental network adequacy, providing oversight and strategic direction in the quality of dental services provided, actively engaged in the development and implementation of quality initiatives, and monitor the performance of the dental benefit manger if dental benefits are subcontracted.

A full-time Director of Quality Management who is a Pennsylvania-licensed RN, physician or physician's assistant or is a Certified Professional in Healthcare Quality by the National Association for Healthcare Quality Certified in Healthcare Quality and Management by the American Board of Quality Assurance and Utilization Review Providers. The Director of Quality Management must be located in Pennsylvania and have experience in quality management and quality improvement. Sufficient local staffing under this position must be in place to meet QM Requirements. The primary functions of the Director of Quality Management position are:

- Evaluate individual and systemic quality of care
- Integrate quality throughout the organization
- Implement process improvement
- Resolve, track, and trend quality of care complaints
- Develop and maintain a credentialed Provider network

- A full-time CFO to oversee the budget and accounting systems implemented by the PH-MCO. The CFO must ensure the timeliness and accuracy of all financial reports. The CFO shall devote sufficient time and resources to responsibilities under this Agreement.

- A full-time Information Systems (IS) Coordinator, who is responsible for the oversight of all information systems issues with the Department. The IS Coordinator must have a good working knowledge of the PH-MCO's entire program and operation, as well as the technical expertise to answer questions related to the operation of the information system.

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

N. Other Administrative Components

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

- A QM Coordinator who is a Pennsylvania-licensed physician, registered nurse or physician's assistant with past experience or education in QM systems. The Department may consider other advanced degrees relevant to QM in lieu of professional licensure.

  - A BH Coordinator who is a behavioral health professional and is located in Pennsylvania. The Behavioral Health Coordinator shall monitor the PH-MCO for adherence to BH requirements in this Agreement. The primary functions of the BH Coordinator are:

- Coordinate Member care needs with BH Providers.
- Develop processes to coordinate behavioral healthcare between PCPs and BH Providers.
- Participate in the identification of best practices for BH in a primary care setting.
- Coordinate behavioral care with medically necessary services.
- Be knowledgeable of the BH Managed Care Agreement requirements and coordinate with the BH-MCO to effectuate the requirements.

- A UM Coordinator who is a Pennsylvania-licensed physician, registered nurse or physician's assistant with past experience or education in UM systems. The Department may consider other advanced degrees relevant to UM in lieu of professional licensure.

- A full-time SNU Coordinator who is a Pennsylvania-licensed or certified medical professional (or other health related license or certification), or has a bachelor's degree in social work, teaching, or human services. In addition, the individual must have a minimum of three years past experience in dealing with special needs populations similar to those served by MA. The SNU Coordinator must have access to and periodically consult with the PH-MCO's Medical Director and must work in close collaboration with the SNU and SNU staff. The PH-MCO will notify the Department within thirty (30) days of a change in the SNU Coordinator.

- A full-time Government Liaison who serves as the Department's primary point of contact with the PH-MCO for the day-to-day management of contractual and operational issues. The PH-MCO must have a designated back-up trained to be able to handle urgent or time-sensitive issues when the Government Liaison is not available.

- A Maternal Health/EPSDT Coordinator who is a Pennsylvania-licensed physician, registered nurse or physician's assistant; or has a Master's degree in Health Services, Public Health, or Health Care Administration to coordinate maternity and prenatal care and EPSDT services.

- A Member Services Manager who oversees staff to coordinate communications with Members and act as Member advocates. There must be sufficient Member Services staff to enable Members to receive prompt resolution to their issues, problems or inquiries.

- A Provider Services Manager who oversees staff to coordinate communications between the PH-MCO and its Providers. There must be sufficient PH-MCO Provider Services, or equivalent department that

addresses this function, staff to promptly resolve Provider Disputes, problems or inquiries. Staff must also be adequately trained to understand Cultural, Linguistic, and Disability competencies

- A Complaint, Grievance and DHS Fair Hearing Coordinator whose qualifications demonstrate the ability to assist Members throughout the Complaint, Grievance and DHS Fair Hearing processes.

- A Claims Administrator who oversees staff to ensure the timely and accurate processing of Claims, Encounter forms and other information necessary for meeting Agreement requirements and the efficient management of the PH-MCO.

- A Provider Claims Educator who is located in Pennsylvania and facilitates the exchange of information between the Grievances, Claims processing, and Provider relations systems. The primary functions of the Provider Claims Educator are to:

  - Educate contracted and non-contracted Providers regarding appropriate Claims submission requirements, coding updates, electronic Claims transactions and electronic fund transfer, and available PH-MCO resources such as Provider manuals, website, fee schedules, etc.
  - Interface with the PH-MCO's call center to compile, analyze, and disseminate information from Provider calls.
  - Identify trends and guide the development and implementation of strategies to improve Provider satisfaction.
  - Communicate frequently (i.e., telephonic and on-site) with Providers to provide for the effective exchange of information and to gain feedback regarding the extent to which Providers are informed about appropriate claims submission practices.

- A Contract Compliance Officer who ensures that the PH-MCO is in compliance with all the requirements of the Agreement.

- A designated HEDIS Project Manager who acts as the point person with the Department and the Department's EQR contractor.

- A Special Investigations Unit (SIU) Director who serves as the Department's primary contact for program integrity functions. The SIU Director oversees staff responsible for fraud, waste and abuse activities.

The PH-MCO must ensure all staff have appropriate training, education, experience and orientation to fulfill the requirements of the position and maintain documentation of completion. The PH-MCO must update job

descriptions for each of the positions if responsibilities for these positions change.

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

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

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

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

O. Administration

The PH-MCO must have an administrative office within each HC Zone covered by this Agreement. The Department may grant exceptions to this requirement on an individual basis if the PH-MCO has administrative offices

elsewhere in Pennsylvania and the PH-MCO is in compliance with all standards set forth by the DOH and PID.

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

1. Recipient Restriction Program

A Centralized Recipient Restriction (lock-in) Program is in place for the MA FFS and the Managed Care delivery systems and is managed by the Department's Bureau of Program Integrity (BPI).

The PH-MCO will maintain a Recipient Restriction Program to interface with the Department's Recipient Restriction Program, will provide for appropriate professional resources to manage the Program and to cooperate with the Department in all procedures necessary to restrict Recipients. In accordance with 42 C.F.R. §431.54(e), the restrictions do not apply to emergency services furnished to the Recipient. The Department has the sole authority to restrict Recipients and has oversight responsibility of the PH-MCO's Recipient Restriction Program. The PH-MCO must obtain approval from the Department prior to implementing a restriction, including approval of written policies and procedures and correspondence to Members. The PH-MCO's process must include:

- Designating a Recipient Restriction Coordinator within the MCO to manage processes.
- Identifying Members who are overutilizing and/or misutilizing medical services, receiving unnecessary services or may be defrauding the MA program.
- Evaluating the degree of abuse including review of pharmacy and medical claims/encounter history, diagnoses and other documentation, as applicable.
- Offering a voluntary restriction to a member to protect his/her medical card from alleged misuse. For example, a voluntary restriction can be imposed when a member loses their card or believes their benefits are being used by someone other than themselves. A voluntary restriction may be ended at any time.
- Proposing whether the Member should be restricted to obtaining services from a single, designated Provider for a period of five years.

- Forwarding case information and supporting documentation to BPI at the address below or via secure electronic method, for review to determine appropriateness of restriction and to approve the action.
- Forwarding case information to BPI for allegations of member fraud.
- Upon BPI approval, sending notification to Member of proposed restriction, at least ten days in advance, including reason for restriction, effective date and length of restriction, name of designated Provider(s) and option to change Provider, with a copy to BPI.
- Sending notification of Member's restriction to the designated Provider(s) and the CAO.
- Enforcing the restrictions through appropriate notifications and edits in the claims payment system.
- Preparing and presenting case at a DHS Fair Hearing to support restriction action.
- Monitoring subsequent utilization to ensure compliance.
- Changing the selected Provider per the Member's or Provider's request, within thirty (30) days from the date of the request, with prompt notification to BPI through the Intranet Provider change process.
- Continuing a Member restriction from the previous delivery system as a Member enrolls in an MCO, with written notification to BPI.
- Reviewing the Member's services prior to the end of the five-year period of restriction to determine if the restriction should be removed or maintained, with notification of the results of the review to BPI, Member, Provider(s) and CAO.
- Submitting member's claim data to BPI, upon request, within ten (10) business days.
- Performing necessary administrative activities to maintain accurate records.
- Educating Members and Providers to the restriction program, including explanations in handbooks and printed materials.

MA Recipients have the right to appeal a restriction by requesting a DHS Fair Hearing. Members may not file a Complaint or Grievance with the PH-MCO regarding the restriction. A request for a DHS Fair Hearing must be in writing, signed by the Member and sent to:

Department of Human Services
Office of Administration
Bureau of Program Integrity

Division of Program and Provider Compliance
Recipient Restriction Section
P.O. Box 2675
Harrisburg, Pennsylvania 17105-2675

Phone number: (717) 772-4627

2. Contracts and Subcontracts

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

a. for the provision of and/or arrangement for the services to be provided under this Agreement;

b. for the evaluation of the prospective Subcontractor's ability to perform the activities to be delegated;

c. for the payment of any and all claims payment liabilities owed to Providers for services rendered to Members under this Agreement, for which a Subcontractor is the primary obligor provided that the Provider has exhausted its remedies against the Subcontractor; provided further that such Provider would not be required to continue to pursue its remedies against the Subcontractor in the event the Subcontractor becomes Insolvent, in which case the Provider may seek payment of such claims from the PH-MCO. For the purposes of this section, the term "Insolvent" shall mean:

i. The adjudication by a court of competent jurisdiction or administrative tribunal of a party as a bankrupt or otherwise approving a petition seeking reorganization, readjustment, arrangement, composition, or similar relief under the applicable bankruptcy laws or any other similar, applicable Federal or State law or statute; or

ii. The appointment by such a court or tribunal having competent jurisdiction of a receiver or receivers, or trustee, or liquidator or liquidators of a party or of all or any substantial part of its property upon the application of any creditor or other party entitled to so apply in any

insolvency or bankruptcy proceeding or other creditor's suit; and

d. for the oversight and accountability for any functions and responsibilities delegated to any Subcontractor. These functions and responsibilities shall include the requirements provided in 42 C.F.R. §438.230(3)(i).

e. The PH-MCO shall require Subcontractors to comply with all Medicaid rules, regulations, and guidance including the requirement that the subcontractor and Network Providers agree to the audit and inspection authority of the Pennsylvania Office of Attorney General Medicaid Fraud Control Section pursuant to 42 C.F.R. §438.230(3) for services provided pursuant to the Agreement.

The above notwithstanding, if the PH-MCO makes payments to a Subcontractor over the course of a year that exceed one-half of the amount of the Department's payments to the PH-MCO, the PH-MCO is responsible for any obligation by the Subcontractor to a Provider for services rendered to Members by such Provider that has not been paid within sixty (60) days after the latter of (i) the determination by the Subcontractor that the claim is payable, and (ii) the exercise by the Provider and the completion of all levels of the available Provider appeals process of the Subcontractor for a claim that was, and continues to be, incorrectly denied, rejected or not adjudicated by the Subcontractor. Notwithstanding the foregoing, the PH-MCO shall not have such an obligation to a Provider under this section in the event the Department has failed to make payment of amounts due and owing to the PH-MCO, where such amounts past due equal or exceed one percent of the revenue received by the PH-MCO in the prior calendar year from the Department under this or any other HealthChoices Agreement. Any such obligation of the PH-MCO to a provider under this section shall be considered satisfied if payment thereof is made by the Subcontractor.

PH-MCO shall indemnify and hold the Commonwealth of Pennsylvania, the Department and their officials, representatives and employees harmless from any and all liabilities, losses, settlements, claims, demands, and expenses of any kind (including but not limited to attorneys' fees) which are related to any and all Claims payment liabilities owed to Providers for services rendered to Members under this Agreement for which a Subcontractor is the primary obligor, except to the extent that the PH-MCO and/or

Subcontractor has acted with respect to such Provider Claims in accordance with the terms of this Agreement.

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

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

3. Records Retention

The PH-MCO will comply with the program standards regarding records retention, which are set forth in federal and state law and regulations and in Exhibit D, Standard Grant Terms and Conditions for Services, of this Agreement, except that, for purposes of this Agreement, all records must be retained for a period of ten (10) years beyond expiration or termination of the Agreement, unless otherwise authorized by the Department. Upon thirty (30) days notice from the Department, the PH-MCO must provide copies of all records to the Department at the PH-MCO's site or other location determined by the Department, if requested. This thirty (30) days notice does not apply to records requested by the state or federal government including the Pennsylvania Office of Attorney General's Medicaid Fraud Control Unit, for purposes of fiscal audits or Fraud and/or Abuse investigations. In the event records requested by the state or federal government for the purposes of fiscal audits or fraud and/or abuse investigations, the PH-MCO must provide records requested by Federal or State government agencies pursuant to audits or investigations within the timeframe designated by the requesting agency. The retention requirements in this section do not apply to DHS-generated Remittance Advices.

4. Fraud, Waste, and Abuse

The PH-MCO must develop a written compliance plan that contains the following elements described in 42 C.F.R. §438.608(a)(1)(i-vii) and CMS publication "Guidelines for Constructing a Compliance Program

for Medicaid Managed Care Organizations and Prepaid Health Plans" found on the CMS website and that includes the following:

- Written policies, procedures, and standards of conduct that articulate the organization's commitment to comply with all applicable requirements and standards under the Agreement, and all applicable Federal and State requirements.

- The designation of a Compliance Officer who is responsible for developing and implementing policies, procedures, and practices designed to ensure compliance with the requirements of the Agreement and who reports directly to the Chief Executive Officer and the board of directors.

- The establishment of a Regulatory Compliance Committee on the Board of Directors and at the senior management level charged with overseeing the organization's compliance program and its compliance with the requirements under the Agreement.

- A system for training and education for the Compliance Officer, the organization's senior management, and the organization's employees on the applicable Federal and State requirements and applicable standards and requirements under the Agreement.

- Effective lines of communication between the compliance officer and PH-MCO employees.

- Enforcement of standards through well publicized disciplinary guidelines.

- Establishment and implementation of procedures and a system with dedicated staff for routine internal monitoring and auditing of compliance risks, prompt response to compliance issues as they are raised, investigation of potential compliance problems as identified in the course of self-evaluation and audits, correction of such problems promptly and thoroughly (or coordination of suspected criminal acts with law enforcement agencies) to reduce the potential for recurrence, and ensure ongoing compliance with the requirements under the Agreement.

- Procedures for systematic confirmation of services actually provided.

- Policies and procedures for reporting all Fraud, Waste, and Abuse to the Department and applicable law enforcement agency .

- Policies and procedures for Fraud, Waste, and Abuse prevention, detection and investigation.

- A policy of non-intimidation and non-retaliation for good faith participation in the compliance program, including, but not limited to, reporting potential issues, investigating issues, conducting self-evaluations, audits and remedial actions, and reporting to appropriate officials.

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

a. Fraud, Waste and Abuse Unit

The PH-MCO must establish a Fraud, Waste and Abuse Unit comprised of experienced Fraud, Waste and Abuse reviewers as required in 42 C.F.R. §438.608(a)(1)(vii). This Unit must have the primary purpose of preventing, detecting, reducing, investigating, referring, and reporting suspected Fraud, Waste and Abuse that may be committed by Network Providers, Members, Caregivers, Employees, or other third parties with whom the PH-MCO contracts. If the PH-MCO has multiple lines of business, the Fraud, Waste and Abuse Unit is required to have a dedicated full time HC MA investigator to Member ratio of at least one investigator per 60,000 members devoted to the HealthChoices Program's Fraud, Waste and Abuse activities. The Department will make the final determination regarding whether or not the PH-MCO is in compliance with these requirements in accordance with 42 C.F.R. § 438.608(a)(7)).

b. Written Policies

The PH-MCO must create and maintain written policies and procedures for the prevention, detection, investigation, reporting and referral of suspected Fraud, Waste and Abuse, including any and all fraud and abuse policies delineated under state and or federal mandate including but not limited to 42 C.F.R. §438.608(a)(1)(i).

c. Access to Provider Records

The PH-MCO's Fraud, Waste and Abuse policies and procedures must provide and certify that the PH-MCO's Fraud, Waste and Abuse unit as well as the entire Department, and the Pennsylvania Office of Attorney General

Medicaid Fraud Control Section has timely access to records of Network Providers, subcontractors, and the PH-MCOs, as outlined in this Agreement.

d. Audit Protocol

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

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

e. Procedure for Identifying Fraud, Waste and Abuse

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

i. A description of the methodology and standard operating procedures used to identify and investigate Fraud, Waste and Abuse.

ii. A method for verifying with Members whether services billed by providers were received, as required by 42 C.F.R. 438.608(a)(5) and 438.608(d)(1)(i-iv)....

iii. Process to recover overpayments or otherwise sanction Providers as required by 42 C.F.R. §§438.608(a)(5) and 438.608(d)(1)(i-iv).

iv. Provisions for payment suspension to a network provider for which the State determines that there is a credible allegation of fraud as required in 42 C.F.R. §§455.23 and 438.608(a)(8).

v. Policies and procedures to initiate a prepayment review of a network provider's services where a review indicates billings are inconsistent with MA regulations or PH-MCO policies, are unnecessary, are inappropriate to the members' health needs or contrary to customary standards of practice.

vi A description of specific controls in place for Fraud, Waste and Abuse detection, including an explanation of the technology used to identify aberrant billing patterns, overlapping billings, Claims edits, post processing review of Claims, and record reviews.

f. Referral to the Department

The PH-MCO must establish a policy for referral of suspected Fraud, Waste and Abuse to the Department as required in 42 C.F.R. §438.608(a)(7). A standardized referral process is outlined in Exhibit KK of this Agreement, Reporting Suspected Fraud, Waste and Abuse to the Department and to the Pennsylvania Office of Attorney General Medicaid Fraud Control Section.

The PH-MCO must promptly report to the Department all cases of suspected fraud, waste or abuse, in the manner specified by the Department. If a PH-MCO fails to promptly report a case of suspected fraud or abuse before the suspected fraud or abuse is identified by the Commonwealth of Pennsylvania, its designees, the United States or private parties acting on behalf of the United States, any portion of the fraud or abuse recovered by the Commonwealth of Pennsylvania or designee shall be retained by the Commonwealth of Pennsylvania or its designees.

g. Education Plan

C.F.R.The PH-MCO must create and disseminate written materials for the purpose of educating its employees, Providers, subcontractors and subcontractors' employees about healthcare Fraud laws, the PH-MCO's policies and procedures for preventing and detecting Fraud, Waste, and Abuse and the rights of individuals to act as whistleblowers. PH-MCO must provide written policies to all employees and to any contractor or agent that provide detailed information about the False Claims Act and other Federal and State laws described in 42 U.S.C. § 1396a(a)(68), including information about rights of employees to be protected as whistleblowers.

h. Referral to Senior Management

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

i. Prior Department Approval

The Fraud, Waste and Abuse policies and procedures must be submitted to the Department for prior approval, and the Department may, upon review of these policies and procedures, require that specified changes be made within a designated time in order for the PH-MCO to remain in compliance with the terms of the Agreement. To the extent that changes to the Fraud, Waste and Abuse unit are made, or the policies or procedures are altered, updated policies and procedures must be submitted promptly to the Department. The Department may also require new or updated policies and procedures during the course of the Agreement period.

j. Duty to Cooperate with Oversight Agencies

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

Such cooperation must include providing access to all necessary case information, computer files, and appropriate staff as well as the results of associated internal investigations and audits. In addition, such cooperation will include participating in periodic Fraud, Waste and Abuse training sessions, meetings, and joint reviews of subcontracted Providers or Members.

k. Hotline Information

The PH-MCO must distribute the Department's toll-free MA Provider Compliance Hotline number and accompanying explanatory statement to its Members and Providers through its Member and Provider handbooks. The explanatory

statement needs to include at a minimum the following information:

i. *Recipient Fraud*: Including, but not limited to, someone who receives cash assistance, Supplemental Nutritional Assistance Program (SNAP) benefits, Heating/Energy Assistance (LIHEAP), child care, medical assistance, or other public benefits AND that person is not reporting income, not reporting ownership of resources or property, not reporting who lives in the household, allowing another person to use his or her ACCESS/MCO card, forging or altering prescriptions, selling prescriptions/medications, trafficking SNAP benefits or taking advantage of the system in any way.

ii. *Provider Fraud*: Including, but not limited to, billing for services not rendered, billing separately for services in lieu of an available combination code; misrepresentation of the service/supplies rendered (billing brand named for generic drugs; upcoding to more expensive service than was rendered; billing for more time or units of service than provided, billing incorrect provider or service location); altering claims, submission of any false data on claims, such as date of service, provider or prescriber of service, duplicate billing for the same service; billing for services provided by unlicensed or unqualified persons; billing for used items as new.

I. Duty to Notify

i. Department's Responsibility

The Department will provide the PH-MCO with prompt notice via electronic transmission or access to Medicheck listings or upon request if a Provider with whom the PH-MCO has entered into a Provider Agreement is subsequently suspended or terminated from participation in the MA or Medicare Programs. Upon notification from the Department that a Network Provider is suspended or terminated from participation in the MA or Medicare Programs, the PH-MCO must immediately act to terminate the Provider from its Network. Terminations for loss of licensure and criminal convictions must coincide with the MA effective date of the action.

The PH-MCO is required to check the SSADMF, and NPPES at the time of initial enrollment and re-enrollment as well as providers, owners, agents, and managing employees against the HHS-OIG LEIE, the EPLS on the SAM, and the PA Medicheck list on a monthly basis as required in 42 C.F.R. §455.436.

ii. PH-MCO's Responsibility

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

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

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

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

The PH-MCO must immediately notify the Department, in writing, if a Network Provider or Subcontractor is subsequently suspended, terminated or voluntarily withdraws from participation in the MA program as a result of suspected or confirmed Fraud, Waste or Abuse. The PH-MCO must also immediately notify the Department, in writing, if it terminates or suspends an employee as a result of suspected or confirmed Fraud, Waste or Abuse. The PH-MCO must inform the Department, in writing, of the specific underlying

conduct that lead to the suspension, termination, or voluntary withdrawal. Provider Agreements must carry notification of the prohibition and sanctions for submission of false Claims and statements. PH-MCOs who fail to report such information are subject to sanctions, penalties, or other actions. The Department's enforcement guidelines are outlined in Exhibit LL, Guidelines for Sanctions Regarding Fraud, Waste and Abuse.

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

m. Sanctions

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

n. Subcontractor and Provider Agreements

i. The PH-MCO will require via written agreements that all Network Providers and all Subcontractors take such actions as are necessary to permit the PH-MCO to comply with the Fraud, Waste and Abuse requirements listed in this Agreement as well as federal regulations including but not limited to 42 C.F.R. §438.608.

ii. To the extent that the PH-MCO delegates oversight responsibilities to a third party (such as a Pharmacy Benefit Manager), the PH-MCO must require that such third party complies with the applicable provisions of this Agreement relating to Fraud, Waste and Abuse.

iii. The PH-MCO will require, via its Provider Agreement, that Network Providers comply with MA regulations

and any enforcement actions directly initiated by the Department under its regulations, including termination and restitution actions.

iv. The PH-MCO must suspend payment to a Network Provider when the Department determines there is a credible allegation of fraud, waste or abuse against that Network Provider, unless the Department determines there is good cause for not suspending such payments pending the investigation.

v. The PH-MCO shall require its Subcontractors to comply with the requirements set forth at 42 C.F.R. 438.230(c)(3).

vi. The PH-MCO subcontractor agreement must specifically state that the subcontractor will grant the Department, CMS, the Pennsylvania Office of Attorney General Medicaid Fraud Control Section, HHS OIG, the Comptroller General, or their designees access to audit, evaluate, and inspect books, records, etc., which pertain to the delivery of or payment for Medicaid services under this Agreement. Subcontractor must make such books, records, premises, equipment, staff etc. all available for an audit at any time. Right to inspect extends for ten (10) years after termination of the Agreement, or conclusion of an audit, whichever is later.

o. Fraud, Waste and Abuse and Prosecution Agencies

Disputes of any kind resulting from any action taken by the oversight agencies are directed to the responsible agency. Examples include: Department's BPI, its vender or other designee, the Pennsylvania Office of the Attorney General's Medicaid Fraud Control Section, the Pennsylvania Office of Inspector General, the CMS Office of Inspector General, and the United States Justice Department.

p. Provider Reviews and Overpayment Recovery

- The PH-MCO shall audit, review and investigate Providers within its network through prepayment and retrospective payment reviews. The PH-MCO shall cost avoid or recover any overpayments directly from its Network Providers for

audits, reviews or investigations conducted solely by the PH-MCO or through Network Provider self-audits.

- The PH-MCO will void encounters for those claims involving full recovery of the payment and adjust encounters for partial recoveries.
- The PH-MCO must notify BPI in writing when it plans to recover and when it has recovered overpayments or improper payments related to Fraud, Abuse or Waste of Medical Assistance services.

- The Department has the right to audit, review and investigate MA Providers within the PH-MCO's network.

  - The Department developed a vetting process to coordinate audits, reviews or investigations of the PH-MCO's Network Providers to avoid duplication of effort.
  - Through the vetting process, the PH-MCO must provide information to BPI as requested including, but not limited to the PH-MCO's claims history, policies/procedures, provider contracts, provider/member review history and current status, complaints, barriers to reviewing the subject provider/member and payment methodology/arrangement.
  - The PH-MCO must provide this information within thirty (30) calendar days of the Department's request. The PH-MCO must respond to Urgent requests within two business days.
  - The PH-MCO cannot initiate a review of a Network Provider after the Department advises the PH-MCO of its intention to open a review or investigation by the Department, its designee, or another state or federal agency, without written Departmental authorization to proceed.
  - The PH-MCO will not notify providers/members of the Department's intention to initiate a review.
  - The Department will inform the PH-MCO and the Provider(s) of its request for records, preliminary and final findings related to BPI's review of the PH-MCOs Network Providers.

  Overpayment recoveries resulting from audits, reviews or investigations initiated by or on behalf of the Department, that are not part of mutually agreed upon joint investigation, will be recouped from the PH-MCO.

- The PH-MCO should recoup overpayments resulting from audits, reviews or investigations conducted independently by the Department, from its Network Provider after the PH-MCO receives notice of the final findings from the Department.

    - The Department will deduct the restitution demanded from a future payment to the PH-MCO after 45 days from the mail date of the Department's notice of final determination.
    - The PH-MCO must submit a corrective action plan to the Department, upon request, to resolve any Network Provider's regulatory violations identified through the Department's, its vendor's, or other designee's audit, review or investigation.

- The Department may require the PH-MCO to withhold payment to a Network Provider or to initiate a pre-payment review as a result of law enforcement reviews and activities or the Department's audits, reviews or investigations as required in 42 C.F.R. §§438.608(a)(8) and 455.23.

- The PH-MCO will monitor claims to a provider during a payment suspension, and report on a monthly basis in writing to BPI the amount of funds withheld to the provider during the payment suspension. If the provider is subsequently convicted, these funds will be adjusted from the capitated payments.

Joint reviews, audits or investigations between the PH-MCO, the Department or its designee may be conducted. Any recoveries as a result of a joint audit, review or investigation shall be shared equally between the PH-MCO and Department after payment of any required contingency fee to the vendor. DHS's, its contractor's or other designee's request for vetting of a provider and/or the MCO's provision of information related to a provider review, audit or investigation does not constitute a mutually agreed upon joint review.

The Department may periodically monitor and evaluate the PH-MCO's audits, reviews and investigations of MA Providers/Members within the PH-MCO's network.

5. Management Information Systems

The PH-MCO must have a comprehensive, automated and integrated MIS that includes a test environment, and is capable of meeting the requirements listed below and throughout this Agreement. Information available on the DHS Internet site at:
http://www.dhs.pa.gov/provider/busandtechstandards/index.htm

a. The PH-MCO must have a minimum of the following MIS components or the capability to link to other data systems containing: Membership, Provider, Claims Processing, Prior Authorization, and Reference.

b. The PH-MCO must have an MIS sufficient to support data reporting requirements specified in this Agreement.

c. The PH-MCO's membership management system must have the capability to receive, update and maintain its membership files consistent with specifications provided by the Department. The PH-MCO must have the capability to provide daily updates of membership information to Subcontractors and Providers who have responsibility for processing Claims and authorizing services based on membership information.

d. The PH-MCO's Provider database must be maintained with detailed information on each Provider sufficient to support Provider payment and meet the Department's reporting and Encounter Data requirements.

The PH-MCO must be able to cross-reference its internal Provider identification number to the correct MMIS Provider ID and/or the Provider's NPI number in the Department's MMIS for each location in which the Provider renders services for the PH-MCO.

The PH-MCO must ensure that each provider service location is enrolled and active with Medical Assistance and that information for all service locations is maintained in its own system.

The PH-MCO must ensure that each provider's license information is valid in the Department's MMIS, and must outreach to providers to stress the importance of maintaining up to date information in the Department's MMIS.

The PH-MCO must ensure that providers enrolled in their network with specific provider types and specialties have the

same provider types and specialties in the Department's MMIS for each service location.

e. The PH-MCO's Claims processing system must have the capability to process Claims consistent with timeliness and accuracy requirements identified in this Agreement.

f. The PH-MCO's Prior Authorization system must be linked with its Claims processing component.

g. The PH-MCO's MIS must be able to maintain its Claims history with sufficient detail to meet all Department reporting and Encounter Data requirements.

h. The PH-MCO's credentialing system must have the capability to store and report on Provider specific data sufficient to meet the Department's credentialing requirements listed in Exhibit M(1), Quality Management and Utilization Management Program Requirements, of this Agreement.

i. The PH-MCO must have sufficient telecommunication capabilities, including electronic mail, to meet the requirements of this Agreement.

j. The PH-MCO must have the capability to electronically transfer exchange files with the Department and the EAP broker. The PH-MCO must use a secure FTP product that is compatible with the Department's product.

k. The PH-MCO's MIS must be bi-directionally linked to all operational systems listed in this Agreement, so that data captured in Encounter data matches data in Member, Provider, Claims and Prior Authorization files. Encounter Data will be utilized for:

- Member and Provider profiling
- Claims validation
- Fraud and Abuse monitoring activities
- Rate setting
- Any other research and reporting purposes defined by the Department.

l. The PH-MCO must comply with the Commonwealth's business and technical standards including connectivity to the Commonwealth's network for Extranet access. The PH-MCO must also comply with any changes made to these standards.

PH-MCOs must comply with the Department's Se-Government Data Exchange Standards.

Whenever possible, the Department will provide advance notice of at least sixty (60) days prior to the implementation of changes. For more complex changes, the Department will make every reasonable effort to provide additional notice.

m. The PH-MCO must be prepared to document its ability to expand claims processing or MIS capacity should either be exceeded through the enrollment of Members.

n. The PH-MCO must designate appropriate staff to participate in DHS directed development and implementation activities.

o. Subcontractors must meet the same MIS requirements as the PH-MCO and the PH-MCO will be held responsible for MIS errors or noncompliance resulting from the action of a Subcontractor. The PH-MCO must provide its Subcontractors with the appropriate files and information to meet this requirement (e.g. daily eligibility file and provider files)

p. The PH-MCO's MIS shall be subject to review and approval during the Department's HealthChoices Readiness Review process as referenced in Section VI of this Agreement, Program Outcomes and Deliverables.

q. Prior to any major modifications to the PH-MCO's MIS, including upgrades and/or new purchases, the PH-MCO must inform the Department in writing of the potential changes at least 180 days prior to the change. Subsequently, within 90 days the PH-MCO must provide a work plan detailing recovery efforts and the use of parallel systems testing.

r. The PH-MCO must be able to accept and generate HIPAA compliant transactions as required in the ASC X12 Implementation Guides.

s. The Department will make Drug, Procedure Code, and Diagnosis Code reference files available to the PH-MCO on a routine basis to allow it to effectively meet its obligation to provide services and record information consistent with requirements in this Agreement. If the PH-MCO chooses not to use these files, it must use comparable files to meet its

obligation with this Agreement. Information about these files is available on the Pennsylvania HealthChoices Extranet site.

t. The Department will supply provider files on a routine basis to allow the PH-MCO to meet its obligation consistent with requirements in this Agreement. These files include:

- List of Active and Closed Providers (PRV414 and PRV415);
- NPI Crosswalk (PRV430);
- Special Indicators (PR435);
- Provider Revalidation File (PRV720).
- Quarterly Network Provider File (Managed Care Affiliates, PRV640Q)

The PH-MCO must use the PRV414 or PRV415 file with the PRV430 on a monthly basis to reconcile its Provider database with that of the Department to confirm:

- All participating providers are enrolled in MA for all service locations as defined by MA enrollment rules.

- Participating provider license information is valid in PROMISe™.

- Provider Types and Specialties match.

- Each NPI, Taxonomy, and Nine-digit Zip code for each service location .

Any provider that does not enroll with MA cannot be enrolled as a participating provider in the PH-MCO. Discrepancies must be addressed with the provider.

PH-MCOs must use the PRV640Q file to reconcile Provider information previously submitted on the Network Provider File (PRV640M).

Information about these files is available on the Pennsylvania HealthChoices Extranet site.

u. The PH-MCO must have a disaster recovery plan in place, which includes information on system backup and recovery efforts in the event of a disaster.

v. The PH-MCO must reconcile the 820 capitation payment file with its internal membership information and report any discrepancies to the Department within thirty (30) days.

w. To support the PH-MCOs in meeting the requirements of this agreement, the Department will provide access to the following systems:

- Client Information System (CIS)
- Pennsylvania HealthChoices Extranet
- The Department's MMIS
- Docushare

Access to these systems is in addition to the various files that PH-MCOs will receive via secure file transfer. Information on obtaining access to these resources is on the Pennsylvania HealthChoices Extranet.

6. Department Access and Availability

Upon request by the Department, the PH-MCO must provide Department staff with access to appropriate on-site private office space and equipment including, but not limited to, the following:

- Two (2) desks and two (2) chairs;
- One (1) telephone which has speaker phone capabilities;
- One (1) personal computer and printer with on-line access to the PH-MCO's MIS;

The PH-MCO must grant the Department, CMS, the Pennsylvania Office of Attorney General Medicaid Fraud Control Section, HHS OIG, the Comptroller General, or their designees access to audit, evaluate, and inspect books, records, etc., which pertain to the delivery of or payment for Medicaid services under this Agreement. Subcontractors and providers must make such books, records, premises, equipment, staff, etc. all available for an audit at any time. Right to inspect extends for ten (10) years after termination of Agreement, or conclusion of an audit, whichever is later.

The PH-MCO must provide the Department with access to administrative policies and procedures pertaining to operations under this Agreement, including, but not limited to;

- Personnel policies and procedures

- Procurement policies and procedures

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

P. Special Needs Unit

1. Establishment of Special Needs Unit

a. The PH-MCO must develop, train, and maintain a SNU within its organizational structure that will be responsible to provide support and case management services to Members with Special Needs. The purpose of the SNU is to ensure that all Members with special needs are able to receive all necessary services and supports in a timely manner. The SNU must also assist each member with a special need with access to services and information relevant to their special condition or circumstance. The SNU must proactively identify and outreach to members with special needs to provide these services and information. These services will include all those needed by a member with special needs to address their condition or circumstance and will include but not be limited to all functions and requirements as stated in Exhibit NN, Special Needs Unit. The PH-MCO must employ or execute agreements with experts in the treatment of Special Needs to provide consultation to the SNU staff as needed.

b. The PH-MCO must comply with the Department's non-categorical definition as determined by the requirements outlined in Exhibit NN, Special Needs Unit.

c. The SNU must arrange for and provide coordination between the PH-MCO, the BH-MCOs and other health, education, and human service systems for Members with Special Needs. See Exhibit OO, Coordination of Care Entities, for an example but not an all-inclusive list. The PH-MCO must coordinate the comprehensive in-plan package of services with entities providing Out-of-Plan Services.

d. The PH-MCO must require that outpatient case management services for Members are not provided through any individual employed by the PH-MCO or through a Subcontractor of the PH-MCO if the individual's responsibilities include outpatient utilization

review or otherwise include reviews of requests for authorization of outpatient benefits.

e. If the PH-MCO provides Case Management Services to Members under the age of twenty-one (21) through the SNU, the PH-MCO must require that the SNU assists individuals in gaining access to necessary medical, social, education, and other services.

f. In addition to other telephone and alternative communication channels, it is required that a dedicated Special Needs hotline be established and maintained as a toll free direct dial access to the Special Needs Unit. This hotline shall be staffed by Special Needs Staff members during normal business hours, Monday through Friday and in sufficient numbers that calls are answered in a timely manner, with no longer than a one minute wait time, or provision made to call the member back within one hour following the initial call.

g. The PH-MCO SNU must assess and assist members with social factors that affect health outcomes. Social determinants of health include, but are not limited to, housing, food insecurity, health literacy, access to transportation, education, and employment.

h. The PH-MCO will partner with the Department on any program-wide efforts to address targeting Social Determinant of Health factors including employment. This includes supporting any members who self-select to participate in any Department designed programs.

2. Special Needs Coordinator

The PH-MCO must employ a full-time SNU Coordinator. Required qualifications for this position are set forth in Section V.N, Other Administrative Components.

3. Responsibilities of Special Needs Unit Staff

a. The PH-MCO will require that staff members employed within the SNU assist Members in accessing services and benefits and act as liaisons with various government offices, Providers, public entities, and county entities which shall include, but shall not be limited to the list of Providers in Exhibit OO, Coordination of Care Entities.

b. The staff members of this unit must work in close collaboration with the Bureau of Managed Care Operations Special Needs Unit (BMCO SNU) and the EAP broker's SNU contact person.

c. The PH-MCO must have SNU staff that is qualified to perform the functions outlined in Exhibit NN, Special Needs Unit.

Q. Assignment of PCPs

The PH-MCO must have written policies and procedures for Members and parents, guardians, or others acting in loco parentis for Members with Special Needs, who require assistance in the selection of a PCP. The PH-MCO must receive advance written approval by the Department regarding these policies and procedures. The PH-MCO's submission of new or revised policies and procedures for review and approval by the Department shall not act to void any existing policies and procedures which have been prior approved by the Department. Unless otherwise required by law, the PH-MCO may continue to operate under such existing policies and procedures until such time as the Department approves the new or revised version thereof.

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

- The PH-MCO must honor a Member's selection of a PCP through the EAP broker upon commencement of PH-MCO coverage. If the PH-MCO is not able to honor the selection, the PH-MCO must follow the guidelines described further under this provision.

- The PH-MCO may allow selection of a PCP group. Should the PH-MCO permit selection of a PCP group and the Member has selected a PCP group in the PH-MCO's Network through the Enrollment Specialist, the PH-MCO must honor upon commencement of the PH-MCO coverage, the Member's selection. In addition, the PH-MCO is permitted to assign a PCP group to a Member if the Member has not selected a PCP or a PCP group at the time of Enrollment.

- If the Member has not selected a PCP through the Enrollment Specialist for reasons other than cause, the PH-MCO must make contact with the Member within seven (7) Business Days of his or her Enrollment and provide information on options for selecting a PCP, unless the PH-MCO has information that the Member should be immediately contacted due to a medical condition requiring immediate care. To the extent practical, the PH-MCO must offer freedom of choice to Members in making a PCP selection.

- If a Member does not select a PCP within fourteen (14) Business Days of Enrollment, the PH-MCO must make an automatic assignment. The PH-MCO must consider such factors (to the extent they are known), as current Provider relationships, need of children to be followed by a pediatrician, special medical needs, physical disabilities of the Member, language needs, area of residence and access to transportation. The PH-MCO must then notify the Member by telephone or in writing of his/her PCP's name, location and office telephone number. The PH-MCO must make every effort to determine PCP choice and confirm this with the Member prior to the commencement of the PH-MCO coverage in accordance with Section V.F, Member Enrollment and Disenrollment, so that new Members do not go without a PCP for a period of time after Enrollment begins.

- The PH-MCO must take into consideration, language and cultural compatibility between the Member and the PCP.

- If a Member requests a change in his or her PCP selection following the initial visit, the PH-MCO must promptly grant the request and process the change in a timely manner.

- The PH-MCO must have written policies and procedures for allowing Members to select or be assigned to a new PCP whenever requested by the Member, when a PCP is terminated from the PH-MCO's Network or when a PCP change is required as part of the resolution to a Grievance or Complaint proceeding. The policies and procedures must receive advance written approval by the Department.

- In cases where a PCP has been terminated for reasons other than cause, the PH-MCO must immediately inform Members assigned to that PCP in order to allow them to select another PCP prior to the PCP's termination effective date. In cases where a Member fails to select a new PCP, re-assignment must take place prior to the PCP's termination effective date.

- The PH-MCO must consider that a Member with Special Needs can request a specialist as a PCP. If the PH-MCO denies the request, that Denial is appealable.

- If a member with special health care needs (including but not limited to chronic illnesses or physical and developmental disabilities) who is 18 (eighteen) years of age or older uses a Pediatrician or Pediatric Specialist as a PCP, the PH-MCO must, upon request from a family member, assist with the transition to a PCP who provides services for adults.

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

R. Provider Services

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

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

1. Provider Manual

The PH-MCO must keep its Network Providers up-to-date with the latest policy and procedures changes as they affect the MA Program. The key to maintaining this level of communication is the publication of a Provider manual. The PH-MCO must distribute copies of the Provider manual in a manner that makes them easily accessible to all Network Providers. The PH-MCO may specifically delegate this responsibility to large Providers in its Provider Agreement. The Provider manual must be updated annually. The Department may grant an exception to this annual requirement upon written request from the PH-MCO provided there are no major changes to the manual. For a complete description of the Provider manual contents and information requirements, refer to Exhibit PP of this Agreement, Provider Manuals.

2. Provider Education

The PH-MCO must demonstrate that its Provider Network is knowledgeable and experienced in treating Members with Special Needs. The PH-MCO must submit an annual Provider Education and Training workplan to the Department that outlines its plans to educate and train Network Providers. The format for this workplan will be designated by the Department through its Operations Reporting requirements found on the Pennsylvania HealthChoices Extranet. This training plan can be done in conjunction with the SNU training requirements as outlined in Exhibit NN, Special Needs Unit, and must also include Special Needs Recipients, advocates and family members in developing the design and implementation of the training plan.

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

At a minimum, the PH-MCO must conduct the Provider training for PCPs and dentists, as appropriate, and include the following areas:

a. EPSDT training for any Providers who serve Members under age twenty-one (21).

b. Identification and appropriate referral for mental health, drug and alcohol and substance abuse services.

c. Sensitivity training on diverse and Special Needs populations such as persons who are deaf or hard of hearing: how to obtain sign language interpreters and how to work effectively with sign language interpreters.

d. Cultural Competency, including: the right of Members with LEP to engage in effective communication in their language; how to obtain interpreters, and; how to work effectively with interpreters.

e. Treating Special Needs populations, including the right to treatment for individuals with disabilities.

f. Administrative processes that include, but are not limited to: coordination of benefits, Recipient Restriction Program, Encounter Data reporting and Dual Eligibles.

g. Issues identified by Provider relations or Provider hotline staff in response to calls or complaints by Providers.

h. Issues identified through the QM process.

i. Identifying and making referrals to the PH-MCO SNU.

j. Guidance to providers on the process to submit materials to the PH-MCO to make utilization review and Prior authorization review decisions about members. Submitted materials may include but not be limited to letters of medical necessity.

k. Information to providers on the complaint, grievance and appeal process including but not limited to expectations should a provider represent a member at a grievance review.

l. Information on PIP such as the Provider Pay for Performance (P4P) outlined in Exhibit B(3) and how providers may benefit from participation in these programs.

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

3. Panel Listing Requirements

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

- Member identification (Last, First and Middle Name)
- Date of birth
- Age
- Telephone number

- Address
- Identification of new patients
- Date of last EPSDT Screen
- Screen Due or Overdue

S. Provider Network

The PH-MCO must establish and maintain adequate Provider Networks to serve all of the eligible HealthChoices populations in each HealthChoices Zone covered by this Agreement. Provider Networks must include, but not be limited to: hospitals, children's tertiary care hospitals, specialty clinics, trauma centers, facilities for high-risk deliveries and neonates, specialists, dentists, orthodontists, physicians, pharmacies, emergency transportation services, long-term care facilities, rehab facilities, home health agencies, certified hospice providers and DME suppliers in sufficient numbers to make available all services in a timely manner. Detailed requirements related to the composition of Provider Networks and members' access to services from the providers in those networks are located in Exhibit AAA, Provider Network Composition/Service Access, as applicable.

If the PH-MCO's Provider Network is unable to provide necessary medical services covered under the Agreement, to a particular Member, the PH-MCO must adequately and timely cover these services out-of-network, for the Member for as long as the PH-MCO is unable to provide them and must coordinate with the Out-of-Network Provider with respect to payment.

1. Provider Agreements

The PH-MCO must have written Provider Agreements with a sufficient number of Providers to ensure Member access to all Medically Necessary services covered by the HealthChoices Program.

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

2. Cultural Competency

Both the PH-MCO and Network Providers must demonstrate Cultural Competency and must understand that racial, ethnic and cultural differences between Provider and Member cannot be permitted to present barriers to accessing and receiving quality health care; must

demonstrate the willingness and ability to make the necessary distinctions between traditional treatment methods and/or non-traditional treatment methods that are consistent with the Member's racial, ethnic or cultural background and which may be equally or more effective and appropriate for the particular Member; and demonstrate consistency in providing quality care across a variety of races, ethnicities and cultures. For example, language, religious beliefs, cultural norms, social-economic conditions, diet, etc., may make one treatment method more palatable to a Member of a particular culture than to another of a differing culture.

3. Primary Care Practitioner Responsibilities

The PH-MCO must have written policies and procedures for ensuring that every Member is assigned to a PCP. The PCP must serve as the Member's initial and most important point of contact regarding health care needs. At a minimum, the PH-MCO Network PCP are responsible for:

a. Providing primary and preventive care and acting as the Member's advocate, providing, recommending and arranging for care.

b. Documenting all care rendered in a complete and accurate Encounter record that meets or exceeds the DHS data specifications.

c. Maintaining continuity of each Member's health care.

d. Communicating effectively with the Member by using sign language interpreters for those who are deaf or hard of hearing and oral interpreters for those individuals with LEP when needed by the Member. Services must be free of charge to the Member. Notice of nondiscrimination and the taglines must be posted in physical locations where providers interact with the public.

e. Making referrals for specialty care and other Medically Necessary services, both in and out-of-plan.

f. Maintaining a current medical record for the Member, including documentation of all services provided to the Member by the PCP, as well as any specialty or referral services.

g. Arranging for Behavioral Health Services in accordance with Exhibit U of this Agreement, Behavioral Health Services.

The PH-MCO will retain responsibility for monitoring PCP actions to ensure they comply with the provisions of this Agreement.

4. Specialists/School Based Health Centers as PCPs

A Member may qualify to select a specialist to act as PCP if s/he has a disease or condition that is life threatening, degenerative, or disabling. The PH-MCO must allow members to access school based health centers for primary care services regardless of PCP on record.

The PH-MCO must adopt and maintain procedures by which a Member with a life-threatening, degenerative or disabling disease or condition shall, upon request, receive an evaluation and, if the PH-MCO's established standards are met, be permitted to receive:

- A standing referral to a specialist with clinical expertise in treating the disease or condition; or

- The designation of a specialist to provide and coordinate the Member's primary and specialty care.

The referral to or designation of a specialist must be pursuant to a treatment plan approved by the PH-MCO, in consultation with the PCP, the Member and, as appropriate, the specialist. When possible, the specialist must be a Health Care Provider participating in the PH-MCO's Network. If the specialist is not a Network Provider, the PH-MCO may require the specialist to meet the requirements of the PH-MCO's Network Providers, including the PH-MCO's credentialing criteria and QM/UM Program policies and procedures.

Information for Recipients must include a description of the procedures that a Member with a life-threatening, degenerative or disabling disease or condition shall follow and satisfy to be eligible for:

- A standing referral to a specialist with clinical expertise in treating the disease or condition; or

- The designation of a specialist to provide and coordinate the Member's primary and specialty care.

The PH-MCO must have adequate Network capacity of qualified specialists to act as PCPs. These physicians may be predetermined and listed in the directory but may also be determined on an as needed basis. All determinations must comply with specifications set out by Act 68 regulations. The PH-MCO must establish and maintain its own credentialing and recredentialing policies and procedures to ensure compliance with these specifications.

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

5. Hospital Related Party

The Department requires that a PH-MCO that is a Related Party to a Hospital or system must insure that the Related Party is willing to negotiate in good faith with other PH-MCOs regarding the provision of services to Recipients. The Department reserves the right to terminate this Agreement with the PH-MCO if it determines that a hospital related to the PH-MCO has refused to negotiate in good faith with other PH-MCOs.

6. Mainstreaming

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

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

- Denying or not providing a Member any MA covered service or availability of a facility within the PH-MCO's Network. The PH-MCO must have explicit policies to provide access to complex interventions such as cardiopulmonary resuscitations, intensive care, transplantation and rehabilitation when medically indicated and must educate its Providers on these policies. Health care and treatment necessary to preserve life must be provided to all persons who are not terminally ill or permanently unconscious, except where a competent Member objects to such care on his/her own behalf.

- Subjecting a Member to segregated, separate, or different treatment, including a different place or time from that provided to other Members, public or private patients, in any manner related to the receipt of any MA covered service, except where Medically Necessary.

- The assignment of times or places for the provision of services on the basis of the race, color, creed, religion, age, sex, national origin, ancestry, marital status, sexual orientation, gender identity or expression, income status, program membership, language, MA status, health status, disease or pre-existing condition, anticipated need for health care or physical or mental disability of the participants to be served.

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

7. Network Changes/Provider Terminations

a. Network Changes

i. Notification to the Department
Other than terminations outlined below in Section 7.b (Provider Terminations), the PH-MCO must review its network and notify the Department of any changes to its Provider Network (closed panels, relocations, death of a provider, etc.) through the quarterly additions/deletions provider network reporting.

ii. Procedures and Work Plans

The PH-MCO must have procedures to address changes in its Network that impact Member access to services, in accordance with the requirements of Exhibit AAA, as applicable, Network Composition, of this Agreement. Failure of the PH-MCO to address changes in Network composition that negatively affect Member access to services may be grounds for termination of this Agreement.

iii. Timeframes for Notification to Members
The PH-MCO must update web-based Provider directories to reflect any changes in the Provider Network as required in Section V.F.16, Provider Directories, of this Agreement.

b. Provider Terminations

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

c. The Commonwealth must screen, enroll and periodically revalidate all MA providers. The PH-MCO may execute network provider agreements pending the outcome of the revalidation process of up to 120 days. The PH-MCO must terminate a network provider immediately upon notification from the Commonwealth that the network provider cannot be revalidated, or the expiration of one 120 day period without revalidation of the provider. The PH-MCO must notify affected members in accordance with the provider termination requirements of this agreement.

8. Other Provider Enrollment Standards

The PH-MCO will comply with the program standards regarding Provider enrollment that are set forth in this Agreement.

The PH-MCO must require all Network Providers to be enrolled in the Commonwealth's MA Program and possess an active MMIS Provider ID for each location at which they provide services for the PH-MCO. The PH-MCO must be able to store and utilize the MMIS Provider ID and NPI stored in the Department's MMIS for each location.

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

The Department encourages the use of Providers currently contracting with the County Children and Youth Agencies who have experience with the foster care population and who have been providing services to children and youth Recipients for many years.

9. Twenty-Four Hour Coverage

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

10. Opioid Use Disorder Centers of Excellence

The Department will implement OUD-COEs in the Physical Health Program throughout the Commonwealth. This initiative will increase the capacity to care for those seeking treatment for OUD, as well as increase the overall quality of care. The PH-MCO must comply with the Department's OUD-COE requirements specified in Exhibit G Opioid Use Disorder Centers of Excellence.

11. Health Information Organization

PH-MCOs must contract with at least one Health Information Organization (HIO) that is capable of connecting to the PA Patient and Provider Network, or P3N. Information about certified regional networks of HIOs can be found at: http://dhs.pa.gov/provider/healthinformationexchange/. Contracting efforts must be documented to demonstrate the PH-MCOs effort in complying with this requirement.

T. QM and UM Program Requirements

1. Overview

The PH-MCO must comply with the Department's QM and UM Program standards and requirements described in Exhibit M(1) Quality Management and Utilization Management Program Requirements, Exhibit M(2) External Quality Review, and Exhibit M(4) Healthcare Effectiveness Data and Information Set (HEDIS) and Consumer Assessment of Healthcare Providers and Systems (CAHPS®). The PH-MCO must comply with the Quality Management/Utilization Management Reporting Requirements on the Pennsylvania HealthChoices Extranet site. The Department retains the right of advance written approval and to review on an ongoing basis all aspects of the PH-MCO QM and UM programs, including subsequent changes. The PH-MCO must comply with all QM and UM program reporting requirements and must submit data in formats to be determined by the Department.

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

2. Healthcare Effectiveness Data and Information Set (HEDIS)

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

3. External Quality Review (EQR)

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

4. Pay for Performance Programs

The Department conducts a Pay for Performance (P4P) Program that provides financial incentives for PH-MCOs that meet quality goals. Information regarding MCO Pay for Performance Programs may be found in Exhibit B(1), HealthChoices MCO Pay for Performance Program. Information regarding the Provider Pay for Performance Program may be found in Exhibit B(3), HealthChoices Provider Pay for Performance Program.

5. QM/UM Program Reporting Requirements

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

6. Delegated Quality Management and Utilization Management Functions

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

7. Consumer Involvement in the Quality Management and Utilization Management Programs

The PH-MCO will participate and cooperate in the work and review of the Department's formal advisory body through participation in the Medical Assistance Advisory Committee (MAAC) and its subcommittees.

8. Confidentiality

The PH-MCO must have written policies and procedures for maintaining the confidentiality of data that addresses medical records, Member information and Provider information and is in compliance with

the provisions set forth in Section 2131 of the Insurance Company Law of 1921, as amended, 40 P.S. §991.2131; 55 Pa. Code Chapter 105; and 45 C.F.R. Parts 160 and 164 (Standards for Privacy of Individually Identifiable Health Information).

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

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

9. Department Oversight

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

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

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

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

10. PH-MCO and BH-MCO Integrated Care Plan (ICP) Pay for Performance Program

The Department will provide financial incentives to the PH-MCOs and BH-MCOs for the ICP Program. The Department expects the ICP

Program to improve the quality of healthcare and reduce expenditures through enhanced coordination of care among PH-MCOs, BH-MCOs and providers. The targeted membership for this incentive program will be members with persistent serious mental illness PSMI. Information regarding this incentive program is found in Exhibit B(2)-- PH-MCO and BH-MCO Integrated Care Plan Pay for Performance Program.

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

1. Mergers and Acquisitions

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

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

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

SECTION VI: PROGRAM OUTCOMES AND DELIVERABLES

The PH-MCO must obtain the Department's prior written approval of all Deliverables prior to the operational date of the Initial Term and throughout the duration of the Agreement unless otherwise specified by the Department.

The Department may require the PH-MCO to resubmit for Department approval previously approved Deliverables, as needed, to conform to the Agreement or applicable law. Unless otherwise specified by the Department, previously approved Deliverables remain in effect until approval of new versions. If the PH-MCO makes changes to previously approved Deliverables, these Deliverables must be resubmitted for Department review and approval unless otherwise specified by the Department.

The Department will conduct on-site Readiness Reviews, for implementation of a new procurement or reprocurement, to document the

PH-MCO's compliance with this Agreement. Upon request by the Department, as part of the readiness review, the Contractor must provide detailed written descriptions of how the Contractor is complying with Agreement requirements and standards. The Department may continue development of readiness review elements, program standards and forms prior to scheduling the actual on-site readiness review visits.

SECTION VII: FINANCIAL REQUIREMENTS

A. Financial Standards

The PH-MCO must comply with all financial requirements included in this Agreement, in addition to those of the PID. As proof of financial responsibility and adequate protection against insolvency in accordance with 42 C.F.R. §438.116, the following applies:

1. Risk Protection Reinsurance for High Cost Cases

If the PH-MCO is eligible for inclusion in the High Cost Risk Pool, for every HealthChoices Zone of operation, per Appendix 3k, then risk protection reinsurance is not required. Reinsurance is also not required if the PH-MCO has, at a minimum, a combined membership of 60,000 Members across all Pennsylvania lines of business.

a. If risk protection reinsurance is required, the PH-MCO must obtain reinsurance to cover, at a minimum, eighty (80) percent of inpatient costs incurred by one (1) Member in one (1) year in excess of $200,000 except as provided at 1. b) below the Department may alter or waive the reinsurance requirement if the PH-MCO proposes an alternative risk protection arrangement that the Department determines is acceptable.

The PH-MCO may not change or discontinue the approved risk protection arrangement without advance written approval from the Department, which approval shall not be unreasonably withheld. Not less than forty-five (45) days before each risk protection arrangement expires, the PH-MCO must provide the Department with a detailed plan for risk protection after the current arrangement expires, including any planned changes. The PH-MCO must submit each risk protection arrangement to the Department for prior approval. If the risk protection arrangement is an annual agreement, the PH-MCO must submit each annual agreement to the Department for prior written approval.

b. The reinsurance threshold requirement shall be $100,000, if any of the following criteria is met:

i. The PH-MCO has been operational (providing medical benefits to any type of consumer) for less than three (3) years; or

ii. The PH-MCO's SAP basis Equity is less than six (6.0) percent of revenue earned by the licensed HMO during the most recent four (4) quarters for which the due date has passed for submission of the unaudited reports filed by the PH-MCO with the PID; or

iii. The net income as reported to the PID over the past three (3) years was less than zero.

c. The PH-MCO may not purchase required reinsurance risk protection from a Related Party or an Affiliate unless all of the following conditions are met:

- The Related Party or Affiliate is a reinsurance or insurance company in the business to provide such reinsurance risk protection;

- The PH-MCO's reinsurance risk protection annual premium is less than six (6.0) percent of the Related Party or Affiliate's total annual written reinsurance or insurance related premium; and

- The PH-MCO has received prior written approval from the Department to purchase the reinsurance risk protection from the Related Party or Affiliate.

2. Equity Requirements and Solvency Protection

The PH-MCO must meet the Equity and solvency protection requirements set forth below.

The PH-MCO must maintain SAP-basis Equity equal to the highest of the amounts determined by the following "Three (3) Part Test" as of the last day of each calendar quarter:

- $20.00 million;

- 7.000% of Revenue earned by the licensed HMO during the most recent four (4) calendar quarters; or

- 7.000% of Revenue earned by the licensed HMO during the current quarter multiplied by three (3).

Revenue, for the purpose of the Equity requirement calculation, is defined as the total gross Direct Business Premiums, for all Pennsylvania lines of business, reported in Schedule T, “Premiums and Other Considerations,” of the PID report.

For the purpose of this requirement, Equity amounts, as of the last day of each calendar quarter, shall be determined in accordance with statutory accounting principles as specified or accepted by the PID. The Department will accept PID determinations of Equity amounts, and in the absence of such determination, will rely on required financial statements filed by the PH-MCO with PID to determine Equity amounts.

The PH-MCO must provide the Department with reports as specified in Section VIII.D and E. Financial Reports and Equity.

With approval from the Department, the PH-MCO may elect this alternative equity requirement. This alternative requirement has three parts:

a. PH-MCO RBC ratio of at least three (3.0); and

b. Substitution of five and one-half percent (5.5%) where the figure seven percent (7.0%) is included in the Three Part Test above; and

c. Compliance with the Three Part Test with the figure of eight and three tenths percent (8.3%), where seven percent (7.0%) is stated, by individual at-risk Subcontractors who collectively receive at least seventy five percent (75%) of the revenue provided by the Department to the PH-MCO. Revenue, for the purpose of this alternative equity requirement, would be premium revenue reported on the most recently available audited statements and updated to incorporate more recent quarterly information.

The PH-MCO must provide documentation of compliance that is satisfactory to the Department, and failing that, must comply with the standard Three Part Test equity requirement.

3. Risk Based Capital (RBC)

The PH-MCO must maintain a RBC ratio of 2.0.

4. Prior Approval of Payments to Affiliates

With the exception of payment of a Claim, the PH-MCO may not pay money or transfer any assets for any reason to an Affiliate without prior approval from the Department, if any of the following criteria apply:

a. The PH-MCO's RBC ratio was below the requirement in Section VII.A.3 as of December 31 of the most recent year for which the due date for filing the annual unaudited PID financial report has passed;

b. The PH-MCO was not in compliance with the Agreement Equity and solvency protection requirement as of the last day of the most recent quarter for which the due date for filing PID financial reports has passed;

c. After the proposed transaction took place, the PH-MCO would not be in compliance with the Agreement Equity and solvency protection requirement; or

d. Subsequent adjustments are made to the PH-MCO's financial statement as the result of an audit, or are otherwise modified, such that after the transaction took place, a final determination is made that the PH-MCO was not in compliance with the Agreement Equity requirements. In this event, the Department may require repayment of amounts involved in the transaction.

The Department may elect to waive the requirements of this section.

5. Change in Independent Actuary or Independent Auditor

The PH-MCO must notify the Department within ten (10) calendar days when its contract with an independent auditor or actuary has ended. The notification must include the date and reason for the change or termination and the name of the replacement auditor or actuary, if any. If the change or termination occurred as a result of a disagreement or dispute, the PH-MCO must disclose the nature of the disagreement or dispute.

6. Modified Current Ratio

The PH-MCO must maintain current assets, plus long-term investments that can be converted to cash within five (5) Business Days without incurring an assessment of more than twenty (20) percent, which equal or exceed current liabilities.

- If an assessment for conversion of long-term investments is applicable, only the value net of the assessment may be counted for the purpose of compliance with this requirement.

- The definitions of current assets and current liabilities are included in the Financial Reporting Requirements.

- Restricted assets may be included only with authorization from the Department.

- The following types of long-term investments may be counted, consistent with above requirements, so long as they are not issued by or include an interest in an Affiliate:

  – Certificates of Deposit
  – United States Treasury Notes and Bonds
  – United States Treasury Bills
  – Federal Farm Credit Funding Corporation Notes and Bonds
  – Federal Home Loan Bank Bonds
  – Federal National Mortgage Association Bonds
  – Government National Mortgage Association Bonds
  – Municipal Bonds
  – Corporate Bonds
  – Stocks
  – Mutual Funds

7. Assessments

In addition to the Department's general assessment authority specified in Section VIII.H of this Agreement, Assessments, if the PH-MCO fails to comply with the requirements of Section VII.A, the Department will take any or all of the following actions:

- Discuss fiscal plans with the PH-MCO's management;

- Suspend payments or a portion of payments for Members enrolled until CMS or the Department is satisfied that the reason for the imposition of the Assessment no longer exists and is not likely to recur;

- Require the PH-MCO to submit and implement a corrective action plan;

- Suspend some or all Enrollment of Members into the PH-MCO, including auto-assignments; and/or

- Terminate this Agreement upon forty-five (45) days written notice, in accordance with Section X of this Agreement, Termination and Default.

8. DSH/GME Payment for Disproportionate Share Hospitals Graduate Medical Education

The Department will make direct payments of DSH/GME to network providers. DSH and GME amounts shall not be included in FFS cost equivalent projections or in Capitation payments paid by the Department to the PH-MCO.

9. Member Liability

In accordance with 42 C.F.R. §438.106, the PH-MCO must provide that Members are not held liable for the following:

a. Debts of the PH-MCO in the event of the PH-MCO's insolvency.

b. Services provided to the Member in the event of the PH-MCO fails to receive payment from the Department.

c. Services provided to the Member in the event of a Health Care Provider with a contractual, referral or other arrangement with the PH-MCO fails to receive payment from the Department or the PH-MCO for such services.

d. Payments to a Provider that furnishes compensable services under a contractual, referral or other arrangement with the PH-MCO in excess of the amount that would be owed by the Member if the PH-MCO had directly provided the services.

10. Related Party Hospitals

The PH-MCO may not include a related party hospital in its network unless the related party hospital, and all physician sites and clinics owned or controlled by the hospital, are included in the network of all but one other PH-MCO that has an Agreement with the Department to operate in the applicable zone. The Department may waive this

requirement if the PH-MCO satisfies the Department that a sufficient number of PH-MCOs are unwilling to contract with the hospital at reasonable terms.

B. Commonwealth Capitation Payments

1. Payments for In-Plan Services

The obligation of the Department to make payments shall be limited to Capitation payments, maternity care payments, and any other payments provided by this Agreement.

a. Capitation Payments

i. The PH-MCO shall receive capitated payments for In-Plan Services as defined in Section VII.B.1 of this Agreement, Payments for In-Plan Services, and in Appendix 3b, Explanation of Capitation Payments.

ii. The Department will compute Capitation payments using per diem rates. The Department will make a monthly payment to the PH-MCO for each Member enrolled in the PH-MCO, for the first day in the month the Member is enrolled in the PH-MCO and for each subsequent day, through and including the last day of the month.

iii. If a PH-MCO Member is enrolled into a CHC MCO, the Department will pay capitation to the PH-MCO only through the day prior to the CHC begin date.

iv. The Department will not make a Capitation payment for a Member Month if the Department notifies the PH-MCO before the first of the month that the individual's MA eligibility or PH-MCO Enrollment ends prior to the first of the month.

v. The Department will make arrangements for payment by wire transfer or electronic funds transfer. If such arrangements are not in place, payment shall be made by U.S. Mail.

vi. Upon notice to the PH-MCO, and for those months specified by the Department, by the fifteenth (15th) of each month, the Department will make a Capitation payment for each Member for all dates of Enrollment

indicated on the Department's CIS through the last day of the current month. This payment will be limited to those days for which the Department has not previously made payment to the PH-MCO.

vii. Unless paragraph vi. above applies, by the fifteenth (15th) of each month, the Department will make a Capitation payment for each Member for all dates of Enrollment indicated on the Department's CIS prior to the first day of the current month. This payment will be limited to those days for which the Department has not previously made payment to the PH-MCO.

Exceptions:

a) Any Capitation payment that would otherwise be payable in the month of May will be payable by July 19 of the same year.

b) Any Capitation payment that would otherwise be payable in the month of June will be payable by July 12 of the same year.

c) An exception does not apply if the Department has notified the PH-MCO that vi above will apply.

d) An exception does not apply if a PH-MCO becomes responsible to provide Member benefits effective February 1, March 1, April 1, or May 1 and is not responsible to provide Member benefits in any zone in an earlier month of the same year per any physical health HealthChoices Agreement.

viii. The Department will recover Capitation payments made for Members who were later determined to be ineligible for managed care for up to twelve (12) months after the service month for which payment was made. The Department will recover Capitation payments made for deceased Members or for Members aged twenty-one through sixty-four (21 – 64) residing in a free-standing IMD at least 16 days during the calendar month and the Member's condition is not related to Substance Use Disorder for up to eighteen (18) months after the service month for which payment

was made. The Capitation amount recovered for IMD Members is calculated in accordance with Section VII.E.13.

2. Maternity Care Payment

For each live birth, the Department will make a one-time maternity care payment to the PH-MCO with whom the mother is enrolled on the date of birth. However, if the mother is admitted to a hospital and a change in the PH-MCO coverage occurs during the hospital admission, the PH-MCO responsible for the hospital stay shall receive the maternity care payment. Similarly, if the mother is covered by FFS when admitted to the hospital and then assumes PH-MCO coverage while still in the hospital, the Department will not make a maternity care payment to the PH-MCO. In the event of multiple births (twins, etc.), the Department will make only one maternity care payment.

The PH-MCO must pay fees for delivery services at least equal to the Department's MA fee schedule when the PH-MCO is the primary payer.

The PH-MCO must submit information on maternity events to the Department's MMIS in accordance with Section VIII.B.6.

3. Program Changes

Amendments, revisions, or additions to the MA State Plan or to state or federal regulations, laws, guidelines, or policies shall, insofar as they affect the scope or nature of benefits available to eligible Members, amend the PH-MCO's obligations as specified herein, unless the Department notifies the PH-MCO otherwise. The Department will inform the PH-MCO of any changes, amendments, revisions, or additions to the Medicaid State Plan or changes in the Department's regulations, guidelines, or policies in a timely manner.

If the scope of Recipients or services, inclusive of limitations on those services that are the responsibility of the PH-MCO is changed, the Department will determine whether the change is sufficient that an actuarial analysis might conclude that a rate change is appropriate. If yes, the Department will arrange for the actuarial analysis, and the Department will determine whether a rate change is appropriate. The Department will take into account the actuarial analysis, and the Department will consider input from the PH-MCO, when making this determination. At a minimum, the Department will adjust the rates as necessary to maintain Actuarial Sound Rates. If the Department

makes a change, the Department will provide the analysis used to determine the rate adjustment. If the scope of services or consumers that are the responsibility of the PH-MCO is changed, upon request by the PH-MCO, the Department will provide written information on whether the rates will be adjusted and how, along with an explanation for the Department's decision.

The rates in Appendix 3f, Capitation Rates will remain in effect until agreement is reached on new rates and their effective date**,** unless modified to reflect changes to the scope of services or consumers in the manner described in the preceding paragraph.

C. Acceptance of Actuarially Sound Rates

By executing the Agreement, the PH-MCO has reviewed the rates as set forth in the Rate Appendices in this Agreement, Capitation Rates, and accepts the rates for the relevant Agreement period.

D. Claims Processing Standards, Monthly Report and Assessments

These requirements and assessments are applied separately by zone.

1. Timeliness Standards

The PH-MCO must adjudicate Provider Claims consistent with the requirements below. These requirements apply collectively to Claims processed by the PH-MCO and any Subcontractor. Subcapitation payments are excluded from these requirements.

The adjudication timeliness standards follow for each of three (3) categories of Claims:

a. Claims received from a hospital for inpatient admissions ("Inpatient"):

90.0% of Clean Claims must be adjudicated within thirty (30) days of receipt.

100.0% of Clean Claims must be adjudicated within forty-five (45) days of receipt.

100.0% of all Claims must be adjudicated within ninety (90) days of receipt.

b. Drug Claims:

90.0% of Clean Claims must be adjudicated within thirty (30) days of receipt.

100.0% of Clean Claims must be adjudicated within forty-five (45) days of receipt.

100.0% of all Claims must be adjudicated within ninety (90) days of receipt.

c. All Claims other than inpatient and drug:

90.0% of Clean Claims must be adjudicated within thirty (30) days of receipt.

100.0% of Clean Claims must be adjudicated within forty-five (45) days of receipt.

100.0% of all Claims must be adjudicated within ninety (90) days of receipt.

The adjudication timeliness standards do not apply to Claims submitted by Providers under investigation for Fraud or Abuse from the date of service to the date of adjudication of the Claims. Providers can be under investigation by a governmental agency or the PH-MCO; however, if under investigation by the PH-MCO, the Department must have immediate written notification of the investigation.

The PH-MCO must adjudicate every Claim entered into the PH-MCO's computer information system that is not a Rejected Claim. The PH-MCO must maintain an electronic file of Rejected Claims, inclusive of a reason or reason code for rejection. The PH-MCO must deny a claim for a Recipient who was not a MCO Member as of the date of service at the time of processing of the claim and must notify the Provider.

The amount of time required to adjudicate a paid Claim is computed by comparing the date the Claim is received with the check date or the MCO bank notification date for electronic payment. The check date is the date printed on the check. The amount of time required to adjudicate a Denied Claim is computed by comparing the date the Claim is received with the date the denial notice was created or the transmission date of an electronic denial notice. The PH-MCO must mail checks not later than three (3) Business Days from the check

date and make electronic payments within three (3) Business Days of the bank notification date.

The PH-MCO must record, on every Claim processed, the date the Claim was received. A date of receipt imbedded in a Claim reference number is acceptable for this purpose. This date must be carried on Claims records in the Claims processing computer system. Each hardcopy Claim received by the PH-MCO, or the electronic image thereof, must be date-stamped with the date of receipt no later than the first (1st) Business Day after the date of receipt. The PH-MCO must add a date of receipt to each Claim received in the form of an electronic record or file within one (1) Business Day of receipt.

If responsibility to receive Claims is subcontracted, the date of initial receipt by the Subcontractor determines the date of receipt applicable to these requirements.

2. Assessments

The Department will utilize the monthly report that is due on the fifth (5th) calendar day of the fifth (5th) subsequent month after the Claim is received to determine Claims processing timeliness. For example, the Department shall utilize the monthly report that is due January 5th, to determine Claims processing timeliness for Claims received in the previous August. The Department shall utilize the monthly report that is due February 5th, to determine Claims processing timeliness for Claims received in the previous September. The Department shall utilize the monthly report that is due March 5th, to determine Claims processing timeliness for Claims received in the previous October, and so on.

All Claims received during the month, for which an assessment is being computed, that have not been adjudicated at the time the assessment is being determined, shall be considered a Clean Claim.

If a Commonwealth audit, or an audit required or paid for by the Commonwealth, determines Claims processing timeliness data that are different than data submitted by the PH-MCO, or if the PH-MCO has not submitted required Claims processing data, the Department will use the audit results to determine the assessment amount.

The assessments included in the charts below shall apply separately to:

a. Inpatient Claims

b. Claims other than inpatient and drug

The PH-MCO will be considered in compliance with the requirement for adjudication of 100.0% of all inpatient Claims if 99.5% of all inpatient Claims are adjudicated within ninety (90) days of receipt. The PH-MCO will be considered in compliance with the requirement of adjudication of 100.0% of all Claims other than inpatient and drug if 99.5% of all Claims other than inpatient and drug are adjudicated within ninety (90) days of receipt.

The Department will reduce the assessments in the charts below by one-third if the PH-MCO has 25,000-50,000 Members and by two-thirds if the PH-MCO has less than 25,000 Members.

The total assessment for the current month will increase to $10,000 if the following conditions exist:

- PH-MCO fails to comply with any adjudication timeliness requirement for Claims received in any seven (7) of the nine (9) previous months; and

The sum of adjudication timeliness assessments for the current month is greater than zero (0) but less than $10,000.

CLAIMS ADJUDICATION MONTHLY ASSESSMENT CHART

The Department will compute assessments as for failure to adjudicate inpatient Claims and Claims other than inpatient or pharmacy.

Percentage of Clean Claims Adjudicated in 30 Days	Assessment
88.0 – 89.9	$1,000
80.0 – 87.9	$3,000
70.0 – 79.9	$5,000
60.0 – 69.9	$8,000
50.0 – 59.9	$10,000
Less than 50.0	$15,000
Percentage of Clean Claims Adjudicated in 45 Days	Assessment
98.0 – 99.5	$1,000
90.0 – 97.9	$3,000
80.0 – 89.9	$5,000
70.0 – 79.9	$8,000
60.0 – 69.9	$10,000
Less than 60.0	$15,000

Percentage of All Claims Adjudicated in 90 Days	Assessment
98.0 – 99.5	$1,000
90.0 – 97.9	$3,000
80.0 – 89.9	$5,000
70.0 – 79.9	$8,000
60.0 – 69.9	$10,000
Less than 60.0	$15,000

E. Other Financial Requirements

1. Physician Incentive Arrangements

a. PH-MCOs must comply with the PIP requirements included under 42 C.F.R. §§ 422.208 and 422.210, which apply to Medicaid managed care under 42 C.F.R. §438.3.

b. PH-MCOs are only permitted to operate PIPs if 1) no specific payment is made directly or indirectly to a physician or physician group as an inducement to reduce or limit Medically Necessary services furnished to a Member; and 2) the disclosure, computation of Substantial Financial Risk, Stop-Loss Protection, and Member survey requirements of this section are met.

c. PH-MCOs must provide information specified in the regulations to the Department and CMS, upon request. In addition, PH-MCOs must provide the information on their PIPs to any Member, upon request. PH-MCOs that have PIPs placing a physician or physician group at Substantial Financial Risk for the cost of services the physician or physician group does not furnish must assure that the physician or physician group has adequate Stop-Loss Protection. PH-MCOs that have PIPs placing a physician or physician group at Substantial Financial Risk for the cost of service the physician or physician group does not furnish must also conduct surveys of Members and disenrollees addressing their satisfaction with the quality of services and their ability to access services.

d. PH-MCOs must provide the following disclosure information concerning its PIPs to the Department prior to approval of the contract:

- whether referral services are included in the PIP,

- the type of incentive arrangement used, i.e. withhold bonus, capitation,

- a determination of the percent of payment under the contract that is based on the use of referral services to determine if Substantial Financial Risk exists,

- panel size, and if Members are pooled, pooling method used to determine if Substantial Financial Risk exists,

- assurance that the physician or physician group has adequate Stop-Loss Protection and the type of coverage, if this requirement applies.

Where Member/disenrollee survey requirements apply, the PH-MCOs must provide the survey results.

e. The PH-MCO must provide the disclosure information specified in 1.d. above to the Department annually, unless the Department has provided the PH-MCO with notice of suspension of this requirement.

2. Retroactive Eligibility Period

The PH-MCO shall not be responsible for any payments owed to Providers for services that were rendered prior to the effective date of a Member's Enrollment into the PH-MCO.

3. Payment for Services Provided by In-Network Providers

The PH-MCO must make timely payment for Medically Necessary, covered services rendered by Network Providers when:

a. Services were rendered to treat an Emergency Medical Condition;

b. Services were rendered under the terms of the PH-MCO's agreement with the Provider;

c. Services were Prior Authorized; or

d. It is determined by the Department, after a hearing, that the services should have been authorized.

4. Payments for Out-of-Network Providers

a. The PH-MCO must make timely payments to Out-of-Network Providers for Medically Necessary, covered services when:

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

ii. Services were Prior Authorized;

iii. It is determined by the Department, after a hearing, that the services should have been authorized; or

iv. A child enrolled in the PH-MCO is placed in emergency substitute care and the county placement agency cannot identify the child nor verify MA coverage.

b. The PH-MCO is not financially liable for:

i. Services rendered to treat a non-emergency condition in a hospital emergency department (except to the extent required by law), unless the services were Prior Authorized; or

ii. Prescriptions presented at Out-of-Network Provider pharmacies that were written by Non-participating providers or Out–of-Network Providers unless:

- the Non-participating Provider or Out-of-Network provider arrangements were approved in advance by the PH-MCO and any prior authorization requirements (if applicable) were met;

- the Non-participating Provider or Out-of-Network Provider prescriber and the pharmacy are the Member's Medicare providers; or

- the Member is covered by a third party carrier and the Non-participating or Out-of-Network Provider prescriber and the pharmacy are the Member's third party providers.

The PH-MCO must assume financial responsibility, in accordance with applicable law, for emergency services and urgently needed services as defined in 42 C.F.R. §417.401 that are obtained by its Members from Providers and suppliers outside the PH-MCO's Provider Network even in the absence of the PH-MCO's prior approval.

5. Payments to FQHCs and RHCs

Effective with dates of services beginning on or after January 1, 2016, the PH-MCO must pay all FQHCs and RHCs rates that are not less than the FFS Prospective Payment System (PPS) rate(s), as determined by the Department. Beginning on or after December 1, 2016, the PH-MCO must also make a payment separate from the PPS rate(s) to any FQHC that has opted–in to the Alternative Payment Methodology for inpatient deliveries. The PH-MCO must also include in its Provider Network every FQHC and RHC located within this HealthChoices Zone that the MCO operates its Program in that is willing to accept PPS rates as payment in full. The PH-MCO must pay all FQHCs and/or RHCs in the Network for eligible visits regardless of whether the FQHC and/or RHC is the Member's primary care physician. This requirement applies to any Subcontractor of the PH-MCO, as required by Section V.O.2.
If a FQHC/RHC has opted-out of receiving the PPS rate from the PH-MCOs, upon notification from the Department of the date that the FQHC/RHC has opt-out, the PH-MCO is no longer required to make payment at the FFS PPS rate, as noted above. Effective with the FQHC/RHC opt-out, the PH-MCO must negotiate and pay the opted-out FQHC/RHC at rates that are no less than what the PH-MCO pays to other providers who provide comparable services within the PH-MCO's Provider Network.

6. Payments to Ambulance Service Providers

Effective with dates of services beginning January 1. 2019, the PH-MCO must pay rates for certain ambulance services that are not less than the amounts listed in PA's MA fee schedule:

- Basic Life Support
- Advanced Life Support
- Air Ambulance Transport
- Ground Mileage
- Air Mileage

This requirement applies to any Subcontractor of the PH-MCO, as required by Section V.O.2.

7. Prohibited Payments

a. In compliance with the Social Security Act §1903(i)(2)(A-C) and (i)(16-18), the PH-MCO is prohibited from paying for: Medically

necessary medical services or products provided or dispensed to Members when:

i. The provider is excluded from participation under this or any other Federal funded program;

ii. The service is provided at the medical direction or on the prescription of a physician, during the period when such physician is excluded from participation under this or any other Federally funded program;

iii. When the provider furnishing the medical product or service knew or had reason to know of the ordering or referring physician's exclusion from participation under this or any other Federally funded program (after a reasonable time period after reasonable notice has been furnished to the provider); or

iv. When the Department has failed to suspend payments during any period when there is a pending investigation of credible allegation of fraud against a provider, unless the Department determines there is good cause not to suspend such payments in accordance with regulations at 42 C.F.R. 455.23 promulgated by the Secretary of Health and Human Services for purposes of Section 1862(o) of the Social Security Act.

v. Exception – When the medically necessary medical service or product is provided as an emergency service to the Member.

b. The PH-MCO shall not make payment with respect to any amount expended for which funds may not be used under the Assisted Suicide Funding Restriction Act of 1997.

c. The PH-MCO shall not make payment with respect to any amount expended for roads, bridges, stadiums, or any other item or service not covered under the Medicaid State Plan.

d. The PH-MCO shall not make payment with respect to any amount expended for home health care services provided by any agency or organization, unless the agency or organization provides the Department with a surety bond as specified in §1861(o)(7) of the Social Security Act.

8. Value Based Purchasing (VBP)

Value-based purchasing (VBP) is the Department's initiative to transition providers to being paid for the value of the services provided, rather than simply the volume of services. VBP programs and payment models are critical for improving quality of care, efficiency of services, and reducing cost. Additionally, PH-MCOs should consider implementation of strategies to integrate with BH-MCOs and address the social determinants of health through VBP arrangements, given the known improvements in health and wellbeing by doing so.

a. Strategies

The PH-MCO must enter into arrangements with Providers that incorporate VBP strategies, all of which must comply with the Physician Incentive Plan (PIP) requirements. The Department will accept any of the following arrangements as VBP strategies:

i. Provider pay for performance programs: FFS contracts in which additional payments are linked to Network Provider performance. The PH-MCO must measure Network Providers against quality benchmarks, or incremental improvement benchmarks, and must include in the contract incentives or penalties or both based upon meeting these benchmarks.

ii. PCMH: The PH-MCO must include all requirements for PCMHs as defined in Exhibit DDD to have the arrangement qualify as a PCMH for the purposes of VBP.

iii. Shared savings contractual arrangements: Supplemental payments to Network Providers if they are able to reduce health care spending relative to a benchmark, either for a defined Member population or the total Member population served by a Network Provider or practice site. The payment is a percentage of the net savings generated by the Network Provider. These arrangements may also include shared risk with Network Providers if costs are higher relative to a benchmark. The PH-MCO must measure Network Providers against quality

benchmarks, with incentives or penalties or both dependent upon meeting these benchmarks.

iv. Bundled or global payment arrangements:

a) Bundled payments include all payments for services rendered to treat a Member individual for an identified condition. The payments may either be made in bulk, or be paid over regular predetermined intervals, so long as they are prospective. Providers must also be measured against quality benchmarks, with incentives and/or penalties dependent upon meeting these benchmarks. DHS may specify certain services that must be paid through bundled payments.

b) Global payment arrangements are prospective and population based, and must cover all health needs of a defined Member population (for example, covering all care for oncology patients rather than just the chemotherapy). They can also include covering all health care delivered by certain kinds of clinicians (for example, primary care or orthopedics). These payments can either be made in bulk or delivered over regular predetermined intervals (capitation payments). The PH-MCO and Provider are organizationally distinct. Providers must be measured against quality benchmarks, with incentives or penalties or both dependent upon meeting these benchmarks.

v. Full risk or Accountable Care Organization (ACO) payment arrangements:

a) Full-risk models are defined as those models that give prospective, population-based payments to take care of the total cost of care of all Members for certain Providers, with all savings or losses to be gained or lost by the Provider group. Providers must be measured against quality benchmarks, with incentives or penalties or both dependent upon meeting these benchmarks.

b) An ACOs arrangement must have the integration of the financing arm with the delivery arm within the same organization, such that both are

collectively responsible for the total cost of care of a Member. They may include joint ventures between the PH-MCO and Provider groups, PH-MCOs that own Provider groups, or Provider groups that offer health care coverage. ACO arrangements may include shared savings and shared risk. Providers must be measured against quality benchmarks, with incentives and/or penalties dependent upon meeting these benchmarks.

The financial goals for the VBP strategies for each calendar year are based on a percentage of the PH-MCO's expenditures to the medical portion of the risk adjusted capitation and maternity revenue without consideration of risk sharing risk pools, P4P or other revenue or revenue adjustments. These goals apply collectively to all HealthChoices Agreements between the PH-MCO and the Department in all HealthChoices Zones. For the purpose of this requirement, Capitation revenue is gross of premiums for risk sharing or risk pool arrangements without adjustment for risk sharing or risk pool results. The PH-MCO must achieve the following percentages through VBP arrangements:

i Calendar year 2017 – 7.5% of the medical portion of the capitation and maternity care revenue must be expended through VBP strategies. The 7.5% may be from any combination of the five (5) strategies listed.

ii Calendar year 2018 – 15% of the medical portion of the capitation and maternity care revenue rate must be expended through VBP strategies. At least 50% of the 15% must be from a combination of strategies ii. through v.

iii Calendar year 2019 – 30% of the medical portion of the capitation and maternity care revenue rate must be expended through VBP. At least 50% of the 30% must be from a combination of strategies iii. through v.

iv Calendar year 2020 – 50% of the medical portion of the capitation and maternity care revenue rate must be expended through VBP. At least 50% of the 50% must be from a combination of strategies iii. through v.

b. Reporting

The Department will measure compliance through required reports that have been accepted by the Department. By January 1 of each calendar year, the PH-MCO must submit its proposed VBP plan to the Department that outlines and describes its plan for compliance in that calendar year. The Department will review and provide feedback on the plan to the PH-MCO. By the last work day of every quarter, the PH-MCO must submit a progress report.

By June 30 of the subsequent calendar year, the PH-MCO must submit a report on accomplishments from the prior year. This annual report must include a listing of the VBP arrangements by provider; and an explanation of each arrangement; and the dollar amount spent for medical services provided during the previous year through these arrangements. The dollar amounts that qualify toward meeting the VBP goals are as follows:

i. Provider pay for performance programs – dollar value of performance (bonus) payments and direct payments made to the Provider for Members attributed to the provider's panel during the calendar year.

ii. Patient Centered Medical Homes – dollar value of any PCMH payments, performance (bonus) payments, direct payments made to the provider and total medical costs, incurred by the PH-MCO for Members of the provider's panel during the time period of the calendar year the Member was attributed to the provider's panel.

iii. Shared savings contractual arrangements – dollar value of any performance (bonus) payments, direct payments made to the provider and total medical costs incurred by the PH-MCO for Members of the provider's panel during the time period of the calendar year the Member was attributed to the provider's panel.

iv. Bundled or global payment arrangements – dollar value of bundled payments made to providers.

v. Full risk or Accountable Care Organization payment arrangements – dollar value of any performance (bonus) payments, direct payments made to the provider and total medical costs incurred by the PH-MCO for Members of the provider's panel inclusive of any previous (bonus) payments during the time period

of the calendar year the Member was attributed to the provider's panel.

c. New Agreements

If a new PH-MCO Agreement is executed and effective during a calendar year, the reporting requirements are applicable to the calendar year that crosses Agreements, and the Department will determine compliance for the complete calendar year.

d. Assessment

This section provides for an assessment against the PH-MCO's revenue if an annual goal is not met.

Not later than 60 calendar days after receipt from the PH-MCO of the annual report on VBP accomplishments, the Department will notify the PH-MCO of its determination about compliance with the goal for the preceding year. The PH-MCO may provide a response within 30 calendar days. After considering the response from the PH-MCO, if any, the Department will notify the PH-MCO of its final determination of compliance.

If the PH-MCO fails to provide a timely and adequate report on VBP accomplishments, the Department may determine that the PH-MCO is not compliant with the goal of the preceding year.

If the determination results in a finding of non-compliance, the Department will reduce the next monthly capitation payment by an amount equivalent to one (1) percent of the capitation it paid to the PH-MCO for December of the prior calendar year.

e. Data Sharing

The PH-MCOs must provide timely and actionable data to its providers participating in VBP arrangements. This data should include, but is not limited to, the following:

i. Identification of high risk patients;

ii. Comprehensive care gaps inclusive of gaps related to quality metrics used in the VBP arrangement; and

iii. Service utilization and claims data across clinical areas such as inpatient admissions, non-inpatient facility (Short Procedure Unit/Ambulatory Surgical Center), emergency department, radiology services, lab services, durable medical equipment and supplies, specialty physician services, home health services, and prescriptions.

9. Financial Obligations when the Agreement has Ended

The Department's obligation to make payments under this HealthChoices Agreement survives the expiration or termination of the Agreement

10. Liability During an Active Grievance or Appeal

The PH-MCO shall not be liable to pay Claims to Providers if the validity of the Claim is being challenged by the PH-MCO through a Grievance or appeal, unless the PH-MCO is obligated to pay the Claim or a portion of the Claim through a separate agreement with the Provider.

11. Financial Responsibility for Dual Eligibles

Dual Eligibles age 21 and older who the Department has confirmed are enrolled in Medicare Part D will not participate in HealthChoices and will be disenrolled from HealthChoices prospectively. The PH-MCO must pay Medicare deductibles and coinsurance amounts relating to any Medicare-covered service for qualified Medicare beneficiaries up to the managed care plan Disenrollment date, in accordance with Section 4714 of the Balanced Budget Act of 1997. The PH-MCO will not be responsible for copayments or cost-sharing for Medicare Part D prescriptions.

If no contracted PH-MCO rate exists or if the Provider of the service is an Out-of-Network Provider, the PH-MCO must pay deductibles and coinsurance up to the applicable MA fee schedule for the service.

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

The PH-MCO, its Subcontractors and Providers are prohibited from balance billing Members for Medicare deductibles or coinsurance. The PH-MCO must provide a Member who is Dual Eligible access to a Medicare product or service from the Medicare Provider of his or her choice. The PH-MCO must pay any Medicare coinsurance and deductible amount, whether or not the Medicare Provider is included in the PH-MCO's Provider Network and whether or not the Medicare Provider has complied with the Prior Authorization requirements of the PH-MCO.

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 PH-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.

12. Financial Responsibility for transitioning CHC Members

A. Section 12.A applies to the PH-MCO's responsibility to provide benefits to a Member who is transitioning to CHC due to approval of LTSS and does not have a spend down period.

   i. Residence in a nursing facility is not cause for disenrollment from the PH-MCO.

   ii. The PH-MCO is responsible for nursing facility services so long as the Member is enrolled in the PH-MCO. Once the PH-MCO is notified that a Member has been determined Nursing Facility Clinically Eligible (NFCE), despite not being enrolled in CHC at the time, the PH-MCO would continue to be responsible to provide nursing facility benefits and all other covered health benefits from the thirty-first (31st) day forward.

   iii. If CIS provides a CHC start date and if the PH-MCO's responsibility to provide benefits absent this information continues up to the date prior to the CHC start date or an earlier date in the same month, the last day of the PH-MCO's responsibility to provide nursing facility benefits and all other covered health benefits is the date prior to the Member's CHC start date.

B. Section 12.B applies to the PH-MCO's responsibility to provide benefits to a Member who is transitioning to CHC due to approval for LTSS and is subject to a spend down period.

i. Residence in a nursing facility is not cause for disenrollment from the PH-MCO.

ii. The PH-MCO will not be responsible to pay the nursing facility benefits for the Member having a spend down period for any day after the thirtieth (30th) consecutive day the Member resides in the nursing facility and is a Member of this PH-MCO.

iii. The PH-MCO is responsible for all other services covered by this Agreement on the 31st consecutive day and all subsequent days that the Member is enrolled in the PH-MCO. This exemption from responsibility to pay the nursing facility will continue unabated if the Member is admitted to a hospital and returns to the nursing facility. It is acceptable for the PH-MCO to decline to accept or approve nursing facility claims for days after the thirtieth (30th) consecutive day the Member is in the nursing facility until notice is received that the Member's spend down requirement has been met.

iv. The PH-MCO's responsibility for nursing facility benefits begins the date after the spend down period is complete.

v. If CIS provides a CHC start date and if the PH-MCO's responsibility to provide benefits absent this information continues up to the date prior to the CHC start date or an earlier date in the same month, the last day of the PH-MCO's responsibility to provide nursing facility benefits and all other covered health benefits is the date prior to the Member's CHC start date. The CHC start date may be retroactive to the date the Member both received NFCE status and the spend down period commenced.

C. Section 12.C applies to the PH-MCO's responsibility to provide benefits to a Member who was determined not to be NFCE due to a penalty period.

i. Residence in a nursing facility is not cause for disenrollment from the PH-MCO.

ii. The PH-MCO will not be responsible to pay the nursing facility during the Member's penalty period, as determined by the Department.

iii. The PH-MCO is responsible for all other services covered by this Agreement during the Member's penalty period as long as the Member remains enrolled in the PH-MCO.

iv. This exemption from responsibility to pay the nursing facility will continue unabated if the Member is admitted to a hospital and returns to the nursing facility within the Member's penalty period. It is acceptable for the PH-MCO to decline to accept or approve nursing facility claims during the Member's established penalty period.

v. If the Member's penalty period has ended and the Member remained enrolled in the PH-MCO, then the PH-MCO is responsible for nursing facility benefits the day after the penalty period is complete and all subsequent days the Member remains enrolled in the PH-MCO.

vi. If CIS provides a CHC start date and if the PH-MCO's responsibility to provide benefits absent this information continues up to the date prior to the CHC start date or an earlier date in the same month, the last day of the PH-MCO's responsibility to provide nursing facility benefits and all other covered health benefits is the date prior to the Member's CHC start date, which is a date subsequent to completion of the Member's penalty period.

D. Section 12.D applies to the PH-MCO's responsibility to provide benefits to a Member who was determined not to be NFCE.

i. Residence in a nursing facility is not cause for disenrollment from the PH-MCO.

ii. The PH-MCO is responsible to pay the nursing facility after the thirtieth (30th) day of residence until the participant leaves the facility, including situations when the member passes away or is discharged prior to being determined eligible for CHC.

13. Coverage for Members in an IMD

Effective January 1, 2020, the Department will make Capitation payments for a Member aged twenty-one through sixty-four (21 – 64) residing in a freestanding IMD and the Member's condition is not related to Substance Use Disorder (SUD) based on the following criteria:

- If the stay is no more than fifteen (15) cumulative days during the period of the monthly capitation payment and the provision of inpatient psychiatric treatment in a freestanding IMD meets the requirements for *in lieu of* services in 42 C.F.R. 438.3 (e) (2)(i) through (iii), payment will be full capitation in which a Member is enrolled in the PH-MCO.
- If the stay is at least sixteen (16) cumulative days during the period of the monthly capitation payment and the provision of inpatient psychiatric treatment in a freestanding IMD meets the requirements for *in lieu of* services in 42 C.F.R. 438.3 (e) (2)(i) through (iii), the payment will be based as follows: per diem rate identified in Section VII.B.1 multiplied by the number of days the Member is both enrolled in the PH-MCO and not residing in a freestanding IMD.

14. Telephonic Psychiatric Consultation Team Services

The PH-MCO will provide documentation on the expenditure of the funds upon request.

15. Confidentiality

The Department may from time to time share with the PH-MCO an internal Business Requirements Document (BRD) or an internal Business Design Document (BDD). The Department may also elect to share FFS inpatient hospital rates and cost-to-charge ratio information with the PH-MCO. The PH-MCO shall not use this information for a purpose other than support for the PH-MCO's mission to perform its responsibilities per its Agreement with the Department and related responsibilities provided by law. The PH-MCO may share a BRD, a BDD, or the FFS/ inpatient hospital rates and cost-to-charge ratio information provided by the Department with another party, provided that the other party does not use the information for a purpose other than support for the PH-MCO's mission to perform its responsibilities per this Agreement and any other related responsibilities provided by law.

16. Audits

The PH-MCO is responsible to comply with audit requirements as specified in Exhibit WW of this Agreement, HealthChoices Audit Clause.

17. Restitution for Overpayments

The PH-MCO must make full and prompt restitution to the Department, as directed by the Department, for any payments received in excess of amounts due to the PH-MCO under this Agreement whether such overpayment is discovered by the PH-MCO, the Department, or other third party.

F. Third Party Liability

The PH-MCO must comply with the TPL procedures defined by Section 1902(a)(25) of the Social Security Act, 42 U.S.C. 1396a(a)(25) implemented by the Department. Under this Agreement, the TPL responsibilities of the Department will be allocated between the Department and the PH-MCO.

1. Cost Avoidance Activities

a. The PH-MCO will have primary responsibility for cost avoidance through the COB relative to federal and private health insurance-type resources including, but not limited to, Medicare, private health insurance, ERISA plans, and Workers Compensation. Except as provided in subparagraph b., the PH-MCO must attempt to avoid initial payment of Claims, whenever possible, where federal or private health insurance-type resources are available. The number of claims cost avoided by the MCO's claims system should be reported in Financial Report #8A, “Claims Cost Avoided.” The PH-MCO shall not be held responsible for any TPL errors in the Department's Eligibility Verification System (EVS) or the Department's TPL file.

b. The PH-MCO and its Subcontractors must pay, and then chase all Clean Claims for 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 PH-MCO is notified by the Department of such support orders or to the extent the PH-MCO becomes aware of such orders, and then seek reimbursement from liable third parties. The PH-MCO recognizes that cost avoidance of

these claims is prohibited with the exception of hospital delivery claims, which may be cost-avoided.

c. The PH-MCO may not deny or delay approval of otherwise covered treatment or services based upon TPL considerations. The PH-MCO may neither unreasonably delay payment nor deny payment of claims unless the existence of TPL 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. Other resources include, but are 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. The Department is assigned the Contractor's subrogation rights to collect the "Other Resources" covered by this provision. Any correspondence or Inquiry forwarded to the PH-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 Member and the services which were provided, must be immediately forwarded to the Department's Division of TPL. The PH-MCO may neither 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.

With respect to any third party payment received by the PH-MCO from a Provider, the PH-MCO shall return all casualty funds to the Department. PH-MCOs shall not instruct providers to send funds directly to the Department. These third party payments shall not be held by the PH-MCO for more than 30 calendar days. If the casualty funds received by

the Department must be returned to the PH-MCO for any reason, for example, an outdated check or the amount of the check does not match supporting documentation, the PH-MCO shall have 60 calendar days to return all casualty funds to the Department using the established format.

The PH-MCO must pursue, collect and retain recoveries of a claim involving Workers' Compensation.

c. Due to potential time constraints involving cases subject to litigation and due to the large dollar value of many claims which are potentially recoverable by the Department's Division of TPL, 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 PH-MCO's untimely submission of notice of legal involvement where the PH-MCO has received such notice, the amount of the Department's actual loss of recovery shall be assessed against the PH-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. 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 or 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 PH-MCO.

e. Encounter Data that is not submitted to the Department in accordance with the data requirements and/or time frames identified in this Agreement can possibly result in a loss of revenue to the Department. Strict compliance with these requirements and time frames shall therefore be enforced by the Department and could result in the assessment of penalties against the PH-MCO.

f. The PH-MCO has the sole and exclusive responsibility and right to pursue, collect and retain all health-related insurance resources for a period of nine (9) months from the date of service or six (6) months after the date of payment, whichever is later. The PH-MCO must indicate their intent to recover on health-related insurance by providing to the Department an

electronic file of those cases that will be pursued. The cases must be identified and a file provided to the Department by the PH-MCO within the window of opportunity afforded by the nine (9) months from the date of service or six (6) months after the date of payment unless otherwise granted by the Department. The Department's Division of TPL may pursue, collect and retain recoveries of all health-related insurance cases which are outstanding, that is, not identified by the PH-MCO for recovery, after the later of nine (9) months from the date of service or six (6) months after the date of payment. Notification of intent to pursue, collect and retain health-related insurance is the sole responsibility of the PH-MCO, and cases not identified for recovery will become the sole and exclusive right of the Department to pursue, collect and retain. In such cases where the PH-MCO has identified the cases to be pursued, the PH-MCO shall retain the exclusive responsibility for the cases for a period not to exceed eighteen (18) months. The calculation of the eighteen (18) month period shall commence with receipt of the file from the PH-MCO identifying the cases to be pursued. Any case not completed within the eighteen (18) month period will become the sole and exclusive right of the Department to pursue, collect and retain. The PH-MCO is responsible to notify the Department through the prescribed electronic file process of all outcomes for those cases identified for pursuit. Cases included in Encounter files that were suspended will not be able to be included in the flagging process since the Claims cannot be adjusted in the Department's automated processing system.

With respect to any third party payment received by the PH-MCO from a Provider, the PH-MCO shall ensure that the funds are within their right of recovery following the proscribed order outlined above. If the funds are outside the allowable recovery window, the funds shall be returned to the Department. These third party payments shall not be held by the MCO for more than 30 calendar days. If the provider funds received by the Department must be returned to the PH-MCO for any reason, for example, an outdated check or the amount of the check does not match supporting documentation, the PH-MCO shall have 60 calendar days to return all provider funds to the Department using the established format.

3. Health Insurance Premium Payment Program

The HIPP Program pays for employment-related health insurance for Recipients when it is determined to be cost effective.

4. Requests for Additional Data

The PH-MCO must provide, at the Department's request, information not included in the Encounter Data submissions that may be necessary for the administration of TPL activity. The PH-MCO must provide this information within fifteen (15) calendar days of the Department's request. The PH-MCO must respond to Urgent requests within forty-eight (48) hours. Confidentiality of the information must be maintained as required by Federal and State regulations. The Department may request information such as individual medical records for the express purpose of determining TPL for the services rendered.

5. Accessibility to TPL Data

The Department will provide the PH-MCO with access to data maintained on the TPL monthly file.

6. Third Party Resource Identification

The PH-MCO must supply to the Department's TPL Division Third Party Resources identified by the PH-MCO or its Subcontractors, which do not appear on the Department's TPL database, within two weeks of its receipt by the PH-MCO must be supplied to the Department's TPL Division by the PH-MCO. In addition to newly identified resources, the PH-MCO must provide information on coverage for other household members, addition of a coverage type, changes to existing resources, including termination of coverage and changes to coverage dates to the Department's TPL Division. The method of reporting must be by electronic file or by any alternative method approved by the Department. TPL resource information must be submitted within two weeks of its receipt by the PH-MCO. A web-based referral is only to be submitted in the following instance: the PH-MCO is no longer the recipient's MCO or the Contract/Policy ID number is longer than 12 digits, or HIPP Referrals. For web-based referrals, the PH-MCO must use an exact replica of the TPL resource referral form supplied by the Department. For electronic submissions, the PH-MCO must follow the required report format, data elements, and specifications supplied by the Department.

The Department will contact the PH-MCO when the validity of a resource is in question. The PH-MCO shall verify inconclusive resource information within two (2) business days of notification by

the Department that the resource information is in dispute. Unless the verification notification is requested on the last business day of the week, then the PH-MCO must respond by the close of business that day to avoid a potential access to care issue for the Member.

The PH-MCO must use the Department's verification systems (EVS) and secured services on the internet (previously known as 'POSNet') to identify insurance information the recipients have on file. If there is additional or different insurance information the PH-MCO or their Subcontractors must communicate the information as directed above.

7. Estate Recovery

The Department's Division of TPL is solely responsible for administering the Estate Recovery Program.

SECTION VIII: REPORTING REQUIREMENTS

A. General

The PH-MCO must comply with state and federal reporting requirements that are set forth in this section and throughout this Agreement.

The PH-MCO must certify data submitted to the Department as required by 42 C.F.R. §438.604, whether in written or electronic form. The PH- MCO must submit certification concurrently with the certified data and the certification of accuracy, completeness and truthfulness of the data must be based on the knowledge, information and belief of the CEO, CFO or an individual who has delegated authority to sign for, and who reports directly to the CEO or CFO.

The PH-MCO will provide the certification via hard copy or electronic format, on the form provided by the Department.

B. Systems Reporting

The PH-MCO must submit electronic data as specified by the Department. To the extent possible, the Department will provide reasonable advance notice of modifications or additions to required electronic data submissions.

Information on the submission of the Department's data files is available on the Pennsylvania HealthChoices Extranet site.

1. Encounter Data Reporting

The PH-MCO must record for internal use and submit complete, timely, and accurate Encounter Data to the Department. The PH-MCO shall only submit Encounter Data for Members enrolled in its plan on the date of service and must not submit duplicate records.

The PH-MCO must maintain appropriate systems and mechanisms to obtain all data from its Health Care Providers needed to comply with Encounter Data reporting requirements. Failure of a Health Care Provider or Subcontractor to provide the PH-MCO with necessary Encounter Data shall not excuse the PH-MCO's noncompliance with this requirement.

The Department will provide a minimum of sixty (60) days advance written notice to the PH-MCO regarding changes to Encounter Data requirements.

a. Data Format

The PH-MCO must submit Encounter Data to the Department using established protocols. Prior to submission of production data, the PH-MCO must pass Encounter Data certification for all transaction types.

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

- 837P
  - Professional
  - Professional Crossover
  - Professional Drug
- 837I
  - Inpatient
  - Inpatient Crossover
  - Outpatient
  - Outpatient Crossover
  - Outpatient Drug
  - LTC
- 837D
  - Dental
- NCPDP D.0
  - NCPDP Pharmacy
  - Compound Pharmacy

b. Timing of Data Submittal

i. Provider Claims

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

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

ii. Encounter Submissions

All Encounter Data except NCPDP transactions must be submitted by the PH-MCO and approved by the Department on or before the last calendar day of the third month after the adjudication calendar month in which the PH-MCO adjudicated the Claim. NCPDP transactions must be submitted to and approved in the Department's MMIS within thirty (30) days following the PH-MCO adjudication date.

Encounter Data sent to the Department is considered approved when all Department edits are passed.

A file with Encounter Data records that deny due to Department edits will be sent to the PH-MCO. These records must be corrected and resubmitted as "new" Encounter records if appropriate and within the timeframes referenced above.

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

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

iii. Encounter File Specifications

The PH-MCO must adhere to the file size, format specifications, and agreed upon submission schedule.

iv. Response Files

The PH-MCO Encounter Data system must have a mechanism in place to receive, process, and reconcile the U277, NCPDP, and ESC Supplemental response files. The PH-MCO must also store the Department's MMIS ICN associated with each processed Encounter Data record returned on the files.

c. Data Completeness

The PH-MCO must submit Encounter Data each time a Member has an Encounter with a Health Care Provider. The PH-MCO must have a data completeness monitoring program in place that:

i. Demonstrates that all Claims and Encounters submitted to the PH-MCO by its Health Care Providers and Subcontractors are submitted accurately and timely as Encounters and that denied Encounters are resolved and resubmitted;

ii. Evaluates Health Care Provider and Subcontractor compliance with contractual reporting requirements; and

iii. Demonstrates the PH-MCO has processes in place to act on the information from the monitoring program and takes appropriate action to ensure full compliance with Encounter Data reporting.

The PH-MCO must submit upon request from the Department a Data Completeness Plan for review and approval. This plan must include the three elements listed above.

d. Financial Sanctions

The PH-MCO must provide complete, accurate, and timely Encounter Data to the Department. In addition, the PH-MCO must maintain complete medical service history data.

The Department will request the PH-MCO submit a Corrective Action Plan when areas of noncompliance are identified.

The Department may assess financial sanctions as provided in Exhibit XX, Encounter Data Submission Requirements and Sanctions, based on the identification of instances of non-compliance.

e. Data Validation

The PH-MCO will assist the Department in its validation of Encounter Data by making available medical records and Claims data as requested. The validation may be completed by Department staff, an independent, external review organizations or both.

In addition, the PH-MCO must validate files sent to them when requested.

f. Secondary Release of Encounter Data

The Department owns all Encounter Data recorded to document services rendered to Recipients. Access to this data is provided to the PH-MCO and its agents for the sole purpose of operating the HealthChoices Program. The PH-MCO and its agents are prohibited from releasing any data resulting from this Agreement to any third party without the advance written approval of the Department. This prohibition does not apply to internal quality improvement or Disease Management activities undertaken by the PH-MCO or its agents in the routine operation of a managed care plan.

g. Drug Rebate Supplemental File

The PH-MCO must submit a complete, accurate and timely monthly file containing supplemental data for NCPDP, 837P Professional Drug, and 837I Outpatient Drug transactions used for the purpose of drug rebate dispute resolution. The PH-MCO must submit the file by the 15th day of the month following the month in which the drug transaction was processed in the Department's MMIS as specified on the Pennsylvania HealthChoices Extranet site.

2. Third Party Liability Reporting

Third Party Resources identified by the PH-MCO or its Subcontractors, which do not appear on the Department's TPL database, must be supplied to the Department's Division of TPL within two weeks of its receipt by the PH-MCO. The Department will

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

3. PCP Assignment for Members

The PH-MCO must provide a weekly file (EVS/PCP) to the Department of PCP assignments for all its Members. This file is used to update the Department's Eligibility Verification System.

The PH-MCO must provide this file at least weekly or more frequently if requested by the Department. The PH-MCO must confirm that the PCP assignment information is consistent with all requirements specified by the Department by utilizing the response report provided by the Department. The PH-MCO must use this report to reconcile and correct any errors. The PH-MCO must comply with the file submission requirements found on the Pennsylvania HealthChoices Extranet.

4. Provider Network

The PH-MCO must provide a monthly Network Provider File (PRV640M) to the Department. The initial file must contain records for its entire Provider Network, including Subcontractors. Subsequent monthly files should contain only updates.

The PH-MCO must confirm the information is consistent with all requirements by utilizing the response report (PRM640M) provided by the Department. The PH-MCO must use this report to reconcile and correct any errors. The PH-MCO must comply with the file submission requirements on the Pennsylvania HealthChoices Extranet.

5. Alerts

The PH-MCO must report to the Department on a Weekly Enrollment/Disenrollment/Alert file: pregnancy (not on CIS), death (not on CIS), newborn (not on CIS) and returned mail.

The PH-MCO must confirm the information is consistent with all requirements specified by the Department on the Pennsylvania HealthChoicesExtranet.

6. Maternity Care

The PH-MCO must submit maternity care claims to the Department using established protocols. Prior to submission of production data, the PH-MCO must pass Maternity Care certification for all transaction types.

The PH-MCO must use either an 837P transaction or the Internet to submit information on maternity events and confirm the information is consistent with all requirements specified by the Department on the Pennsylvania HealthChoices Extranet.

C. Operations Reporting

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

1. Federal Waiver Reporting Requirements

As a condition of approval of the Waiver for the operation of HealthChoices in Pennsylvania, CMS has imposed specific reporting requirements related to the Home and Community Based Waiver. In the event that CMS requests this information, the PH-MCO must provide the information necessary to meet these reporting requirements. To the extent possible, the Department will provide reasonable advance notice of the required reports.

2. Fraud and Abuse

The PH-MCO must submit to the Department quarterly statistical reports which relate to its Fraud and Abuse detection and sanctioning activities regarding Providers. The PH-MCO must include information for all situations where a Provider action caused an overpayment to occur and must identify cases under review

(including approximate dollar amounts), Providers terminated due to Medicare/Medicaid preclusion, overpayments recovered and cost avoidance issues related to identifying and/or identified fraud, waste, and abuse (42 C.F.R. 438.608(a)(2)).

The PH-MCO must comply with all requirements regarding Operations Report format and timeframes provided on the DHS/PH-MCO DocuShare Reporting pages and the Pennsylvania HealthChoices Extranet at Managed Care Program/*Fraud and Abuse.*

D. Financial Reports

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

The Department will distribute financial reporting requirements to the PH-MCO. The PH-MCO must furnish all financial reports timely and accurately, with content in the format prescribed by the Department. This includes, but is not limited to, the HealthChoices financial reporting requirements issued by the Department on the Pennsylvania HealthChoices Extranet at Managed Care Program/*Program Information-Reporting Requirements.*

E. Equity

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

- A copy of quarterly reports filed with PID, for the quarter ending the last day of the second (2nd) previous month.
- A statement that its Equity is in compliance with the Equity requirements or is not in compliance with the Equity requirements.
- If Equity is not in compliance with the Equity requirements, a report that provides an analysis of its fiscal health and steps that management plans to take, if any, to improve fiscal health.

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

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

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

F. Claims Processing Reports

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

If the PH-MCO fails to submit a timely, accurate fully compliant Claims processing report, The Department may impose the following assessments: up to $200 per calendar day for the first ten (10) calendar days from the date that the report is due and up to $1,000 per day for each calendar day thereafter.

G. Presentation of Findings

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

H. Sanctions

1. Sanctions may be imposed when a PH-MCO acts or fails to act as follows:

    - Fails substantially to arrange for Medically Necessary services that the PH-MCO is required to provide under law or under this Agreement to a Member covered under the Agreement.

    - Imposes on Members premiums or charges that are in excess of the premiums or charges permitted under the MA Program.

    - Acts to discriminate among Members on the basis of their health status or need for health care services.

    - Misrepresents or falsifies information that it furnishes to CMS, the Department, Members, potential Members, or Health Care Providers.

    - Fails to comply with requirements for PIPs as set forth in 42 C.F.R. §§422.208 and 422.210.

- Fails to comply with the Agreement requirements pertaining to Program Integrity and Fraud, Waste and Abuse.

- Has distributed directly or indirectly through any agent or independent contractor, marketing materials that have not been approved by the Department or that contain false or materially misleading information.

The Department may impose sanctions as may be applicable for noncompliance with the requirements under this Agreement, failure to meet applicable requirements of the Social Security Act and 42 C.F.R. Subpart I. The sanctions which may be imposed will depend on the nature and severity of the noncompliance, which the Department, in its reasonable discretion, will determine as follows:

a. Imposing civil monetary penalties of a minimum of $1,000.00 per calendar day for noncompliance;

b. Requiring the submission of a corrective action plan;

c. Limiting Enrollment of new Recipients;

d. Suspension of payments;

e. Temporary management subject to applicable federal or state law;

f. Termination of the Agreement: The Department may terminate a PH-MCO Agreement and enroll its Members in another PH-MCO or provide MA benefits through other options included in the State plan.

2. Where this Agreement provides for a specific sanction, the Department may, at its discretion, apply the specific sanction provided for the noncompliance or apply any of the general sanctions set forth in this section. Specific sanctions contained in this Agreement include the following:

a. Claims Processing: Sanctions related to Claims processing are provided in Section VII D. of this Agreement, Claims Processing Standards, Monthly Reports and Sanctions.

b. Report or File Reports, exclusive of Audit Reports: If the PH-MCO fails to provide any report or file that is specified by this Agreement by the applicable due date, or if the PH-MCO provides any report or file specified by this Agreement that

does not meet established criteria, the Department may reduce a subsequent payment to the PH-MCO. The reduction shall equal the number of days that elapse between the due date and the day that the Department receives a report or file that meets established criteria, multiplied by the average PMPM Capitation rate that applies to the first (1st) month of the Agreement year. If the PH-MCO provides a report or file on or before the due date, and if the Department notifies the PH-MCO after the fifteenth (15th) calendar day after the due date that the report or file does not meet established criteria, no reduction in payment shall apply to the sixteenth (16th) day after the due date through the date that the Department notifies the PH-MCO.

c. Encounter Data Reporting: The Sanctions related to the submission of Encounter Data are set forth in Section VIII.B, Systems Reports, and Exhibit XX, Encounter Data Submission Requirements and Sanctions.

d. Marketing: The sanctions for engaging in unapproved marketing practices are described in Section V.F.3, PH-MCO Outreach Activities.

e. Access Standard: The sanction for noncompliance with the access standard is set forth in Exhibit AAA, as applicable, Provider Network Composition/Service Access, Part 4, Compliance with Access Standards.

f. Subcontractor Prior Approval: The PH-MCO's failure to obtain advance written approval of a Subcontract will result in the application of a penalty of one (1) month's Capitation rate for a categorically needy adult female TANF consumer for each day that the Subcontractor was in effect without the Department's approval.

g. Outpatient Drug Encounters: Sanctions for non-compliance with outpatient drug encounter data timeliness is set forth in Exhibit BBB, 9. Outpatient Drug Encounters.

h. Pursuant to 42 C.F.R. 438.704(c), if the State imposes a civil monetary penalty on the PH-MCO for charging premiums or charges in excess of the amounts permitted under Medicaid, the State will deduct the amount of the overcharge from the penalty and return it to the affected enrollee.

I. Non-Duplication of Financial Penalties

The Department will not assess duplicate financial sanctions for non-compliance where financial sanctions have already been issued.

J. Provider-Preventable Conditions

1. In compliance with 42 C.F.R. 434.6(a)(12)(i) and 447.26 (d) the PH-MCO will report all identified provider-preventable conditions in the form and frequency detailed in the MCO Operations Reporting Requirements on Docushare.

2. The PH-MCO is prohibited from making payment to a provider for provider-preventable conditions that meet the following criteria:

a. Is identified in the State Plan;
b. Has been found by the State, based upon a review of medical literature by qualified professionals, to be reasonably preventable through the application of procedures supported by the evidence-based guidelines;
c. Has a negative consequence for the beneficiary;
d. Is auditable;
e. Includes, at a minimum, wrong surgical or other invasive procedure performed on a patient; surgical or other invasive procedure performed on the wrong body part; surgical or other invasive procedure performed on the wrong patient.

SECTION IX: REPRESENTATIONS AND WARRANTIES OF THE PH-MCO

A. Accuracy of Proposal

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

B. Disclosure of Interests

1. The PH-MCO must:

a. Disclose to the Department, in writing, the name of any person or entity having a direct or indirect ownership or control interest of five percent (5%) or more in the PH-MCO;

b. Inform the Department, in writing, of any change in or addition to the ownership or control of the PH-MCO;

c. Submit to the Department the date of birth and Social Security Number (SSN) of and individual with an ownership or control interest in the PH-MCO and its subcontractors;

d. Submit to the Department other tax identification number of any corporation with an ownership or control interest in the PH-MCO and any subcontractor in which the PH-MCO has a five percent (5%) or more interest;

e. Submit information on whether an individual or corporation with an ownership or control interest in the PH-MCO is related to another person with ownership or control interest in the PH-MCO as a spouse, parent, child, or sibling;

f. Submit information on whether a person or corporation with an ownership or control interest in any subcontractor in which the PH-MCO has a five percent (5%) or more interest is related to another person with ownership or control interest in the PH-MCO as a spouse, parent, child, or sibling; and

g. Submit the name, address, date of birth, and SSN of any managing employee of the PH-MCO.

2. In accordance with 42 C.F.R. 455.104, the PH-MCO must disclose the following information to the state for any person or corporation with ownership or control interest in the PH-MCO:

a. Name and address (the address for corporate entities must include as applicable primary business address, every business location, and P.O. Box address);

b. Date of birth and Social Security Number (in the case of an individual);

c. Other tax identification number (in the case of a corporation);

d. Whether the person (individual or corporation) with an ownership or control interest in the PH-MCO or a PH-MCO subcontractor is

related to another person with ownership or control interest in the PH-MCO as a spouse, parent, child, or sibling;

e. The name of any other Medicaid provider or fiscal agent in which the person or corporation has an ownership or control interest; and

f. The name, address, date of birth and Social Security Number of any managing employee of the PH-MCO.

Such disclosure must be made within thirty (30) calendar days of any change or addition. The PH-MCO agrees that any failure to comply with this provision in any material respect, or making of any misrepresentation which would cause the PH-MCO to be precluded from participation in the MA Program, shall entitle the Department to recover all payments made to the PH-MCO subsequent to the date of the misrepresentation.
Pursuant to Section 1903(m)(4)(B) of the Social Security Act the PH-MCO will make reports of any transactions between the PH-MCO and parties in interest that are provided to the State or other agencies available to PH-MCO enrollees upon reasonable request.

C. Disclosure of Change in Circumstances

The PH-MCO will report to the Department, as well as the DOH and PID, within ten (10) Business Days of the PH-MCO's notice of same, any change in circumstances that may have a material adverse effect upon financial or operational conditions of the PH-MCO, its Affiliates or Related Parties. Such reporting must be provided upon the occurrence of, by way of example and without limitation, the following events, any of which must be presumed to be material and adverse:

1. Suspension or intent of Suspension, debarment or exclusion of PH-MCO, PH-MCO's parent(s), or any Affiliate or Related Party of either, by any state or the federal government;

2. Suspension or intent of Suspension, debarment or exclusion of a director, officer, partner or person with beneficial ownership of more than five percent (5%) of the PH-MCO's Equity.

3. Notice of an intent to suspend, debar or exclude issued by any state or the federal government to PH-MCO, PH-MCO's parent(s), any Affiliate or Related Party of either, any individuals with employment, consulting or other arrangements that are material and significant; and

4. Any new or previously undisclosed lawsuits or investigations by any federal or state agency involving PH-MCO, PH-MCO's parent(s), or any Affiliate or Related Party of either, which would have a material impact upon the PH-MCO's financial condition or ability to perform under this Agreement.

SECTION X: TERMINATION AND DEFAULT

A. Termination by the Department

In conjunction with termination provisions in Section 18 of Exhibit D, Standard Terms and Conditions for Services, this Agreement may be terminated by the Department upon the occurrence of any of the following events and upon compliance with the notice provisions set forth below:

1. Termination for Convenience Upon Notice

Under Section 18.a of Exhibit D, Standard Terms and Conditions for Services, the Department may terminate this Agreement at any time for convenience upon giving one hundred twenty (120) days advance written notice to the PH-MCO. If the PH-MCO notifies the Department of its intent to terminate or terminates an agreement with the Department to provide services for any Physical Health HealthChoices zone, any HealthChoices Program, including the Behavioral Health HealthChoices Program or Community HealthChoices Program or the Children's Health Insurance Program, the Department, in its sole discretion, may terminate this Agreement for its convenience upon giving one hundred twenty (120) days advance written notice to the PH-MCO. The effective date of the termination shall be the last day of the month in which the one hundred twentieth (120th) day falls. The Department is not required to provide one hundred twenty (120) days advance notice if the Department and the PH-MCO are entering into a new agreement the Physical Health HealthChoices Program in the same zone.

2. Termination for Cause

Under Section 18.c of Exhibit D, Standard Terms and Conditions for Services, the Department may terminate this Agreement for cause upon forty-five (45) days written notice, which notice shall set forth the grounds for termination and, with the exception of termination under Section XI.A.2.b below, shall provide the PH-MCO with forty-five (45) days in which to implement corrective action and cure the deficiency. If corrective action is not implemented to the satisfaction of the Department within the forty-five (45) day cure period, the termination shall be effective at the expiration of the forty-five (45)

day cure period. In addition to the provisions of Section 16 Default of Exhibit D, Standard Terms and Conditions for Services,

a. An act of theft or Fraud against the Department, any state agency, or the Federal Government; or

b. An adverse material change in circumstances as described in Section IX.C, Disclosure of Change in Circumstances.

3. Termination Due to Unavailability of Funds/Approvals

In addition to Section 18.b of Exhibit D, Standard Terms and Conditions for Services, the Department may terminate this Agreement immediately upon the occurrence of any of the following events:

a. Notification by the United States Department of Health and Human Services of the withdrawal of FFP in all or part of the cost hereof for covered services;

b. Notification of the unavailability of funds available for the HealthChoices Program; or

c. Notification that the federal approvals necessary to operate the HealthChoices Program shall not be retained; or

d. Notification by the PID or DOH that the authority under which the PH-MCO operates is subject to suspension or revocation proceedings or sanctions, has been suspended, limited, or curtailed to any extent, or has been revoked, or has expired and shall not be renewed.

B. Termination by the PH-MCO

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

C. Responsibilities of the PH-MCO Upon Termination

1. Continuing Obligations

Termination or expiration of this Agreement shall not discharge the PH-MCO of obligations with respect to services or items furnished prior to termination, including retention of records and verification of

overpayments or underpayments. Termination or expiration shall not discharge the Department's payment obligations to the PH-MCO or the PH-MCO's payment obligations to its Subcontractors and Providers.

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

a. Provide the Department with all information deemed necessary by the Department within thirty (30) days of the request;

b. Be financially responsible for MA Claims with dates of service through the day of termination, except as provided in c. below, including those submitted within established time limits after the day of termination;

c. Be financially responsible for hospitalized patients through the date of discharge or thirty-one (31) days after termination or expiration of this Agreement, whichever is earlier;

d. Be financially responsible for services rendered through 11:59 p.m. on the day of termination, except as provided in c. above or f. below, for which payment is denied by the PH-MCO and subsequently approved upon appeal by the Provider;

e. Be financially responsible for Member appeals of adverse decisions rendered by the PH-MCO concerning treatment of services requested prior to termination that would have been provided but for the denial prior to termination, which are subsequently overturned at a DHS Fair Hearing or Grievance proceeding; and

f. Arrange for the orderly transfer of patient care and patient records to those Providers who will be assuming care for the Member.

2. Notice to Members

In the event that this Agreement is terminated, or expires without a new Agreement in place, the PH-MCO must notify all Members of such termination or such expiration at least forty-five (45) days in advance of the effective date of termination or expiration, if practical. Notice must be made available in an accessible format for individuals with visual impairments and in the relevant language for Members with limited English proficiency. The PH-MCO must coordinate the

continuation of care prior to termination or expiration for Members who are undergoing treatment for an acute condition.

3. Submission of Invoices

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

4. Termination Requirements

In addition to the termination requirements specified in this section, the PH-MCO must also provide the Department with all outstanding Encounter Data. If either the Department or the Contractor provides written notice of termination, the Department will withhold ten percent (10%) of one (1) month's Capitation payment. Once the Department determines that the Contractor has substantially complied with the requirements in this section, the Department will pay the withheld portion of the Capitation payment to the PH-MCO. The Department will not unreasonably delay or deny a determination that the PH-MCO has substantially complied. The Department will share with the PH-MCO the determination on substantial compliance by the first (1st) day of the fifth (5th) month after the Agreement ends. If the Department determines that the PH-MCO has not substantially complied, the Department will share a subsequent determination by the first (1st) day of each subsequent month.

D. Transition at Expiration or Termination of Agreement

If the PH-MCO and the Department have not entered into a new Agreement for any of the HealthChoices Zones covered by this Agreement, the Department will develop a transition plan. During the transition period, the PH-MCO must cooperate with any subsequent PH-MCO and the Department. As part of the transition plan, the Department will define the program information and the working relationship between the PH-MCOs. The Department will consult with the PH-MCO regarding such information and relationship. The length of the transition period shall be no less than three (3) months and no more than six (6) months in duration.

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

The PH-MCO must provide necessary information to a PH-MCO and the Department during the transition period to ensure a smooth transition of responsibility. The Department will define the information required during this period and time frames for submission and may solicit input from the PH-MCOs involved.

SECTION XI: RECORDS

A. Financial Records Retention

1. The PH-MCO must maintain and must cause its Subcontractors to maintain all books, records, and other evidence pertaining to revenues, expenditures, and other financial activity pursuant to this Agreement in accordance with the standards and procedures specified in Section V.O.3, Records Retention.

2. The PH-MCO will submit to the Department or to the Secretary of Health and Human Services or their designees, within thirty-five (35) calendar days of a request, information related to the PH-MCO's business transactions which are related to the provision of services for the HealthChoices Program which shall include full and complete information regarding:

    a. The PH-MCO's ownership of any Subcontractor with whom the PH-MCO has had business transactions totaling more than $25,000 during the twelve (12) month period ending on the date of the request; and

    b. Any significant business transactions between the PH-MCO and any wholly-owned supplier or between the PH-MCO and any Subcontractor during the five (5) year period ending on the date of the request.

3. The PH-MCO will include the requirements set forth in Section XII, Subcontractual Relationships, in all contracts it enters with Subcontractors under the HealthChoices Program.

B. Operational Data Reports

The PH-MCO must maintain and must cause its Subcontractors to maintain all source records for data reports in accordance with the procedures specified in Section V.O.3, Records Retention.

C. Medical Records Retention

The PH-MCO must maintain and must cause its Subcontractors to maintain all medical records in accordance with the procedures outlined in Section V.O.3, Records Retention.

The PH-MCO must provide Members' medical records, subject to this Agreement, to the Department or designee within twenty (20) Business Days of the Department's request. The PH-MCO must mail copies of such records to the Department if requested.

D. Review of Records

1. The PH-MCO must make all records relating to the HealthChoices Program, including but not limited to the records referenced in this Section, available for audit, review, or evaluation by the Department, the Pennsylvania Office of Attorney General Medicaid Fraud Control Unit, and federal agencies or their designees. Such records shall be made available on site at the PH-MCO's chosen location, subject to the Department's approval, during normal business hours or through the mail. The Department will, to the extent required by law, maintain as confidential any confidential information provided by the PH-MCO.

   On request, and consistent with state and federal confidentiality obligations, the PH-MCO must furnish to DHS, the Pennsylvania Office of Attorney General Medicaid Fraud Control Unit and federal agencies or their designees any information regarding payments claimed by the provider for furnishing services under the plan.

   Consistent with state and federal confidentiality obligations, the Department, the Pennsylvania Office of Attorney General Medicaid Fraud Control Unit, and federal agencies or their designees are entitled to the inspection and audit of records or documents and to have access to facilities of the MCO, PIHP, PAHP, or its Subcontractors, at any time, to inspect and audit any records or documents and may, at any time, inspect the premises, physical facilities, and equipment where Medicaid-related activities or work is conducted.

2. In the event that the Department, the Pennsylvania Office of Attorney General Medicaid Fraud Control Unit or federal agencies request access to records, after the expiration or termination of this Agreement or at such time that the records no longer are required by the terms of this Agreement to be maintained at the PH-MCO's location, but in any case, before the expiration of the retention period,

the PH-MCO, at its own expense, must send copies of the requested records to the requesting entity within thirty (30) calendar days of such request.

SECTION XII: SUBCONTRACTUAL RELATIONSHIPS

A. Compliance with Program Standards

With the exception of Provider Agreements, the PH-MCO will comply with the procedures set forth in Section V.O.2, Contracts and Subcontracts and in Exhibit II, Required Contract Terms for Administrative Subcontractors.

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

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

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

1. A requirement for the submission of all Encounter Data for services provided within the time frames required in Section VIII, Reporting Requirements, no matter whether reimbursement for these services is made by the PH-MCO either directly or indirectly through capitation.

2. Language which ensures compliance with all applicable federal and state laws.

3. Language which prohibits gag clauses which would limit the Subcontractor from disclosure of Medically Necessary or appropriate health care information or alternative therapies to Members, other Health Care Providers, or to the Department.

4. A requirement which provides the Department with ready access to any and all documents and records of transactions pertaining to the provision of services to Recipients.

5. The definition of Medically Necessary as outlined in Section II, Definitions.

6. If applicable, adherence to the standards for Network composition and adequacy in the Subcontracts.

7. Compliance with the requirements of Section V.B.1, General Prior Authorization Requirements for Subcontracts for utilization review services.

8. A transition plan for Subcontracts with an entity to provide any information systems This transition plan must include information on how the data, including all historical Claims and service data shall be converted and made available to a new Subcontractor.

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

B. Consistency with Regulations

The PH-MCO agrees that its agreements with all Subcontractors must be consistent, as may be applicable, with DOH regulations governing HMO Contracting with Integrated Delivery Systems at 28 Pa. Code §§ 9.721 – 9.725 and PID regulations at 31 Pa. Code §§ 301.301 – 301.314.

SECTION XIII: CONFIDENTIALITY

A. The PH-MCO agrees to comply with applicable federal and state laws regarding the confidentiality of medical information, as it more fully set forth below. The PH-MCO must also cause that each of its Subcontractors comply with such applicable laws. To facilitate the efficient administration of the Medical Assistance Program and to enhance the treatment of Members requiring behavioral health or other services not the responsibility of the PH-MCO, the PH-MCO shall receive all information relating to the health status of its Members, by the exchange of data and other such mechanisms the Department may approve. To further integrate and coordinate health care for Members who need behavioral health services that are not the responsibility of the PH-MCO, the PH-MCO shall disclose to the BH-MCO all information relating to the health of its Members, by the

exchange of data and such other mechanisms as the Department may approve.

The federal and state laws with regard to confidentiality of medical records include, but are not limited to: Mental Health Procedures Act, 50 P.S. 7101 et seq.; Confidentiality of HIV-Related Information Act, 35 P.S. 7601 et seq.; 45 C.F.R. Parts 160 and 164 (Standards for Privacy of Individually Identifiable Health Information); and the Pennsylvania Drug and Alcohol Abuse Control Act, 71 P.S. 1690.101 et seq., 42 U.S.C. 1396a(a)(7); 62 P.S. 404; 55 Pa. Code 105.1 et seq.; and 42 C.F.R. 431 et seq.

B. The PH-MCO will be liable for any state or federal fines, financial penalties, or damages levied upon the Department for a breach of confidentiality due to the conduct of the PH-MCO in relation to the PH-MCO's systems, staff, or other area of responsibility.

C. The PH-MCO will return all data and material obtained in connection with this Agreement and the implementation thereof, including confidential data and material, at the Department's request. The PH-MCO is prohibited from using material for any purpose after the expiration or termination of this Agreement.

D. To facilitate the efficient administration of the Medical Assistance Program and to enhance the treatment of Members who need behavioral health or other services that are not the responsibility of the PH-M CO, the PH-MCO may receive all information relating to the health status of its Members, including treatment information, by the exchange of data and other such mechanisms as the Department approves, in accordance with applicable federal and state confidentiality laws.

SECTION XIV: INDEMNIFICATION AND INSURANCE

A. Indemnification

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

federal government that the terms of this Agreement are not in accordance with federal law. The obligations under this paragraph shall survive any termination or cancellation of this Agreement.

B. Insurance

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

SECTION XV: DISPUTES

A. In the event that a dispute arises between the parties relating to any matter regarding this Agreement, the PH-MCO must send written notice of an initial level dispute to the Contracting Officer, who will make a determination in writing of his or her interpretation and will send the same to the PH-MCO within thirty (30) calendar days of the PH-MCO's written request. That interpretation shall be final, conclusive, and binding on the PH-MCO, and unreviewable in all respects unless the PH-MCO within twenty (20) calendar days of its receipt of said interpretation, delivers a written appeal to the Secretary of the Department. Unless the PH-MCO consents to extend the time for disposition by the Secretary, the decision of the Secretary shall be released within thirty (30) calendar days of the PH-MCO's written appeal and shall be final, conclusive, and binding, and the PH-MCO must thereafter with good faith and diligence, render such performance in compliance with the Secretary's determination; subject to the provisions of Section XVI.B below. Notice of initial level dispute must be sent to:

Department of Human Services
Office of Medical Assistance Programs
Director, Bureau of Managed Care Operations
Commonwealth Tower, 6th Floor
P.O. Box 2675
Harrisburg, Pennsylvania 17105-2675

B. Any appealable action regarding this Agreement must be filed by the PH-MCO in the Department’s BHA in accordance with 67 Pa.C.S. §§101 – 106 and 55 Pa. Code Chapter 41.

SECTION XVI: GENERAL

A. Suspension From Other Programs

In the event that the PH-MCO learns that a Health Care Provider with whom the PH-MCO contracts is suspended or terminated from participation in any federally funded health care program, the PH-MCO must promptly notify the Department, in writing, of such suspension or termination.

The PH-MCO shall not make any payment any services rendered by a Health Care Provider during the period the PH-MCO knew, or should have known, such Provider was suspended or terminated from a federally funded health care program.

B. Rights of the Department and the PH-MCO

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

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

C. Waiver

No waiver by either party of a breach or default of this Agreement shall be considered as a waiver of any other or subsequent breach or default.

D. Invalid Provisions

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

E. Notice

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

To the Department via U.S. Mail:

Department of Human Services
Director, Bureau of Managed Care Operations
Commonwealth Tower, 6th Floor
P.O. Box 2675
Harrisburg, Pennsylvania 17105

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

Department of Human Services
Director, Bureau of Managed Care Operations
Commonwealth Tower, 6th Floor
303 Walnut Street
Harrisburg, Pennsylvania 17101

With a Copy to:

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

To the PH-MCO – PH-MCO Information, name and address.

F. Counterparts

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

G. Headings

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

H. No Third Party Beneficiaries

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

EXHIBIT A
Managed Care Regulatory Compliance Guidelines

The following apply to all managed care organizations under contract with the Office of Medical Assistance Programs:

- All federal and state laws, including but not limited to 55 Pa. Code Chapters 1101-1249

- Non-compensable or non-covered services (managed care organizations may provide additional services beyond MA Fee for Service (FFS), but must cover, at a minimum, those services on the fee schedule in the same amount, duration and scope as the Fee for Service Program.)
- Scope of Benefits based on Recipient's eligibility (as determined by the County Assistance Office)
- Staff/Provider Licensing/Scope of Practice Requirements
- Frequency of service
- Program standards/quality of care standards
- Provider participation (enrolled as an MA Participating Provider)
- Utilization review
- Administrative sanctions
- Definitions

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

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

CITATION/SPECIFIC EXCLUSION	REGULATORY LANGUAGE DESCRIPTION
Managed care organizations are to adhere to the provisions of 55 Pa. Code Chapter 1101, General Provisions, with the following exceptions:	
1101.21 Definition of "Prior Authorization"	Definitions
1101.21 Definition of "Shared Health Facility", (iv) and (v)	(iv) At least one practitioner receives payment on a fee for service basis. (v) A provider receiving more than $30,000 in payment from the MA Program during the 12-month period prior to the date of the initial or renewal application of the shared health facility for registration in the MA Program.
1101.21 Definition of "Medically Necessary"	A service, item, procedure or level of care that is: (i) Compensable under the MA Program. (ii) Necessary to the proper treatment or management of an illness, injury or disability. (iii) Prescribed, provided or ordered by an appropriate licensed practitioner in accordance with accepted standards of practice.
1101.31(b) (13) "…Dental Services as specified in Chapter 1149 (relating to Dentists' Services)."	Benefits, Scope for categorically needy

CITATION/SPECIFIC EXCLUSION	REGULATORY LANGUAGE DESCRIPTION
1101.31(f) Note: The managed care organizations are not required to impose limits that apply in the Fee-for-Service delivery system, although they are permitted to do so. The managed care organizations may not impose limits that are more restrictive than the limits established in the Fee-for-Service system. If the managed care organizations impose limits, their exception process cannot be more restrictive than the process established in §1101.31(f).	Benefits, Exceptions (for limits specified in subsections (b) and (e) - FFS Program Exception Process
1101.32(a) (1) "…Medically needy children referred from EPSDT are not eligible for pharmaceuticals, medical supplies, equipment or prostheses and orthoses." 1101.32(a)(2)	Coverage Variations, Expanded coverage EPSDT Coverage Variations, Expanded Coverage School Medical Program for Medically Needy school children
1101.33(a) "…If the applicant is determined to be eligible, the Department issues Medical Services Eligibility (MSE) cards that are effective from the first of the month through the last day of the month..."	Recipient Eligibility, Verification of Eligibility (issuance of card)
1101.33(b)	Recipient Eligibility, Services restricted to a single provider
1101.51(a)	Responsibilities, Ongoing responsibilities of providers, Recipient freedom of choice of providers
1101.61	Fees and Payments, Reimbursement policies.
1101.62	Maximum fees
1101.63(b)(1) through (10)	Payment in full, Copayments for MA services
1101.63(c)	Payment in full, MA deductible
1101.64(b) "…Payment will be made in accordance with established MA rates and fees."	Third-party medical resources, Persons covered by Medicare and MA
1101.65	Method of payment
1101.67	Prior Authorization (including timeframes for notice)
1101.68	Invoicing for services
1101.69	Overpayment – underpayment (related to providers)
1101.69(a)	Establishment of a uniform period for the recoupment of overpayments from providers (COBRA)
1101.72	Invoice adjustment
1101.83	Restitution and repayment (related to providers for payments that should not have been made)
Managed care organizations are not required to adhere to the provisions of 55 Pa. Code Chapter 1102, Shared Health Facilities. Managed care organizations are responsible for establishing their own provider networks.	
Managed care organizations are to adhere to the provisions of 55 Pa. Code Chapter 1121, Pharmaceutical Services, with the following exceptions:	
1121.2	Definitions of AWP, Compounded Prescription, Pricing Service, Federal Upper Limit, CMS Multi-source Drug, State MAC, and Usual and Customary Charge
1121.52(a)(6)	Payment conditions for various services (indication for "brand medically necessary")

CITATION/SPECIFIC EXCLUSION	REGULATORY LANGUAGE DESCRIPTION
1121.52(b)	Payment conditions for various services (prenatal vitamins)
1121.53(a)	Limitations on payment (not exceeding UCC to general public)
1121.53(b)(1)	Limitations on payment (conditions when limits on the State MAC will not apply)
1121.53(b)(2)	Limitations on payment (conditions when limits on the State MAC will not apply)
1121.53(c)	Limitations on payment (34 day supply or 100 units, total authorization not exceeding 6 months' or five refill supply)
1121.53(f)	Limitations on payment (Payment to pharmacy for prescriptions dispensed to a recipient in either a skilled nursing facility, an intermediate care facility or an intermediate care facility for the mentally retarded and specific scripts not included in the limitation)
1121.54(10)	Drugs prescribed in conjunction with sex reassignment procedures or other noncompensable procedures. As directed in MAB 99-16-11, this is inconsistent with the Federal Final Rule, "Nondiscrimination in Health Programs and Activities", and will no longer be applied.
1121.55	Method of payment. (relating to the Department's payment to pharmacies)
1121.56	Drug cost determination.
Managed care organizations are to adhere to the provisions of 55 Pa. Code Chapter 1123, Medical Supplies, with the following exceptions:	
1123.1 "and the MA Program fee schedule"	Policy. (Payment for medical supplies is subject to this chapter, Chapter 1101 (relating to general provisions) and the limitations established in Chapter 1150 (relating to MA Program payment policies) and the MA Program fee schedule.
1123.13(a) and (b).	Inpatient services.
1123.22(1).	Scope of benefits for the medically needy. ("Medical supplies which have been prescribed through the School Medical Program...")
1123.22(2) "who are enrolled in EPSDT, or which have been prior authorized by the Department as specified in 1123.56 (a) (2) (relating to vision aids)"	Scope of benefits for the medically needy. ("Eyeglasses which have been prescribed as treatment for individuals under 21 years of age who are enrolled in EPSDT...")
1123.51 "and the MA Program fee schedule"	Payment for Medical Supplies. General payment policy.
1123.53	Hemophilia products.
1123.54 "in accordance with the limitations described in this section and the maximum fees listed in Chapter 1150 (relating to Medical Assistance program payment policies) and the Medical Assistance Program fee schedule"	Orthopedic shoes, molded shoes and shoe inserts (Relating to payment when prescribed for eligible persons to approved MA providers)
1123.54(1) through (5).	Orthopedic shoes, molded shoes and shoe inserts (Relating to prior approval, conditions for payment, payment for modifications necessary for the application of a brace or splint, payment for repairs w/o a prescription or prior authorization, and payment for orthopedic shoes only if the recipient is 20 years of age or younger."
1123.55(a) "The prescription shall contain the cardiopulmonary diagnosis"	Oxygen and related equipment. (Relating to payment conditions)
1123.55(b) and (c).	Oxygen and related equipment. (Relating to prior authorization and prescription inclusion requirements)
1123.55(d) "and recertification shall be kept by the provider"	Oxygen and related equipment. ("A physician shall recertify orders for oxygen at least every 6 months and recertification shall be kept by the provider.")

CITATION/SPECIFIC EXCLUSION	REGULATORY LANGUAGE DESCRIPTION
1123.56(a)(1) through (3)	Vision aids. ("Payment for eyeglasses is made only if the recipient is 20 years of age or younger and the eyeglasses have been one of the following...")
1123.56(b)(1) through(3)	Vision aids. ("Payment for low vision aids is made only if the recipient is categorically needy or if the recipient is medically needy and the low vision aid has been one of the following...")
1123.56(c)	Vision aids. ("Payment for eye prostheses will be made only if the recipient is categorically needy.")
1123.57(a) and (b)	Hearing aids. (Relating to payment for hearing aids only if recipient is 20 years of age or younger and have been prescribed through the EPSDT program, and for repairs to hearing aids owned by the recipient when the invoice is accompanied by an itemized statement.)
1123.58(1) and (2)	Prostheses and orthoses.
1123.60(a) through (i)	Limitations on payments.
1123.61 (1) through (8) and (10)	Noncompensable services and items. (Relating to when payment will not be made. (9) is not excluded, as it relates to items prescribed or ordered by a practitioner who has been barred or suspended during an administrative action from participation in the MA Program.)
1123.62	Method of payment.
Managed care organizations are not required to adhere to the provisions of Medical Assistance Bulletin 05-86-02, Durable Medical Equipment Warranties.	
Managed care organizations are required to adhere to the provisions of Medical Assistance Bulletin 05-87-02, Coverage of Motorized Wheelchairs, with the following exceptions: - requiring Prior Authorization at the State level. - Page 2, number 7.	
Managed care organizations are to adhere to the provisions of Medical Assistance Bulletin 1123-91-01, EPSDT – OBRA '89 with the following exceptions: - Page 3 – Vision Services – the "age of 21" and the MA fee schedule do not apply. - Page 3 – Dental Services – the "age of 21" and the MA fee schedule do not apply. - Page 3 – Hearing Services – the "age of 21" and the MA fee schedule do not apply. - Page 3 – "and use of existing Medical Assistance Program Fee Schedule"	
Managed care organizations are not required to adhere to the provisions of Medical Assistance Bulletin 05-85-02, Policy Clarification for Services Provided to Hospitalized Recipients Under the DRG Payment System.	
Managed care organizations are to adhere to the provisions of 55 Pa. Code Chapter 1126, Ambulatory Surgical Center and Hospital Short Procedure Unit Services, with the following exceptions:	
1126.51(f) through (h) and (k) through (m)	Payment for Same Day Surgical Services. General payment policy. ((f-h)Relating to submission of invoices to the Department, consideration if ASC or SPU has fee schedule based on patient's ability to pay that the Department will consider it as the usual and customary charge, and the Department's payment being the lesser of the facility's charge to general public to be the most frequent charge to the self-paying public for the same service.) and (k-m relating to payment when patient in conjunction with same day service are transferred to a hospital due to complications and when patients due to complications must be transferred to inpatient hospital care)
1126.52(a) and (b)	Payment criteria. (Relating to the Department's maximum reimbursement and developed fees.)
1126.53(b)	Limitations on covered procedures. (Relating to limits for appropriate same day surgical procedures for same day surgery but are not yet included in the established list of covered ASC/SPU services.)
1126.54(a)(7)	Procedures and medical care performed in connection with sex reassignment. As directed in MAB 99-16-11, this is inconsistent with the Federal Final Rule, "Nondiscrimination in Health Programs and Activities", and will no longer be applied.

CITATION/SPECIFIC EXCLUSION	REGULATORY LANGUAGE DESCRIPTION
1126.54(a)(11) through (13) and (b)	Noncompensable services and items. ("...The Department does not pay ASCs and SPUs for services directly or indirectly related to, or in conjunction with...diagnostic tests and procedures that can be performed in a clinic or practitioner's office and diagnostic tests and procedures not related to the diagnosis"; "Services and items for which full payment equal to or in excess of the MA fee is available through Medicare or other financial resources or other health insurance programs"; "Services and items not ordinarily provided to the general public"; and "...if the admission to the ASC or SPU is not certified under the Department's utilization review process applicable to the type of provider furnishing the service".)
Managed care organizations are to adhere to the requirements of 55 Pa. Code Chapter 1127, Birth Center Services, with the following exceptions:	
1127.51(d)	Payment for Birth Center Services. General payment policy. ("Claims shall be submitted to the Department under the provider handbook.")
1127.52(a) through (c)	Payment criteria. (Relating to the Department's establishment of maximum reimbursement fees and payment methodology)
1127.52(d) "The birth center visit fee shall be the amount equal to that of the midwives' or physicians' visit fee under the MA Program fee schedule."	Payment criteria. (Relating to termination of birth center services during prenatal care)
1127.52(e) "The amount of the payment is 50% of the third trimester rate of payment."	Payment criteria (to payment if complications develop during labor and patient is transferred to a hospital)
1127.53(c)	Limitations on payment.
Managed care organizations are to adhere to the provisions of 55 Pa. Code Chapter 1128, Renal Dialysis Facilities, with the following exceptions:	
1128.51(a) "and the MA Program fee schedule"	Payment for Renal Dialysis Services. General payment policy.
1128.51(b)	General payment policy. ("A fee determined by the Department is paid for support services provided to an eligible recipient during the course of a dialysis procedure."
1128.51(c) "and for billings"	General payment policy. ("The dialysis facility is considered the provider regardless of whether the facility is operated directly by the enrolled provider or through contract between the provider and other organizations or individuals. The enrolled provider is responsible for the delivery of the service and for billings.")
1128.51(d) "up to the amount of the MA fee, if the Medicare 80% payment and the amount billed to MA does not exceed the maximum MA fee"	General payment policy. ("The Department will pay for the unsatisfied portion of the Medicare deductible and remaining 20% coinsurance up to the amount of the MA fee, if the Medicare 80% payment and the amount billed to MA does not exceed the maximum MA fee.")
1128.51(f) through (i), (k) and (l)	General payment policy. (Relating to what is included in the fee paid to the facility, procedures fees are applicable to, Department's consideration of provider's usual and customary charge if facility has a fee schedule based on patient's ability to pay, and the Department's payment for dialysis services shall be considered payment in full.)
1128.51(m) "Payment shall be made in accordance with §1128.52 (relating to payment criteria)."	General payment policy. ("If a dialysis facility voluntarily terminates the provider agreement, payment is made for services provided prior to the effective date of the termination of the provider agreement. Payment shall be made in accordance with §1128.52 (relating to payment criteria).")
1128.51(n)	General payment policy. (Relating to payment to out-of-State dialysis facility.)
1128.52	Payment criteria.
1128.53(a) through (e)	Limitations on payment.

CITATION/SPECIFIC EXCLUSION	REGULATORY LANGUAGE DESCRIPTION
1128.53(f) "Payment for backup visits to the facility is limited to no more than 15 in one calendar year"	Limitations on payment.
1128.53(g)	Limitations on payment. (Relating to payment for nonexpendable equipment or installation of equipment necessary for home dialysis)
1128.54(1)	Noncompensable services and items. ("The Department does not pay dialysis facilities for: (1) Services that do not conform to this chapter.")
1128.54(4) through (7)	Noncompensable services and items. (Relating to Diagnostic or therapeutic procedures solely for experimental, research or educational purposes; procedures not listed in the MA Program fee schedule; services that are not medically necessary; and services provided to recipients who are hospital inpatients.)
Managed care organizations are to adhere to the provisions of 55 Pa. Code Chapter 1129, Rural Health Clinic Services, with the following exceptions:	
1129.51(b) and (c)	Payment for Rural Health Clinic Services. General payment policy. (Relating to payment for rural health clinic services made on the basis of an all-inclusive visit fee established by the Medicare carrier. When the cost for a service provided by the clinic is included in the established visit fee, the practitioner rendering the service shall not bill the MA Program for it separately; and adjustment to the all-inclusive visit fee when Medicare determines the difference between the total payment due and the total payment made. The Department will make a lump sum payment for the amount due.)
1129.52	Payment policy for provider rural health clinics.
1129.53	Payment policy for independent rural health clinics.
Managed care organizations are to adhere to the provisions of 55 Pa. Code Chapter 1130, Hospice Services, with the following exceptions:	
1130.22(4) "…Department's…specified in Appendix A." ***Note: The provider must have a Certification of Terminal Illness form containing the information found in Appendix A. The provider is not required to use the Department's Certification of Terminal Illness form.***	Duration of coverage. Certification form. (Relating to certification of terminal illness carried out using the Department's certification of terminal illness form.)
1130.41(a) "…specified in Appendix B." ***NOTE: The provider must have an Election statement containing the information found in Appendix B. The provider is not required to use the Department's Election statement.***	Election of hospice care. Election statement. (Relating to filing of the Election statement by the recipient or recipient's representative.)
1130.41(c) "specified in Appendix C." ***Note: The provider must have a Change of Hospice statement containing the information found in Appendix C. The provider is not required to use the Department's Change of Hospice statement.***	Election of hospice care. Change of designated hospice. (Relating to the ability to the ability to change hospices once in each certification period.)
1130.42(a) "specified in Appendix D." ***Note: The provider must have a Revocation statement containing the information found in Appendix D. The provider is not required to use the Department's Revocation statement.***	Revocation of hospice care. Right to revoke. (Relating to the ability of the recipient or recipient's representative to revoke the election of hospice care at any time utilizing the revocation statement.)

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

CITATION/SPECIFIC EXCLUSION	REGULATORY LANGUAGE DESCRIPTION
1141.54(a)(1) through (3)	Payment conditions for inpatient services. (Relating to when a physician is eligible to bill the Department for services provided to a hospitalized recipient.)
1141.54(f)	Payment conditions for inpatient services. (Relating to inpatient physicians' services billed to the Department shall be performed by the physician, an RN, PA or midwife under the physician's direct supervision.)
1141.55(b)(1) "MA 31"; "in accordance with all instructions in the Provider Handbook"; and "See Appendix A for a facsimile of the Consent Form and the Provider Handbook for detailed instructions on its completion." ***NOTE: A consent form is required and must contain all the information found in Appendix A.***	Payment conditions for sterilizations. (Relating to consent requirements and use of the MA31 Consent Form.)
1141.55(c) "MA 31" 1141.55(c)(2) "in accordance with instructions in the Provider Handbook" 1141.55(c)(3) "in accordance with instructions in the Provider Handbook"	Payment conditions for sterilizations. ("A Consent Form, MA 31, is considered to be completed correctly only if all of the following requirements are met:") Payment conditions for sterilizations. ("The person obtaining informed consent has properly signed the Consent Form in accordance with instructions in the Provider Handbook on the same date that informed consent is given." Payment conditions for sterilizations. ("Any other witness or interpreter has properly signed the Consent Form in accordance with instructions in the Provider Handbook on the same date that informed consent is given.")
1141.56(a)(3) "See the Provider Handbook for a facsimile of the Patient Acknowledgement Form for Hysterectomy, MA 30, and for instructions on its completion."	Payment conditions for hysterectomies. (Relating to Patient Acknowledgement Form for Hysterectomy MA 30)
1141.57(a)(1) "Where a physician has certified in writing and documented in the patient's record that the life of the woman would be endangered if the pregnancy were allowed to progress to term. The decision as to whether the woman's life is endangered is a medical judgment to be made by the woman's physician.	Payment conditions for a physical disorder, physical injury, or physical illness, including a life-endangering physical condition caused by or arising from the pregnancy itself, which would, as certified by a physician, place the woman in danger of death unless an abortion is performed.

CITATION/SPECIFIC EXCLUSION	REGULATORY LANGUAGE DESCRIPTION
1141.57(a)(2) "and the incident was reported to a law enforcement agency or to a public health service within 72 hours of its occurrence in the case of rape and within 72 hours of the time the physician notified the patient that she was pregnant in the case of incest. A law enforcement agency means an agency or part of an agency that is responsible for the enforcement of the criminal laws, such as a local police department or sheriff's office. A public health service means an agency of the Federal, State, or local government or a facility certified by the Federal government as a Rural Health Clinic that provides health or medical services except for those agencies whose principal function is the performance of abortions."	Payment conditions for necessary abortions (Where the recipient was the victim of rape or incest)
1141.57(a)(2)(i) "with the Medical Services Invoice along with documentation signed by an official of the law enforcement agency or public health service to which the rape or incest was reported. The documentation shall include the following": 1141.57(a)(2)(i)(A) and (B)	Payment conditions for necessary abortions (Payment will be made only if a licensed physician submits a signed ''Physician Certification for an Abortion'' form, as set forth in Appendix B,) (A) All of the information specified in subparagraph (ii). (B) A statement that the report was signed by the person making the report.
1141.57(a)(2)(ii)(A) through (D)	Payment conditions for necessary abortions (report of rape or incest)
1141.57(c)	Abortions after the first 12 weeks
1141.59(1) through (5)	Payment for Physician Services, Noncompensable services, Procedures not listed in the Medical Assistance program fee schedule. Medical services or surgical procedures performed on an inpatient basis that could have been performed in the physician's office, the clinic, the emergency room, or a short procedure unit without endangering the life or health of the patient, Medical or surgical procedures designated in the Medical Assistance program fee schedule as outpatient procedures, Dental rehabilitation and restorative services, Diagnostic tests, for which a patient was admitted, that may be performed on an outpatient basis; tests not related to the diagnosis and treatment of the illness for which the patient was admitted; tests for which there is no medical justification.
1141.59(7) and (8)	Payment for Physician Services, Noncompensable services, Hysterectomy performed solely for the purpose of rendering an individual incapable of reproducing, Acupuncture, medically unnecessary surgery, insertion of penile prosthesis, gastroplasty for morbid obesity, gastric stapling or ileo-jejunal shunt—except when all other types of treatment of morbid obesity have failed—
1141.59(10) and (11)	Services to inpatients who no longer require acute inpatient care and surgical procedures and medical care provided in connection with sex reassignment.
1141.59 (14) through (16)	Diagnostic pathological examinations of body fluids or tissues, Services and procedures related to the delivery within the antepartum period and postpartum period, Medical services or surgical procedures performed in a short procedure unit that could have been appropriately and safely performed in the physician's office, the clinic, or the emergency room without endangering the life or health of the patient.

CITATION/SPECIFIC EXCLUSION	REGULATORY LANGUAGE DESCRIPTION
1141.60	Payment for medications dispensed or ordered in the course of an office visit.
Managed care organizations are to adhere to the requirements of 55 Pa. Code Chapter 1142, Midwives' Services, with the following exceptions:	
1142.51 "and the MA payment fee schedule"	General payment policy for Midwife services
1142.52(2) "billed to the Department"	General payment policy for Midwife services
1142.55(1) through (4)	Noncompensable Midwife services. Procedures not listed in the fee schedule in the MA Program fee schedule, More than 12 midwife visits per recipient per 365 days. Services and procedures furnished by the midwife for which payment is made to an enrolled physician, rural health clinic, hospital or independent medical clinic. Services and procedures for which payment is available through other public agencies or private insurance plans as described in § 1101.64 (relating to third party medical resources (TPR)).
Managed care organizations are to adhere to the requirements of 55 Pa. Code Chapter 1143, Podiatrists' Services, with the following exceptions:	
1143.2 Definition of "Medically-necessary"	A term used to describe those medical conditions for which treatment is necessary, as determined by the Department, and which are compensable under the MA Program.
1143.2 Definition of "Non-emergency medical services."	A compensable podiatrists' service provided for conditions not requiring immediate medical intervention in order to sustain the life of the person or to prevent damage to health.
1143.51 "and the MA Program fee schedule" and "as specified in §1101.62(relating to maximum fees)."	General Payment Policy
1143.53	Payment conditions for outpatient services.
1143.54	Payment conditions for inpatient hospital services.
1143.55(1),(2) and (4)	Payment conditions for diagnostic X-ray services performed in the podiatrist's office.
1143.56	Payment conditions for orthopedic shoes, molded shoes and shoe inserts (enrolled medical suppliers). Refers to 1123.54
1143.57	Limitations on payment for podiatrist visits and x-rays.

CITATION/SPECIFIC EXCLUSION	REGULATORY LANGUAGE DESCRIPTION
1143.58(a)(1) through (12)	Noncompensable services and items for podiatry services. (1) Services and items not listed in the MA Program fee schedule. (2) Fabricating or dispensing orthopedic shoes, shoe inserts and other supportive devices for the feet. (3) Casting for shoe inserts. (4) Medical services or surgical procedures performed on an inpatient basis that could have been performed in the podiatrist's office, the emergency room, or a short procedure unit without endangering the life or health of the patient. (5) Medical or surgical procedures designated in the fee schedule in Chapter 1150 (relating to MA Program payment policies) and the MA Program fee schedule as outpatient procedures. (6) Medical services or surgical procedures performed on an inpatient basis if the Department denies payment to the hospital for the days during which the podiatrist's care is rendered. (7) Services rendered in the emergency room of a hospital if the recipient is admitted to the hospital as an inpatient on the same day or the service is a nonemergency medical service. (8) Treatment of flat foot. (9) Treatment of subluxations of the foot. (10) Routine foot care, including the cutting or removal of corns, callouses, the trimming of nails and other routine hygienic care. (11) Physical therapy. (12) Diagnostic or therapeutic procedures for experimental, research or educational purposes.
1143.58(a)(13) "as specified in § 1101.62 (relating to maximum fees)"	Compensable podiatrist services if full payment is available from another agency, insurance or health program.
1143.58(b)	Noncompensable services and items. Payment is not made for sneakers, sandals etc., even if prescribed by a podiatrist.
Managed care organizations are to adhere to the requirements of 55 Pa. Code Chapter 1144, Certified Registered Nurse Practitioner Services, with the following exceptions:	
1144.42(b) "to the Department"	Ongoing responsibilities of providers
1144.52(1)	Payment conditions for CRNP services. CRNP employee
1144.52(2) "billed to the Department"	Payment conditions for CRNP services. CRNP employee
1144.52(3)	Payment conditions for CRNP services. CRNP employee
1144.53(1), (2), and (4)	Noncompensable services. Procedures not listed in the MA Program fee schedule. Services and procedures furnished by the CRNP for which payment is made to an enrolled medical service provider or practitioner. The same service and procedure furnished to the same recipient by a CRNP and physician.
Managed care organizations are to adhere to the requirements of 55 Pa. Code Chapter 1145, Chiropractor's Services, with the following exceptions:	
1145.11	Types of services covered. Evaluation by means of examination. Treatment by means of manual manipulation of the spine.
1145.12	Services are covered when rendered in the chiropractors' office, the home of the patient or in a skilled nursing or intermediate care facility.
1145.13	Chiropractors' services are not covered when rendered in a location in a hospital.
1145.14	Payment will not be made for treatment other than manipulation of the spine, physical therapy, traction, physical examinations, and consultations.
1145.51 "and the MA Program fee schedule" and "Chiropractors' services shall be billed in the name of the chiropractor providing the services."	Payment policy for chiropractor services.

CITATION/SPECIFIC EXCLUSION	REGULATORY LANGUAGE DESCRIPTION
1145.54	Noncompensable services. Payment will not be made to a chiropractor for 1) Orthotics, 2) Prosthetics, 3) Medical supplies, 4) X-rays, 5) Services not included in Chapter 1150
Managed care organizations are to adhere to the requirements of 55 Pa. Code Chapter 1147, Optometrists' Services, with the following exceptions:	
1147.2 Delete the following portion included in the definition of eyeglasses: "untinted."	Definitions - *Eyeglasses*—A pair of untinted prescription lenses and a frame.
1147.12 "Outpatient optometric services are compensable when provided in the optometrist's office, the office of another optometrist during the other optometrist's temporary absence from practice, a hospital, a nursing home or in the patient's home when the patient is physically incapable of coming to the optometrist's office." "and the MA Program Fee Schedule"	Outpatient services
1147.13 "and the MA Program Fee Schedule"	Inpatient services
1147.14(1)	Non-covered services: Orthoptic training.
1147.21 "They are not eligible for eyeglasses unless they are 20 years of age or younger and the eyeglasses have been: " 1147.21(1) through (3)	Scope of benefits for the categorically needy: eyeglasses. Eyeglasses prescribed through EPSDT program, school medical program, and prior authorized by Department through EPSDT program.
1147.22 "They are not eligible for eyeglasses, low vision aids or prostheses unless they are 20 years of age or younger and the eyeglasses, low vision aids or prostheses have been:" 1147.22 (1) through (3)	Scope of benefits for the medically needy: eyeglasses. Eyeglasses prescribed through EPSDT program, school medical program, and prior authorized by Department through EPSDT program.
1147.23 "only" and "They are not eligible for eyeglasses, low vision aids or eye prostheses. However, State Blind Pension recipients are eligible for eye prostheses if they are also categorically needy."	Scope of benefits for State Blind pension recipients.
1147.51 "and §§ 1147.53 and 1147.54 (relating to limitations on payment; and noncompensable services and items)" and "and the MA Program fee schedule" and "Optometric services shall be billed in the name of the optometrist providing the service."	General payment policy for optometric services
1147.53	Limitations on payments for optometric services
1147.54	Noncompensable optometric services and items
Managed care organizations are to adhere to the requirements of 55 Pa. Code Chapter 1149, Dentists' Services, with the following exceptions:	
1149.1 "and the MA Program Fee Schedule"	Dental services general policy
1149.43(6)	Radiographs are requested by the Department for prior authorization purposes

CITATION/SPECIFIC EXCLUSION	REGULATORY LANGUAGE DESCRIPTION
1149.43(9) through (11)	Pathology reports are required for surgical excision services. Pre-operative X-rays are required for surgical services. Postoperative X-rays are required for endodontic procedures.
1149.51 "and the MA Program Fee Schedule" and “The following payment policies are applicable for dental services:”	General payment policy for dental services
1149.51(1) and (2)	General payment policy for dental services
1149.52	Payment conditions for various dental services
1149.54 "and the MA Program Fee Schedule" 1149.54 (1) through (7) 1149.54(10)	Payment policies for orthodontic services
1149.55(1) 1149.55(5) through (8)	Payment conditions for orthodontic services
1149.56	Payment limitations for orthodontic services
1149.57	Noncompensable dental services and items
Managed care organizations are to adhere to the requirements of 55 Pa. Code Chapter 1150, MA Program Payment Policies, with the following exceptions:	
1150.2 Definitions of PSR and Second Opinion program	Definitions
1150.51(a) "Payment will be made to providers. Payment may be made to practitioners' professional corporations or partnerships if the professional corporation or partnership is composed of like practitioners. Payment will be made directly to practitioners if they are members of professional corporations or partnerships composed of unlike practitioners. Practitioners who render services at eligible provider hospitals, either through direct employment or through contract, may direct that payment be made to the eligible provider hospital." **and** "Payment will not be made for services that are not medically necessary." 1150.51(b) 1150.51(c) “facilities and practitioners rendering services which require a PSR or second opinion, or both” and “funeral directors” 1150.51(d) “which is contained in the Provider’s Handbook” and the following” 1150.51(d)(1) “all-inclusive” 1150.51(d) (2) through (8) 1150.51(e) through (h)	General MA Program Payment policies
1150.52	Payment for Anesthesia services
1150.54	Payment for Surgical Services

CITATION/SPECIFIC EXCLUSION	REGULATORY LANGUAGE DESCRIPTION
1150.55	Payment for Obstetrical Services
1150.56	Payment for Medical Services
1150.56a	Payment Policy for Consultations
1150.56b	Payment Policy for Observation Services
1150.57	Payment for Diagnostic Services and Radiation Therapy
1150.58	Prior authorization for services in the MA Program Fee Schedule
1150.59	PSR Program
1150.60	Second Opinion Program
1150.61	Guidelines for Fee Schedule changes
1150.62	Payment levels and notice of rate setting changes
1150.63 1150.63(a) Delete the word “Department” 1150.63(b) Delete the word “Department”. Also delete in second sentence “the practitioner may either …by mail.” 1150.63(c) Delete the first two sentences: The CAO shall …consultants. The office of MA…decision.” 1150.63(d)Delete the word “Department”	Waiver of General Payment Policies. The plan must adhere to the following section, except:
Managed care organizations are to adhere to the requirements of 55 Pa. Code Chapter 1151, Inpatient Psychiatric Services, with the following exceptions:	
1151.34	Inpatient Psychiatric Services, Provider Participation, Changes of ownership or control
1151.41(b)	Payment for inpatient psychiatric services, Readmission within 24 hours after discharge
1151.41(c) (1) and (2)	Payment for Inpatient Psychiatric Services, Admitted and discharged the same calendar day
1151.41(d), (i) and (j)	Payment for Preadmission diagnostics, transfer to another facility due to strike, payment for studies related to the patient’s condition not preprinted regimen.
1151.42 (a), (c) and (d)	Payment methods and rates
1151.43(a) and (b)	Limitations on payments
1151.45(2) and (3)	Nonallowable costs, costs related to a noncompensable item, costs related to preadmission diagnostics
1151.46	Payment rate calculations for FY 1993-94 and 1994 - 95
1151.48(a)(2)through (6), (9) through (16) and (18) through (20)	Noncompensable services and items, experimental procedures and services, inpatient treatment for diagnostic testing that could be done as outpatient, inpatient care if payment is available from another source, services not normally provided to the public, methadone maintenance, days of inpatient care that the patient was absent due to training, meetings or conferences, unnecessary inpatient care, and days of care that are not certified or failure to apply for a court-ordered commitment.
1151.52	Payment for capital costs not included in the base year
1151.53	Billing requirements for inpatient psychiatric services
1151.54	Disproportionate share payments
Managed care organizations are to adhere to the requirements of 55 Pa. Code Chapter 1153, Outpatient Psychiatric Services, with the following exceptions:	
1153.1 “and the MA Program fee schedule”	Outpatient psychiatric services, general policy

CITATION/SPECIFIC EXCLUSION	REGULATORY LANGUAGE DESCRIPTION
1153.2 Psychiatric outpatient clinic services -- "listed in the MA Program Fee Schedule"	Definitions
1153.2 Psychiatric partial hospitalization -- "listed in the MA Program Fee Schedule" and "and a maximum of six hours in a 24 hour period"	Definitions
1153.11 "as specified in the MA Program Fee Schedule"	Types of Outpatient Psychiatric Services
1153.12 "specified in the MA Program Fee Schedule"	Coverage of outpatient Psychiatric services
1153.14(2), (3), (9) and(13)	Noncovered services: cancelled appointments, covered services not rendered, Psychiatric outpatient clinic services and psychiatric partial hospitalization provided on the same day to the same patient, and Services not specifically included in the MA Program Fee Schedule
1153.21 "in the MA Program Fee Schedule"	Scope of benefits for the categorically needy
1153.22 "in the MA Program Fee Schedule"	Scope of benefits for the medically needy
1153.23 "in the MA Program Fee Schedule"	Scope of benefits for State Blind Pension recipients
1153.51 "and the MA Program Fee Schedule"	Payment for Outpatient Psychiatric clinic and partial hospitalization
1153.52(a)(2) "Separate billings for these additional services are not compensable."	Additional interviews with other staff may be included as part of the examination but shall be included in the psychiatric evaluation fee.
1153.52(d) "listed in the MA Program Fee Schedule"	Psychiatric clinic services provided in the home.
1153.53	Limitations on payments
1153.53a	Request for waiver of hourly limits
1153.54	Noncompensable services and items

CITATION/SPECIFIC EXCLUSION	REGULATORY LANGUAGE DESCRIPTION
Managed care organizations are required to adhere to the provisions of <u>Medical Assistance Bulletin 1157-95-01</u> Mental Health Services Provided in a Non-JCAHO Accredited Residential Facility for Children Under 21 Years of Age with the following exceptions: ▪ Page 2, A. 2. c. ▪ Page 3, A. 4. ▪ Page 3, Section B. ▪ Page 3, C. "To receive MA reimbursement," ▪ Page 3, D. 1. ▪ Page 3, D. 2. "Payment will be made only for services prior approved by OMAP." ▪ Pages 5-7 Sections A and B. ▪ Attachment 2, 3.e.; 4.b.; and 4.e. ▪ Attachment 5 ▪ Attachment 6 ▪ Attachment 7 ▪ Attachment 8 ▪ Attachment 9 ▪ Attachment 11	
Managed care organizations are to adhere to the requirements of 55 Pa. Code Chapter 1163, Inpatient Hospital Services, Subchapter A, Acute Care General Hospitals Under the Prospective Payment System, with the following exceptions:	
1163.32	Hospital Units excluded from the DRG prospective payment system
1163.41	General participation requirements for general hospitals and out of state hospitals for Commonwealth recipients
1163.51 (a) through (s)	General payment policy for hospital services
1163.52 through 1163.59	Prospective payment methodology, assignment of DRG, prospective capital reimbursement system, payments for direct medical education, outliers, payment policy for readmissions and transfers, and noncompensable services and items and outlier days.
1163.60(b)(1) “in accordance with the instructions in the Provider Handbook”.	Informed consent for voluntary sterilization
1163.60(c)(2) “in accordance with the instructions in the Provider Handbook”.	The person obtaining informed consent signs and dates the form on same day informed consent was obtained.
1163.60(c)(3) “in accordance with the instructions in the Provider Handbook”.	Another witness or interpreter must sign the consent form.
1163.62 (a) (2) through 1163.65	Payment conditions for abortions if the recipient was a victim of rape or incest, billing, cost reports and payment for out of state services.
1163.67	Disproportionate share payments

CITATION/SPECIFIC EXCLUSION	REGULATORY LANGUAGE DESCRIPTION
1163.70 through 1163.71	Changes of ownership or control and scope of utilization review process
1163.72 (a), (c) through (g)	General utilization review, admissions, day and cost outliers.
1163.73 through 1163.75 (6) and (8) through (12)	Hospital utilization review plan, requirements for hospital utilization review committees, and responsibilities for hospital utilization review committees.
1163.76 through 1163.77	Written plan of care within 2 days of admission and Admission review requirements within 24 hours of admission
1163.78a and 1163.78b	Review requirements for day outliers and cost outliers
1163.92 (a) through (f)	Administrative sanctions
1163.122	Determination of DRG relative values
1163.126	Computation of hospital specific computation rates
Managed care organizations are to adhere to the requirements of 55 Pa. Code Chapter 1163, Inpatient Hospital Services, Subchapter B, Hospitals and Hospital Units Under Cost Reimbursement Principles, with the following exceptions:	
1163.402 Definition of "certified day"	Definitions
1163.451 (a) through (g), (i), (k) through (o)	General payment policy
1163.452	Payment methods and rates
1163.453 (a) and (c)	Allowable and nonallowable costs, allowable costs for inpatient services, payment not higher than hospital's customary charge
1163.453 (d) (2) through (9)	Costs not allowable under the MA Program
1163.453 (e) and (f)	Allowable costs
1163.454	Limitations on payment
1163.455 (a)(1) through (5) and (7) through (16)	Noncompensable inpatient services
1163.455 (b) and (c)	Noncompensable inpatient services
1163.457	Payment policies relating to out of state hospitals
1163.458	Payment policies relating to same calendar day admissions and discharges
1163.459	Disproportionate share payments
1163.481(b) and (c)	Utilization review sanctions
1163.511	Change of ownership or control
Managed care organizations are required to adhere to the provisions of <u>Medical Assistance Bulletin 1165-93-07</u> Payment for Mental Health Services Provided in a Residential Treatment Facility for Eligible Individuals Under 21 Years of Age with the following exceptions: ▪ Page 1 - Beginning with the second sentence "The procedures described in this Bulletin apply to every child." up to "A separate bulletin will describe the procedures necessary to seek reimbursement for other mental health services not on the Medical Assistance Fee Schedule." ▪ Page 2, Section A.4. ▪ Pages 3 - 4, Sections C through E ▪ Attachment 6 ▪ Attachment 7 ▪ Attachment 8 ▪ Attachment 9	

CITATION/SPECIFIC EXCLUSION	REGULATORY LANGUAGE DESCRIPTION
Managed care organizations are required to adhere to the provisions of <u>Medical Assistance Bulletin 1165-95-01</u> Update JCAHO-Accredited RTF Services with the following exceptions: ▪ Page 2 - The two paragraphs following item c. "If a child is admitted . . . alternative to RTF." ▪ Page 2 - The third complete paragraph, "All admissions are subject," through the end of 3. ▪ Page 3, number 4.	
Managed care organizations are to adhere to the requirements of 55 Pa. Code Chapter 1221, Clinic and Emergency Room Services, with the following exceptions:	
1221.43 through 1221.45	Participation requirements for hospital clinics and emergency rooms for higher reimbursement rate, additional participation requirements for independent clinics, and additional participation requirements for medical school clinics.
1221.51 and 1221.52	General payment policy for clinic and emergency room services and payment conditions for various services.
1221.55 (b) (1). NOTE: A consent form is required and must contain all of the information found in Appendix A to 55 PA Code Chapter 1141	Voluntary informed consent for sterilizations
1221.57(a) (2) and 1221.57(c). NOTE: PH-MCO must comply with MA Bulletin 99-95-09	Payment conditions for necessary abortions for victims of rape or incest
1221.58 and 1221.59	Limitations on payments and noncompensable services and items
Managed care organizations are required to adhere to the provisions of Medical Assistance Bulletins related to 55 PA Code Chapter 1221, Clinic and Emergency Room Services, with the following exceptions: ▪ 11-95-04 ▪ 11-95-10 ▪ 11-95-12	
Managed care organizations are to adhere to the requirements of 55 Pa. Code Chapter 1223, Outpatient Drug and Alcohol Clinic Services, with the following exceptions:	
1223.1 “and the MA fee schedule”	Payment for specific medically necessary outpatient drug and alcohol clinic services rendered to eligible recipients by drug/alcohol outpatient clinics.
1223.11 “as specified in the fee schedule in the Medical Assistance program fee schedule”	Medical Assistance Program coverage for outpatient drug/alcohol clinics is limited to professional medical and psychiatric services.
1223.12 "specified in the Medical Assistance program fee schedule"; "and the Medical Assistance program fee schedule"; and "fee for service"	Outpatient drug and alcohol clinic services
1223.14 (3) and (4)	Noncovered services: Cancelled appointments and Covered services that have not been rendered.
1223.14(6) “and the Medical Assistance program fee schedule”	Noncovered services: Vocational rehabilitation; day care; drug/alcohol or mental health partial hospitalization; reentry programs, occupational or recreational therapy; Driving While Intoxicated (DWI) or Driving Under the Influence Programs or Schools; referral, information or education services; experimental services; training; administration; follow-up or aftercare; program evaluation; case management; central intake or records; shelter services; research; drop-in, hot-line or social services; inpatient nonhospital or occupational program services, or any other service or program not specifically identified as a covered service in Chapter 1150.

CITATION/SPECIFIC EXCLUSION	REGULATORY LANGUAGE DESCRIPTION
1223.14 (8) and (9)	Drug/alcohol outpatient clinic services provided to residents of treatment institutions. outpatient clinic services provided to residents of inpatient nonhospital and shelter facilities. outpatient clinic services provided to patients receiving psychiatric partial hospitalization services or drug/alcohol partial hospitalization services
1223.14(14)	Methadone maintenance clinic services provided before the date of the physician's comprehensive medical examination, diagnosis and treatment plan.
1223.21 "in the MA Program fee schedule"	Scope of services for the categorically needy
1223.22 "in the MA Program fee schedule"	Scope of services for the medically needy
1223.23 "in the MA Program fee schedule"	Scope of services for State Blind Pension recipients
1223.51 "and the Medical Assistance program fee schedule"	General payment policy for outpatient drug/alcohol clinic services
1223.52(a)(2) and (a)(3) "Separate billings for these interviews are not compensable."	Additional interviews with other staff
1223.52(a)(5) "listed in the Medical Assistance Program Fee Schedule"	Diagnostic psychological services
1223.52(c) "Separate billings for these interviews are not compensable."	Interviews or consultations with family members alone, without the presence of the family member with a drug/alcohol abuse or dependence problem, are considered to be part of the family psychotherapy fee.
1223.53	Limitations on Payment for outpatient drug and alcohol clinic services
1223.54(2) "and the Medical Assistance program fee schedule"	Items and services not listed as compensable in Chapter 1150
Managed care organizations are to adhere to the requirements of 55 Pa. Code Chapter 1225, Family Planning Clinic Services, with the following exceptions:	
1225.1 "and the MA Program fee schedule"	General provisions
1225.51"and the MA Program fee schedule"	General payment policy
1225.54(2)	Noncompensable family planning services
Managed care organizations are to adhere to the requirements of 55 Pa. Code Chapter 1229, Health Maintenance Organizations Services, with the following exceptions:	
NONE	
Managed care organizations are to adhere to the requirements of 55 Pa. Code Chapter 1230, Portable X-Ray Services, with the following exceptions:	
1230.1 "and the MA Program fee schedule"	General provisions
1230.51 "and the MA fee schedule"	General payment policy for portable x-ray services
1230.52(b) "and the MA Program fee schedule"	Payment for transporting portable X-ray equipment from the provider's office to the place of service
1230.53 (a) through (c)	Portable x-ray services, provider maximum payment, payment for transportation of portable x-ray equipment and electrocardiogram services
1230.54 (1)	Noncompensable services, procedures not listed in the MA Program fee schedule
Managed care organizations are to adhere to the requirements of Medical Assistance Bulletin 99-94-08 (relating to 55 Pa. Code Chapter 1239, Medical Case Management), Medical Assistance Case Management Services for Recipients Under the Age of 21, with the following exceptions: ▪ Discussion ▪ Page 2, paragraph 3 "The OMAP reserves the right to limit the number of recipients in a case manager's caseload." ▪ Page 3, Payment for case management services covered by this bulletin, 1 through 3 and 4 c through f.	

CITATION/SPECIFIC EXCLUSION	REGULATORY LANGUAGE DESCRIPTION
Managed care organizations are to adhere to the requirements of 55 Pa. Code Chapter 1241, Early and Periodic Screening, Diagnosis and Treatment Program, with the following exceptions:	
1241.2 Definition of "Administrative contractors"	Definitions
1241.42(1) "or to the CAO for supportive help in locating an appropriate provider"	If not licensed or equipped to render the necessary treatment or further diagnosis, the screening provider shall refer the individual to an appropriate enrolled practitioner or facility.
1241.51	Payment to the provider
1241.53	Limitations on payments
1241.54 (a) (1) through (5)	Noncompensable services and items
1241.54 (b) (1) through (5)	Noncompensable services and items
Managed care organizations are to adhere to the requirements of 55 Pa. Code Chapter 1243, Outpatient Laboratory Services, with the following exceptions:	
1243.51 "and the MA Program fee schedule"	General payment policy for outpatient laboratory services
1243.52(b) "billed to the Department"	Laboratory services billed to the Department will be based on the written request of the practitioner
1243.53 (a)	The fees listed in the MA Program fee schedule are the maximum allowed
1243.54 (1) and (2)	Noncompensable services
Managed care organizations are to adhere to the requirements of 55 Pa. Code Chapter 1245, Ambulance Transportation, with the following exceptions:	
1245.1 "and the MA Program fee schedule"	General provisions for payment of ambulance transportation to eligible beneficiaries
1245.21 "and the MA Program fee schedule"	Scope of services for the categorically needy
1245.22 "and the MA Program fee schedule"	Scope of services for the medically needy
1245.23 "and the MA Program fee schedule"	Scope of services for State Blind Pension recipients
1245.51 (b)	Ambulance services which obtain Voluntary Ambulance Service Certification (VASC) from the Department of Health will be reimbursed at a higher rate than non-VASC certified services
1245.52(1)	Payment conditions for ambulance transportation, medically necessary
1245.52(3) through (5)	Transportation to the nearest appropriate medical facility and medical services/supplies invoice.
1245.53	Limitations on payment for ambulance service when more than one patient is transported. Payment is made for transportation of the patient whose destination is the greatest distance. No additional payment is allowed for the additional person.
1245.54(1) through (7)	Noncompensable services and items relating to ambulance transportation.
Managed care organizations are to adhere to the requirements of 55 Pa. Code Chapter 1249, Home Health Agency Services, with the following exceptions:	
1249.51 "and the MA Program fee schedule"	General payment policy for Home Health Services
1249.55(b)	Payment conditions for medical supplies. Home health agencies are not reimbursed for supplies routinely needed as part of furnishing home health care services. Payment for these supplies is included in the comprehensive fee.
1249.57	Payment conditions for maternal/child services
1249.58	Payment conditions for travel costs
1249.59	Limitations on payments for home health agency services

EXHIBIT B(1)

MCO PAY FOR PERFORMANCE

This Exhibit B(1) defines a potential payment obligation by the Department to the PH-MCO for Quality Performance Measures achieved per HEDIS® as defined below. This Exhibit is effective only if the PH-MCO operates a HealthChoices program in this HealthChoices zone under this Agreement in the month of December 2020. If the PH-MCO does not operate a HealthChoices program in this HealthChoices zone under this Agreement in the month of December 2020 the Department has no payment obligation under this Exhibit.

This Exhibit supplements but does not supplant Exhibits that provide for Pay for Performance (P4P) and incorporate different dates in Section II. below.

I. Quality Performance Measures

The Department selected ten (10) HEDIS® 2020 and two (2) 2020 Pennsylvania Performance Measure (PAPM) as quality indicators (representing CY 2019 data) for the MCO P4P program. The Department chose these indicators based on an analysis of past data indicating the need for improvement across the HealthChoices Program as well as the potential to improve health care for a broad base of the HealthChoices population. The twelve (12) quality indicators are:

HEDIS®

1. Adolescent Well-Care Visits
2. Annual Dental Visit (Ages 2 – 20 years)
3. Comprehensive Diabetes Care: HbA1c Poor Control
4. Controlling High Blood Pressure
5. Prenatal Care in the First Trimester
6. Postpartum Care
7. Well-Child Visits in the First 15 Months of Life, 6 or more
8. Well Child Visits in the Third, Fourth, Fifth and Sixth Years of Life
9. Medication Management for People with Asthma 75%
10. Lead Screening in Children

PAPM

1. Reducing Potentially Preventable Readmissions
2. Developmental Screening First Three Years of Life

The MCO P4P Program measures Benchmark Performance and Improvement Performance. The PAPM measures, Reducing Potentially Preventable Readmissions and Developmental Screening First Three Years of Life, will be eligible for the Improvement Performance component. In addition, the Department has set a performance goal for Reducing Potentially Preventable Readmissions and Developmental Screening First Three Years of Life While these measures do

not have a national benchmark, the measures value will be calculated the same as HEDIS measures in the benchmark performance, Section I. A., below.

NOTE: The MCO P4P measures are subject to change due to NCQA specifications.

A. Benchmark Performance*:* The Department will award a Benchmark Performance payout amount for each measure in Section I. that will range from 0% up to and including 125% of the measure's value, defined as half of the PH-MCO's Maximum Program Payout amount (equivalent to 1.0% of the sum of the amounts defined in Section II. below) divided by thirteen (13) (consisting of twelve (12) quality indicators with Annual Dental Visit counted twice). The Department will make Benchmark Performance payouts for performance relative to the HEDIS® 2020 (CY 2019) benchmarks, for all measures excluding Reducing Potentially Preventable Readmissions and Developmental Screening First Three Years of Life. A goal of 8.50 percent (8.50%) has been set for Reducing Potentially Preventable Readmissions and a goal of 57 percent (57.00%) has been set for Developmental Screening First Three Years of Life (see Section I.A.4. and Section I.A.5.) If the PH-MCO's HEDIS 2020 (CY 2019) performance rate is below the 50th Percentile Benchmark, the Department will implement a 75% off-set. The Department will distribute the payouts according to the following criteria:

1. All HEDIS® Measures

- HEDIS® 2020 rate at or above the 90th percentile benchmark: 125 percent of the measure value.
- HEDIS® 2020 rate at or above the 75th percentile and below the 90th percentile benchmark: 100 percent of the measure value.
- HEDIS® 2020 rate at or above the 50th percentile and below the 75th percentile benchmark: No payout. HEDIS® 2020 rate below the 50th percentile benchmark:
  -75 percent offset

2. Annual Dental Visit Performance Only

- The Benchmark Performance measure value applicable to Annual Dental Visit Performance is equal to double the Benchmark Performance measure value (as identified in Section I.A.).
- The -50% off-set will be applied to double the Benchmark Performance measure value (as identified in Section I. A.).

3. Medication Management for People With Asthma 75%

- HEDIS® 2020 rate at or above the 90th percentile benchmark: 100 percent of the measure value.
- No penalty

4. Reducing Potentially Preventable Readmissions

- Performance goal at or below 8.50 percent (8.50%): 100 percent of the measure value.
- Performance goal above 8.50 percent (8.50%): No payout.

5. Developmental Screening First Three Years of Life

- Performance goal at or above 57.00 percent (57.00%): 100 percent of the measure value.
- Performance goal below 57.00 percent (57.00%): No payout

B. Benchmark Bonus Bundles: The Department will award a Benchmark Bonus Bundle payment for two groups of measures in the current MCO P4P model. If a bundle payment is earned this payment method will apply in addition to I.A.

The first bundle is the Perinatal and Infant Bundle. The measures in this bundle are:

- Prenatal Care in the First Trimester,
- ,
- Postpartum Care, and
- Well-Child Visits in the First 15 Months of Life, 6 or more

The second bundle is the Child and Adolescent Well Care Bundle. The measures in this bundle are:

- Well-Child Visits in the Third, Fourth, Fifth and Sixth Years of Life,
- Adolescent Well-Care Visits, and
- Lead Screening in Children

1. Perinatal and Infant Bundle:

- If the rate for Prenatal Care in the First Trimester, Postpartum Care and Well-Child Visits in the First 15 Months of Life, 6 or more is ≥75th percentile benchmark: 115% of the measure value payout for each measure.
- If the rate for Prenatal Care in the First Trimester, Postpartum Care and Well-Child Visits in the First 15 Months of Life, 6 or more is ≥90th percentile benchmark: 130% of the measure value payout for each measure.
- If a rate achieved is ≥50th percentile benchmark or below: No bonus payout will be issued.

NOTE: If one or more of the measures in the bundle achieves a ≥ 75th percentile benchmark and another measure(s) achieves a ≥90th percentile benchmark, the measure(s) that achieved the ≥75th percentile benchmark will receive 115% of the measure value payout, while the measure(s) that

achieved a ≥90th percentile benchmark will receive 130% of the measure value payout.

2. Child and Adolescent Well Care Bundle:

- If the rate for Well-Child Visits in the Third, Fourth, Fifth and Sixth Years of Life, Adolescent Well-Care Visits and Lead Screening in Children are ≥75th percentile benchmark: 115% of the measure value payout will be issued for each measure.
- If the rate for each of the measures is ≥90th percentile benchmark: 130% of the measure value payout will be issued for each measure.
- If the rate achieved for any of the measures is ≥50th percentile benchmark or below: No bonus payout will be issued.

NOTE: If one or more of the measures in the bundle achieves a ≥ 75th percentile benchmark and another measure(s) achieves a ≥90th percentile benchmark, the measure (s) that achieved the ≥75th percentile benchmark will receive 115% of the measure value payout, while the other measure(s) that achieved a ≥90th percentile benchmark will receive 130% of the measure value payout.

C. Improvement Performance*:* The Department will award an Improvement Performance payout amount for each measure in Section I. that will range from 0% up to and including 100% of the measure's value, defined as half of the PH-MCO's Maximum Program Payout amount (equivalent to 1.0% of the sum of the amounts defined in Section II. below) divided by thirteen (13) (consisting of twelve (12) unique quality indicators with Annual Dental Visit counted twice).

The improvement performance payout scales will be applied contingent on benchmark percentile performance for each HEDIS 2020 measure (see Section I.C.1. and I.C.2.).

- If improvement is achieved and the benchmark performance for that measure is ≤50th percentile, Scale 1 will be applied.
- If improvement is achieved and the benchmark performance for that measure is >50th percentile and <75th percentile, Scale 1 will be applied.
- If improvement is achieved and the benchmark performance ≥75th percentile (see Section I.C.2.), Scale 2 will be applied.

Scale 2 applies to improvement performance for the PAPMs' Reducing Potentially Preventable Readmissions and Developmental Screening the First Three Years of Life. Receiving the Improvement Performance payout is not contingent on meeting the 8.50 percent (8.50%) goal for Reducing Potentially Preventable Readmissions and the goal of 57 percent (57.00%) for Developmental Screening First Three Years of Life.

1. Scale 1:

The Department will make Improvement Performance payouts for incremental performance improvement from the previous year rate. Incremental performance improvements are measured comparing rates from HEDIS® 2019 (CY 2018) to HEDIS® 2020 (CY 2019).

- ≥ 5 Percentage Point Improvement: 100 percent of the measure value.
- ≥ 4 and < 5 Percentage Point Improvement: 80 percent of the measure value.
- ≥ 3 and < 4 Percentage Point Improvement: 70 percent of the measure value.
- < 3 Percentage Point Improvement: No payout
-

2. Scale 2:

The Department will make Improvement Performance payouts for incremental performance improvement from the previous year rate. Incremental performance improvements are measured comparing rates from HEDIS® 2019 (CY 2018) to HEDIS® 2020 (CY 2019) and PAPM 2019 (CY 2018) to PAPM 2020(CY 2019).

- ≥ 5 Percentage Point Improvement: 100 percent of the measure value.
- ≥ 4 and < 5 Percentage Point Improvement: 100 percent of the measure value.
- ≥ 3 and < 4 Percentage Point Improvement: 100 percent of the measure value.
- ≥ 2 and < 3 Percentage Point Improvement: 85 percent of the measure value.
- ≥ 1 and < 2 Percentage Point Improvement: 75 percent of the measure value.
- ≥ 0.5 and < 1 Percentage Point Improvement: 50 percent of the measure value.
- < 0.5 Percentage Point Improvement: No payout.

3. Annual Dental Visit Performance Only

   The Improvement Performance measure value available for Annual Dental Visit Performance is equal to double the Improvement Performance measure value (identified in Section I.C.).

4. Limitation on Payout Amounts
   The total awarded payout amount to a PH-MCO, which includes Benchmark Performance (I.A.) and Improvement Performance (I.C.),

cannot exceed the Maximum Program Payout amount, as identified in Section II. below.

II. Payment for MCO Pay for Performance

The Department will inform the PH-MCO of the Maximum Program Payout amount by November 30, 2020.
The Maximum Program Payout amount will be equivalent to two (2.0) percent of the sum of the amounts defined below:

Capitation Revenue - For the purpose of this Exhibit, Capitation Revenue is defined as all Capitation revenues paid or payable by the Department to the PH-MCO in accordance with this Agreement or another HealthChoices Agreement, Appendix 3b and Appendix 3f, for the program period July 2019 through June 2020 inclusive of allowance amounts for the risk sharing and risk pool arrangements. Any settlements for the risk sharing and risk pool arrangements will not be considered in the Capitation Revenue.

Maternity Care Revenue - For the purpose of this Exhibit, Maternity Care Revenue is defined as all Maternity Care payments, paid or payable by the Department to the PH-MCO in accordance with this Agreement, for the program period July 2019 through June 2020.

If the PH-MCO has purchased the assets or liabilities of a PH-MCO that previously contracted with the Department to operate a HealthChoices program in the same zone ("Previous PH-MCO"); or if the Department transferred the Members enrolled in the Previous PH-MCO, who did not make a different choice, to the current PH-MCO; then the Department will allow the PH-MCO to include Capitation Revenue and Maternity Care Revenue paid to the Previous PH-MCO for the program period July 2019 through June 2020, provided the Previous PH-MCO relinquishes any claims to payment under the terms of this Exhibit B(1).

Capitation Revenues or Maternity Care Revenue paid or payable by the Department can be included in only one Maximum Program Payout amount provided by the Department. Transition in HealthChoices Agreements or in PH-MCOs will not lead to double counting of any set of revenue when the Department calculates Maximum Program Payout amounts.

Per 42 C.F.R. 438.6(b)(2)(ii) –(iii), this incentive arrangement does not automatically renew and is made available to both public and private PH-MCOs under the same terms of performance.

If the Department has a payment obligation to the PH-MCO pursuant to this Exhibit B(1), the Department will issue the payment by August 31, 2021. If the PH-MCO has a payment obligation to the Department pursuant to this Exhibit B(1), the Department will reduce a subsequent payment to the PH-MCO by this amount.

Exhibit B(2)

PH-MCO and BH-MCO INTEGRATED CARE PLAN (ICP) PROGRAM
PAY FOR PERFORMANCE PROGRAM

This Exhibit B(2) defines a potential payment obligation by the Department to the PH-MCOs for Quality Performance Measures achieved per HEDIS and select Pennsylvania Performance Measures (PAPMs), as defined below.

This Exhibit is effective only if the PH-MCO operates a HealthChoices program in this HealthChoices zone under this Agreement in the month of December 2020. If the PH-MCO does not operate a HealthChoices program in this HealthChoices zone under this Agreement in the month of December 2020, the Department has no payment obligation under this Exhibit.

The Department will provide financial incentives to the PH-MCOs and the Behavioral Health Managed Care Organizations (BH-MCOs) for the Integrated Care Plan (ICP) Program. The Department will provide a funding pool from which dollars will be paid to the PH-MCO based on shared PH/BH-MCO performance measures outlined in this Exhibit. The Department expects this ICP Program to improve the quality of health care and reduce Medical Assistance (MA) expenditures through enhanced coordination of care between the PH-MCOs, BH-MCOs and providers.

In order to be eligible for payments under the ICP, the PH-MCO must submit Operations Report 17 for Calendar Year (CY) 2020 following the time frames outlined within the Report Description and that contains the following specific data requirements for individuals with serious persistent mental illness (SPMI).

1. **Member stratification** - Re-stratification shall be conducted on all members in the targeted SPMI population from the previous calendar year in January. New members shall have an initial stratification level established within sixty (60) days of the date of identification that a member has SPMI. The PH-MCO will report on the member ID, initial stratification level, and six (6) month re-stratification level. Members will be stratified as follows:

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

2. **Integrated Care Plan/Member Profile** - At least **1200 members** must receive an ICP that has been used in care management activity by both the PH and BH MCO. For purposes of this requirement, the Department considers an ICP or member profile, to be the collection, integration and documentation of key physical and behavioral health information that is easily accessible in a timely

manner to persons with designated access. The ICP shall be reviewed and updated at least annually.

3. **Hospitalization Notification and Coordination** - Each PH-MCO and BH-MCO will jointly share responsibility for notification of all inpatient hospital admissions and will coordinate discharge and follow-up. This includes at a minimum the individual's member identification, the date of inpatient admission and name of the acute care hospital. Additional information sharing is encouraged as appropriate per HIPAA and regulatory standards. Notification to the partner MCO of hospital admissions shall occur within one (1) business day of when the responsible MCO partner learns of the admission (e.g., if the PH-MCO knows of an admission, it will notify the BH-MCO within one (1) business day and vice versa). Each PH-MCO will attest on the Operations 17 report that 90% of the admission notifications occurred within one (1) business day of the PH-MCO learning of the admission. The PH-MCO must maintain documentation to support the attestation of 90% admissions notifications.

The Operations Report 17 will be reviewed to verify the accuracy of the stratification, integrated care plan and hospital notification information.

Performance Measures

The performance measures for the 2020 ICP Program include the following:

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

2. Adherence to Antipsychotic Mediations for Individuals with Schizophrenia*

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

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

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

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

Payment for MCO Performance

Ten million dollars ($10M) will be allocated for the ICP Program in CY 2020 for the PH-MCO. The funding will be allocated to each PH-MCO according to its overall percent of HealthChoices member months for CY 2019.

Each of the measures defined below will be weighted equally and receive 20% of the allocated funding. Each component of the Initiation and Engagement of Alcohol and Other Drug Dependence Treatment will receive 10% of the allocated funding. Payments will be based on incremental improvement calculated from the previous HEDIS/PAPM 2019 (measurement year of 2018) to the current HEDIS/PAPM 2020 (measurement year of 2019).

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

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

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

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

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

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

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

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

For measures 4 and 5, 100% payout will be made if there is a reduction of ≥3.0 events per 1,000 member months and a 75% payout if there is a reduction of ≥2.0 events per 1,000 member months.

If the Department has a payment obligation to the PH-MCO and BH-MCO pursuant to this Exhibit B(2), the Department will issue the payment by August 31, 2021.

Exhibit B(3)

PROVIDER PAY FOR PERFORMANCE PROGRAM

The Provider Pay-for-Performance (Provider P4P) program described in this Exhibit B(3) is for services rendered by providers during a Calendar Year (CY) and defined in Section I below.

I. Provider P4P Program Requirements

All Provider P4P programs must target improvements in the quality of or access to health care services for HealthChoices members and must not limit the appropriate use of services by members.

A. The PH-MCO is required to develop a Provider P4P program using the following **mandatory** eleven (11) HEDIS Quality Measures (per HEDIS® 2020 Technical Specifications, Vol. 2), two (2) PA Performance Measures (PAPM) and one (1) Electronic Quality Measure:

HEDIS®

1. Adolescent Well-Care Visit
2. Annual Dental Visit (Age 2 – 20 Years)
   a. Part of the incentive for the Annual Dental Visit measure must include payments to dental providers that must be based on preventive dental services. The incentives must be structured to pay defined minimal amounts to dentists for performing episodes of preventive care for new and established recipients in at least two age bands- (0-5 years and 6-20 years). The specific incentive model will be relatively uniform across the HealthChoices program. The incentive model will be determined by the Department in cooperation with all HealthChoices PH-MCOs.
3. Controlling High Blood Pressure
4. Comprehensive Diabetes Care: HbA1c Poorly Controlled (>9%)
5. Prenatal Care in the First Trimester
6. Postpartum Care
7. Well-Child Visits in the First 15 Months of Life, 6 or more
8. Well-Child Visits in the Third, Fourth, Fifth and Sixth Years of Life
9. Medication Management for People With Asthma 75%
10. Ambulatory Care – ED Visits
11. Lead Screening for Children

PAPM

Reducing Potentially Preventable Readmissions

1. Developmental Screening in the First Three (3) Years of Life

Electronic Quality Measure
Payment for electronic submission of any mandatory measure, the Obstetrical Needs Assessment Form (ONAF), or any Clinical Quality Measure (CQM) approved by the current CMS meaningful use electronic health record program rules. Information on these CQMs may be found at the following link: http://cms.gov/Regulations-and-Guidance/Legislation/EHRIncentivePrograms/eCQM_Library.html

NOTE: The Provider P4P program measures are subject to change due to NCQA specifications.

B. The PH-MCO is required to develop and submit a proposal to the Department using the Provider P4P Submission Template on DocuShare. The proposal must be approved by the Department prior to implementing its Provider P4P program.

C. A PH-MCO's approved Provider P4P program will remain in effect until December 31 of each calendar year. The PH-MCO may submit one (1) revision per quarter only to the provider payout amounts for the Department's review and approval. The PH-MCO must complete and submit the Provider P4P Submission Change Form. Payout revisions must be submitted no later than close of business on the last day of each calendar quarter. No Provider P4P Change Forms will be accepted in the fourth quarter. No other revisions to the Provider P4P program will be accepted.

D. The PH-MCO must provide a quarterly analysis of its approved Provider P4P program through updates at the Quarterly Quality Review Meetings (QQRM).

E. The PH-MCO must annually evaluate and provide an analysis to the Department of the effectiveness of its approved Provider P4P.

F. The Department may request that PH-MCOs share Provider P4P program findings with other HealthChoices PH-MCOs to identify best practices and improve the overall HealthChoices Program.

II. Payments to the PH-MCO

A. The Department will make payments for Provider P4P based on a per member per month (PMPM) rate, noted in Appendix 3f. The Provider P4P payments are

part of the monthly capitation process, as identified in Appendix 3b. Coverage for Members in a freestanding IMD is specified in Section VII. E. 13.

1. If the PH-MCO has unspent Provider P4P funds, as determined by the Department, upon receipt and review of Report #40, the Department may reduce a future payment to the PH-MCO by the unspent amount or the Department may direct unspent Provider P4P funds provided to the PH-MCO per this Exhibit for the current or a prior program year.
2. If at any time the Department determines Provider P4P funds were not disbursed in accordance with the approved Provider P4P plan, upon advanced written notice to the PH-MCO, the Department may elect to reduce a future payment to the PH-MCO by the amount identified.

B. Payments made to the PH-MCO under the Provider P4P program are intended to fund all mandatory measures

III. Payments to Providers

A. All Provider P4P funds received from the Department for this HealthChoices Agreement should be paid to network providers in accordance with the approved Provider P4P program above.
B. The PH-MCO is required to develop and maintain a separate accounting process of the receipts and disbursements of all Provider P4P funds. The PH-MCO must be able to separately identify and track each payment to a provider for each specific mandatory HEDIS Quality Measure identified in the Provider P4P program.
C. Each PH-MCO may determine the frequency of issuing payments to its providers. However, the Department recommends, at a minimum, quarterly payouts. The PH-MCO must issue Provider P4P payments to its providers for services rendered under approved terms of this Exhibit B(3) to be paid out in full no later than June 30 of the subsequent calendar year.

IV. Reporting

A. Clinical Reporting
The PH-MCO is required to meet the Department's reporting requirements for the submissions of quarterly analyses of its approved Provider P4P

Program through updates at the QQRMs and an annual analysis of the effectiveness of its approved Provider P4P program.

B. Financial Reporting
Expenditures for this program are reported on annual Report #40 as required by the annual Financial Reporting Requirements. Reported disbursements should only reflect disbursements for the specified program year.

V. Clinical Review

The Department may choose to perform a clinical review of the Provider Pay-for-Performance program. The PH-MCO must reasonably cooperate with Department staff during the clinical review process.

Exhibit B(4)

HOSPITAL QUALITY INCENTIVE PROGRAM (HQIP)

The Department is administering a HQIP. This program is designed to incentivize acute care general hospitals, and potentially other hospitals, enrolled in HealthChoices to improve the quality of healthcare services. The Department developed this initiative as part of its commitment to promote cost-effective, quality healthcare through an outcome and value-based payment structure. The Department makes an annual determination of Hospital Quality measures.

The Department will measure performance by hospital statewide across HealthChoices. The performance measurements will not be PH-MCO specific. The Department will make one HQIP payment to the PH-MCO on or before October 31, 2020 per this Agreement if the PH-MCO is responsible to operate a HealthChoices program per this Agreement on October 1, 2020, respectively.

The Department's obligation for this program across all PH-MCOs that are responsible to operate a HealthChoices program in any or all zones on October 1, 2020, is $80 million for the 2019 performance year. The Department will divide the $$80 million, respectively, across all PH-MCOs participating in HealthChoices in any or all zones based on each PH-MCO's monthly enrollment, as determined by the Department.

The Department will calculate the HQIP payments by hospital and will provide a schedule of HQIP payment(s) and instructions to each PH-MCO. The PH-MCO will make HQIP payments to hospitals per the instructions within ten business days of the later of the receipt of this payment or the PH-MCO's receipt of payment instructions from the Department. The PH-MCO will not be required to make HQIP payments that exceed, in total, the amount paid by the Department for this purpose.

The Department will continue this HQIP for subsequent calendar years' performance. The Department will share hospital quality data prepared per this program with all PH-MCOs.

Exhibit B(5)

COMMUNITY BASED CARE MANAGEMENT PROGRAM

The Community Based Care Management (CBCM) Program requirements described in this Exhibit B(5) are for care rendered during a CY and defined in the PH-MCO specific CBCM Program approved by the Department per Section I below. Proposals submitted for the CBCM program must increase the use of community-based staff, including certified Community Health Workers where appropriate, to encourage the use of preventive services, identify and resolve barriers to care, and mitigate social determinates of health.

I. Community Based Care Management (CBCM) Program Requirements

A. CBCM activities and funding must primarily be focused on:

1. Addressing social determinants of health,
2. Reducing preventable admissions and readmissions,
3. Reducing non-emergent visits to the emergency department (ED),
4. Supporting the Diabetes Prevention Program (DPP) per Exhibit M(1), Standard V.F,
5. Enhancing behavioral and physical health coordination of services,
6. Targeting providers/organizations that serve a large volume of complex MA recipients including pregnant women;
7. Increasing access to pediatric dental preventive and restorative services;
8. Localized efforts to promote health education and wellness and encouraging the use of preventive health services; and
9. Expansion and capacity building of home-based support services for new parents.

Funding may only be used for approved CBCM services, as defined in the approval letter from the Department.

B. The PH-MCO must implement a minimum of one rapid cycle quality improvement pilot program per year. Rapid cycle quality improvement implies that changes are made and tested over periods of three months or less, rather than the standard twelve-month measurement period. At least one rapid cycle quality improvement pilot program needs to be implemented by the end of the second quarter. Rapid cycle quality improvement pilot programs should be implemented with community-based organizations and will focus on improving health outcomes and address social determinants of health. If a rapid cycle quality improvement pilot program is demonstrating success, the PH-MCO must progressively expand the program.

C. Community based staff must spend the majority of time in face-to face-encounters with members in a community setting, provider outpatient setting, hospital, or ED.

D. CBCM activity must involve care coordination by licensed and non-licensed team members as defined by the latest version of the Operations 15 report. Emphasis should be placed on expanding the use of non- licensed professionals to increase face-to-face interaction with members. Examples of licensed providers include but are not limited to: physicians, dentists, dental hygienists, public health dental hygiene practitioners (PHDHPs), physician's assistants, Certified Registered Nurse Practitioners (CRNPs), nurse midwives, RNs, LPNs, MSWs, dieticians, psychologists, and pharmacists. Examples of non-licensed team members include but are not limited to: medical assistants/technicians, community health workers, doulas, paramedics/EMTs, faith-based ministries, and peer specialists. This list of examples is not fully inclusive. These team members' activities need to be accounted for on the Operations 15 report.

Community based staff can be employed by the PH-MCO, employed by a provider organization, or hired by a third party through a contract with the PH-MCO. The PH-MCO will be responsible for reporting the targeted providers/organizations, targeted recipients, and define the financial spending for each arrangement (see more details below). Because of limited funding, the PH-MCO should target providers/organizations that serve a large volume of complex MA recipients including high risk pregnant women. Preference should be given to large health systems, FQHCs and high-volume dental providers. Preference should be given to programs that focus on co-location of care management services for consumers with Persistent Serious Mental Illness (PSMI) and Substance Use Disorder (SUD).

E. Payment arrangements can include but not be limited to: practice PMPM payments for care management services, payment for direct or contractual employment costs for FTEs, payment of care management CPT codes including transition of care codes, payment for special needs transportation to access MA services, and payment of pharmacy medication management codes.

F. When selecting providers/organizations to fund CBCM, the PH-MCO must require that the provider/organizations make use of electronic medical records with the intent of achieving Meaningful Use under the CMS specifications for Medicare or Medicaid. Providers/organizations that receive direct or indirect funding must be willing to participate in best practice collaborative learning sessions.

G. If the PH-MCO does business in multiple HealthChoices zones, CBCM Program funds can be allocated across any zone in which they are licensed.

H. The PH-MCO is required to develop and submit a proposal to the Department prior to implementing its CBCM Program. The CBCM Program may include multiple programs for use of the CBCM funds. If multiple programs are identified, each one must follow the requirements below. Proposals are due no later than **October 1, 2019** and must be submitted to the appropriate folder in Docushare using the CBCM Proposal template. Each CBCM proposal must include:

1. An initial CBCM program description that lists targeted providers/organizations, an initial six (6) and twelve (12) months budget, and operations timeline that outlines the startup of the program from January 1, 2020 through December 31, 2020.
2. For rapid cycle quality improvement pilot programs, include the budget for the pilot phase of the program. If the program is expanded, a revised budget for the expanded program must be submitted.
3. The targeted providers/organizations, larger volume health systems, FQHC's, or co-location of services being involved with CBCM. The PH-MCO will be responsible for reporting the targeted providers/organizations, targeted recipients, and define the financial spending for each arrangement.
4. The number of FTE's involved with or employed as a CBCM worker whether the FTE is full or part-time, licensed or unlicensed, contracted or part of the PH-MCO staff.
5. Measurable goals for each CBCM program.
6. An outline of interventions that the CBCM worker will be performing for each of the targeted providers.
7. Outline payment mechanisms and time frames to providers for CBCM.
8. Program Budget, which should include the payment terms.

I. A PH-MCO's approved CBCM program will remain in effect until December 31 of each calendar year. The PH-MCO may only submit one quarterly revision for the Department's review and approval. The PH-MCO must complete and submit the CBCM Proposal Change Form, that is available on Docushare. Changes must be submitted no later than close of business on the last day of each calendar quarter. No changes will be accepted for the fourth quarter. No other revisions will be accepted.

J.

The PH-MCO will establish an evidenced-informed, outcomes-based Maternal, Infant and Early Childhood Home Visitation Program for all first-time parents and parents of infants with additional risk factors. In addition to post-partum home visits, the PH-MCO will provide a minimum of two home visits

for all first-time parents and parents of infants with additional risk factors. These home visits must cover parent education on infant development and assessment of social determinates of health including identification of strengths and areas for improvement. The home visiting care manager/parent coaches will work to assist the parents with resources to address the identified needs. After the two home visits, if further follow up is warranted, the PH-MCO should refer the family to available evidence- based home visiting programs, positive parenting programs, child care or other family support programs in the community. If there are concerns about the infant's development, the PH-MCO should refer the family to Early Intervention for evaluation and services if eligible. The PH-MCO will follow-up with parents to identify and resolve any barriers and to ensure progress in obtaining all referred services.

If the PH-MCO currently implements an evidenced-based home visitation program for first time parents and parents of infants with additional risk factors, focus should be placed on expanding the program to new geographic areas and new populations.

Evidenced-informed, outcomes-based programs have a two-generation approach, aimed at improving the well-being of both parents and children across the lifespan. They are all steeped in the Strengthening Families Protective Factors Framework. Children are more likely to thrive when their families have the support they need from the beginning. Home visitors evaluate families' strengths and needs and provide services tailored to those needs, such as: teaching positive parenting skills and parent-child interactions, providing information on a wide range of topics including breastfeeding, safe sleep practices, injury prevention and nutrition, conduct screenings and provide referrals to address postpartum depression, substance use disorders and family violence, as well as developmental screenings of children and connecting families to other services and resources as needed. The list of approved evidence-based home visitation programs/models can be found at https://homvee.acf.hhs.gov/

K. The PH-MCO must implement their evidenced-informed, outcomes-based Maternal, Infant and Early Childhood Home Visitation Program no later than the end of second quarter of the calendar year. The PH-MCO needs to actively recruit and enroll community-based non-medical DPP providers. CBCM funds may be used for DPP infrastructure, data reporting and training of DPP coaches. CBCM funds cannot be used for any other DPP expenses.

II. Payments to the PH-MCO

A. The Department will make payments for CBCM based on a per member per month (PMPM) rate, noted in Appendix 3f. Effective January 1, 2018, CBCM payments to the PH-MCO will be net of those Members between ages 21 and

64 that have been determined by the Department to be in an IMD for 16 or more days in a calendar month and effective July 1, 2018, the Member's condition is not related to Substance Used Disorder (SUD). The CBCM payments are part of the monthly capitation process, as identified in Appendix 3b.

1. If the PH-MCO has unspent CBCM funds, as determined by the Department, determined as of June 30 of the subsequent calendar year, the Department may reduce a future payment to the PH-MCO by the unspent amount or the Department may direct unspent CBCM funds provided to the PH-MCO per this Exhibit for the current or a prior program year. Any directed CBCM funds are to be used in support of an initiative to improve access to care or improved quality outcomes for Members.
2. If at any time the Department determines CBCM funds were not disbursed in accordance with the approved CBCM plan, upon advanced written notice to the PH-MCO, the Department may elect to reduce a future payment to the PH-MCO by the amount identified.
3. The Department will not reimburse the PH-MCOs for CBCM related expenses in excess of payments made by the Department. However, PH-MCOs can chose to spend more than funds paid by the Department to improve quality or access to care.

III. Payments to Providers

The PH-MCO should make payment to providers within the approved time period for the approved CBCM program, as identified above.

IV. Reporting

A. Clinical Reporting

1. All PH-MCOs must submit an analysis of their Comprehensive Care Management in addition to submitting a sub-analysis of the Community Based Case Management program. These analyses must be submitted as part of Operations Report #15 to the Department on the scheduled reporting due date(s).
2. An analysis of CBCM services should be a subset of the Comprehensive Care Management Program which details each provider involved as well as the Community Based Care Management interventions utilized during member interactions that impacted or reduced preventable readmissions or non-emergent visits to the ED, increased use of preventive care, or enhanced coordination of BH/PH services. For dental related services,

MCO will report the impact of CBCM activity to increase the CMS 416 rate of preventive dental services as well as the HEDIS pediatric dental rate.

3. The PH-MCOs will report on the clinical and financial outcomes of the program. The analyses should be a subset of the Operations 15 report and must describe the program's return on investment (ROI).

B. Financial Reporting

The PH-MCO must submit three quarterly financial reports and a final annual financial report for all approved CBCM expenditures paid within one program year. PH-MCOs must submit the financial report in a format approved by the Department. Reports are due upon request from the Department. The final annual financial report is due by June 30 of the subsequent calendar year.

V. Clinical Review

The Department may choose to perform a review of the Community Based Care Management program. The PH-MCO must reasonably cooperate with Department staff during the review process.

Exhibit B(6)

MEDICATION ADHERENCE PAY-FOR-PERFORMANCE

This Exhibit B(6) defines a potential payment obligation by the Department to the PH-MCO for managing certain Members with a diagnosis of Hepatitis C to cure through adherence to their medication regimen as verified through point of sale claims for Hepatitis C medication dispensed and by the Member's subsequent laboratory test post medication regimen for viral load.

The Department will make a one-time payment in the amount of $1,000 to the PH-MCO for each unique Member with a diagnosis of Hepatitis C that has received Hepatitis C medication(s), as identified on the Department's Specialty Drug List, within the given calendar year and received a subsequent laboratory test that confirms the Member has achieved cure.

The Department will verify eligible Members for this incentive payment through encounter data for pharmacy services that have dates of service during the given calendar year and for which the PH-MCO submits a Sustained Virological Response (SVR) that confirms the Member achieved cure. The PH-MCO will notify the Department of SVRs it has obtained that document undetectable Hepatitis C Ribonucleic Acid (RNA) at least twelve weeks following completion of the medication therapy.

The Department will accept a SVR from the PH-MCO if at least one of the following criteria is met, along with other requirements:

A. The PH-MCO has paid for a Hepatitis C drug for the recipient during the given calendar year; OR
B. The recipient is currently enrolled with the PH-MCO.

If the Member changes PH-MCOs during the course of medication therapy, the Department will make a proportional payment to the PH-MCO for a Member that has switched prior to receiving the SVR confirming cure. If the PH-MCO did not make a payment for any days of the medication regimen received by the switching Member, the one-time payment will be multiplied by 10 percent (10.0%); If the PH-MCO paid for 1 to 30 days of the medication regimen received by the switching Member, the one-time payment will be multiplied by 50 percent (50.0%); If the PH-MCO paid for 31 days or more of medication regimen received by the switching Member, the PH-MCO will receive the one-time payment in full. The difference between the one-time payment less the proportional payment, will be paid to the PH-MCO from which the Member switched.

The Department will process one payment to the PH-MCO for each semi-annual period for the given calendar year. Each payment will total the sum of the one-time payments earned plus any proportional payments earned by the PH-MCO during that period. The Department will determine the inclusion of Members in each semi-annual period based on the date of service for that Member's last Hepatitis C medication claim as identified through encounter data. The Department will not process each semi-annual payment until, at the earliest, six months after the end of the semi-annual period. Members that have been determined cured will be included in only one of the two semi-annual periods during the given calendar year.

If the PH-MCO has purchased the assets or liabilities of a PH-MCO that previously had an Agreement with the Department to operate a HealthChoices program ("Previous PH-MCO"); or if the Department transferred the Members enrolled in the Previous PH-MCO, who did not make a different choice, to the current PH-MCO; then the Department will include claims paid by the Previous PH-MCO.

EXHIBIT C

PH-MCO REQUIREMENTS FOR PROVIDER TERMINATIONS

The PH-MCO must comply with the requirements outlined in this Exhibit when they experience a termination with a provider. The requirements have been delineated to identify the requirements for terminations that are initiated by the PH-MCO and terminations that are initiated by the provider. Also provided in this Exhibit are the requirements for submission of workplans and supporting documentation that is to be submitted to the Department for hospital terminations, terminations of a specialty unit within a facility and terminations with large provider groups, which would negatively impact the ability of members to access services.

I. Termination by the PH-MCO

A. Notification to Department

The PH-MCO must notify the Department in writing of its intent to terminate a Network Provider and services provided by a Network Provider (which includes a hospital, specialty unit within a facility, and/or a large provider group) ninety (90) days prior to the effective date of the termination.

The PH-MCO must submit a Provider termination work plan and supporting documentation within ten (10) Business Days of the PH-MCO notifying the Department of the termination and must provide weekly updates to this information. The requirements for the workplan and supporting documentation are found in this Exhibit, under 3. Workplans and Supporting Documentation.

B. Continuity of Care

The PH-MCO must comply with both this section and the PA Department of Health (DOH) requirements found at 28 Pa. Code § 9.684.

Unless the Provider is being terminated for cause as described in 40 P.S. § 991.2117(b), the PH-MCO must allow a Member to continue an ongoing course of treatment from the Provider for up to sixty (60) days from the date the Member is notified by the PH-MCO of the termination or pending termination of the Provider, or for up to sixty (60) days from the date of Provider termination, whichever is greater. A Member is considered to be receiving an ongoing course of treatment from a Provider if during the previous twelve (12) months the Member was treated by the Provider for a condition that requires follow-up care or additional treatment or the services have been Prior Authorized**.** Any adult member with a previously scheduled appointment shall be determined to be in receipt of an ongoing course of treatment from the provider, unless the appointment is for a well adult check-up. Any child (under age 21) with a previously scheduled appointment, including an appointment for well child care, shall be determined to be in receipt of an ongoing

course of treatment from the provider. Per Department of Health regulation Title 28, §9.684(d), the transitional period may be extended by the PH-MCO if the extension is determined to be clinically appropriate. The PH-MCO shall consult with the Member and the health care provider in making the determination. The PH-MCO must also allow a Member who is pregnant to continue to receive care from the Provider that is being terminated through the completion of the Member's postpartum care.

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

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

C. Notification to Members

If the Provider that is being terminated from the Network is a PCP, the PH-MCO, using the template notice titled C(1) Provider Termination Template For PCPs found in Docushare, must notify all Members who receive primary care services from the Provider thirty (30) days prior to the effective date of the Provider's termination. Members who are receiving an ongoing course of treatment from the Provider may continue to receive this treatment for up to sixty (60) days from the date the Member is notified of the termination or pending termination of the Provider, or for up to sixty (60) days from the date of Provider termination, whichever is greater.

If the Provider that is being terminated from the Network is not a PCP or a hospital, the PH-MCO, using the template notice titled C(3) Provider Termination Template for Specialist and FQHC Providers Who Are Not PCPs, found in Docushare, must notify all Members who have received services from the Provider during the previous twelve (12) months, as identified through referral and claims data; all Members who are scheduled to receive services from the Provider; and all Members who have a pending or approved prior authorization request for services from the Provider thirty (30) days prior to the effective date of the Provider's termination. Members who are receiving an ongoing course of treatment from the Provider may continue to receive this treatment for up to sixty (60) days from the date the Member is notified of the termination or pending termination of the Provider, or for up to sixty (60) days from the date of Provider termination, whichever is greater.

If the Provider that is being terminated from the Network is a hospital (including a specialty unit within a facility or hospital), the PH-MCO, using the template notice titled C(2) Hospital/Specialty Unit Within a Facility or Hospital Termination found in Docushare, must notify all Members assigned to a PCP with admitting privileges at the hospital, all Members assigned to a PCP that is owned by the hospital, and all Members who have utilized the hospital's services within the past twelve (12) months thirty (30) days prior to the effective date of the hospital's termination. The MCO must utilize claims data to identify these Members.

If the PH-MCO is terminating a specialty unit within a facility or hospital**,** the Department may require the PH-MCO to provide thirty (30) day advance written notice to a specific Member population or to all of its Members, based on the impact of the termination.

The Department, at its sole discretion, may allow exceptions to the thirty (30) day advance written notice depending upon verified status of contract negotiations between the PH-MCO and Provider.

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

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

The PH-MCO must update hard copy and web-based Provider directories to reflect changes in the Provider Network as required in Section V.F.16, Provider Directories, of this Agreement.

II. Termination by the Provider

A. Notification to Department

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

The PH-MCO must submit a Provider termination work plan within ten (10) Business Days of the PH-MCO notifying the Department of the termination and must provide weekly status updates to the workplan. The requirements for the

workplan are found in this Exhibit, under 3. Workplans and Supporting Documentation.

The PH-MCO must comply with both this section and the PA Department of Health (DOH) requirements found at 28 Pa. Code § 9.684.

B. Notification to Members

If the Provider that is terminating its participation in the Network is a PCP, the PH-MCO, using the template notice titled C(1) Provider Termination Template For PCPs, in Docushare, must notify all Members who receive primary care services from the Provider.

If the Provider that is terminating its participation in the Network is not a PCP or a hospital, the PH-MCO, using the template notice titled C(3) Provider Termination Template for Specialist and FQHC Providers Who Are Not PCPs, found in Docushare, must notify all Members, who have received services from the Provider during the previous twelve (12) months; all Members who were scheduled to receive services from the terminating Provider; and all Members who have a pending or approved Prior Authorization request for services from the Provider thirty (30) days prior to the effective date of the Provider's termination. The PH-MCO must use referral and claims data to identify these Members.

If the Provider that is terminating its participation in the Network is a hospital or specialty unit within a facility, the PH-MCO, using the template notice titled C(2) Hospital/Specialty Unit Within a Facility or Hospital Termination, found in Docushare, must notify all Members assigned to a PCP with admitting privileges at the hospital, all Members assigned to a PCP that is owned by the hospital, and all members who have utilized the terminating hospital's services within the past twelve (12) months thirty (30) days prior to the effective date of the Hospital's termination. The MCO must use referral and claims data to identify these Members.

If the Provider that is terminating its participation in the Network is a specialty unit within a facility or hospital**,** the Department may require the PH-MCO to provide thirty (30) days advance written notice to a specific Member population or to <u>all</u> of its Members ,based on the impact of the termination.

The Department, in coordination with DOH, may require additional information be included in the notice of a termination to Members.

The PH-MCO must update hard copy and web-based Provider directories to reflect changes in the Provider Network as required in Section V.F.16, Provider Directories, of this Agreement.

III. Workplans and Supporting Documentation

A. Workplan Submission

The PH-MCO must submit a Provider termination work plan within ten (10) Business Days of the PH-MCO notifying the Department of the termination and must provide weekly updates to the workplan. The workplan must provide detailed information on the tasks that will take place to ensure the termination is tracked from the time it is first identified until the termination effective date. The workplan should be organized by Task, Responsible Person(s), Target Dates, Completed Date and Status. The workplan should define the steps within each of the Tasks. The Tasks may include, but not be limited to:

- Commonwealth Notifications (DHS and DOH)
- Provider Impact and Analysis
- Provider Notification of the Termination
- Member Impact and Analysis
- Member Notification of the Termination
- Member Transition
- Member Continuity of Care
- Systems Changes
- Provider Directory Updates for Enrollment Contractor (include date when all updates will appear on Provider files sent to enrollment broker)
- PH-MCO Online Directory Updates
- Member Service and Provider Service Script Updates
- Submission of Required Documents to the Department (member notices and scripts for prior approval)
- Submission of Final Member Notices to the Department (also include date that DOH received the final notices)
- Communication with the Public Related to the Termination
- Termination Retraction Plan, if necessary

B. Supporting Documentation

The Department is also requesting the PH-MCO submit the following supporting documentation, in addition to the workplan, within ten (10) Business Days of the PH-MCO notifying the Department of the termination and must provide weekly updates as appropriate. The Department is not prescribing the format for the supporting documentation. However, it is required to be submitted through electronic means, if possible.

1. Background Information

    a. Submit a summary of issues/reasons for termination.

b. Submit information on negotiations or outreach that has occurred between the PH-MCO and the Provider including dates, parties present and outcomes.

1. Member Access to Provider Services

   a. Submit information that identifies Providers remaining in the Network by Provider type and location that would be available within the appropriate travel times for those members once the termination is effective. Provide the travel times for the remaining providers based upon the travel standards outlined in Exhibit AAA of the contract. For PCPs also list current panel sizes and the number of additional members that are able to be assigned to those PCPs.
   b. Submit geographic access reports and maps documenting that all Members currently accessing terminating providers can access services being provided by the terminating Provider from remaining Network Providers who are accepting new Members. This documentation must be broken out by Provider type.
   c. Submit a comprehensive list of all Providers, broken out by Provider type, who are affected by the termination and that also Indicates the current number of members either assigned (for PCPs) or utilizing these providers.
   d. Submit information that includes the admitting privileges at other hospitals or facilities for each affected Provider and whether each affected Provider can serve the PH-MCO's Members at another hospital or facility.
   e. Submit a copy of the final provider notices to the Department.

2. Member Identification and Notification Process

   a. Submit information that identifies the total number of Members affected by the termination, i.e., assigned to an owned/affiliated PCP or utilizing the hospital or owned/affiliated provider within the twelve (12) months preceding the termination date, broken down by Provider.
   b. Submit information on the number of members with prior authorizations in place that will extend beyond the provider termination date.
   c. Submit draft and final Member notices, utilizing the templates included as C(1) – C(4), Provider and Hospital Termination Templates and Continuity of Care Denial Notice, found in Docushare, as appropriate, for Department review and prior approval.

3. Member Services

   a. Submit for Department prior approval, the call center script to be used for the termination.
   b. Identify the plan for handling increased call volume in the call center while maintaining call center standards.

c. Submit to the Department a call center report for the reporting of summary call center statistics, if requested as part of the termination. This call center report should include, at a minimum, the following elements:

- Total Number of Inbound Member Services Calls (broken out by PCP, Specialist, and Hospital)
- Termination Call Reasons (broken out by Inquiries, PCP Change, Opt Out/Plan Change)

4. Affected Members in Care Management

   a. Submit the total number of members in Care Management affected by the termination with sub-breakdowns by members who are pregnant (broken out by total number of pregnant members in care management, those who will deliver before the termination and those members whose due date is past the termination); members with HIV/AIDS; Children in Substitute Care; and members identified as high risk.
   b. Submit the criteria to the Department that the PH-MCO will utilize for continuity of care for members affected by the termination.
   c. Submit an outreach plan and outreach script to the Department for prior approval if outbound calls are to be made to inform members in care management about the termination.

5. Enrollment Services

   a. Submit final, approved member notices to the Department, the member notices should be on PH-MCO letterhead.

6. News Releases

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

7. Website Update

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

EXHIBIT D

STANDARD GRANT TERMS AND CONDITIONS FOR SERVICES

1. TERM OF GRANT

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

2. INDEPENDENT GRANTEE

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

3. COMPLIANCE WITH LAW

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

4. ENVIRONMENTAL PROVISIONS

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

5. POST-CONSUMER RECYCLED CONTENT

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

6. COMPENSATION/EXPENSES

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

7. INVOICES

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

8. PAYMENT

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

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

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

9. TAXES

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

10. WARRANTY

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

11. PATENT, COPYRIGHT, AND TRADEMARK INDEMNITY

The Grantee warrants that it is the sole owner or author of, or has entered into a suitable legal agreement concerning either: a) the design of any product or process provided or used in the performance of the Grant which is covered by a patent, copyright, or trademark registration or other right duly authorized by state or federal law or b) any copyrighted matter in any report document or other material provided to the commonwealth under the Grant. The Grantee shall defend any suit or proceeding brought against the Commonwealth on account of any alleged patent, copyright or trademark infringement in the United States of any of the products provided or used in the performance of the Grant. This is upon condition that the Commonwealth shall provide prompt notification in writing of such suit or proceeding; full right, authorization and opportunity to conduct the defense thereof; and full information and all reasonable cooperation for the defense of same. As principles of governmental or public law are involved, the Commonwealth may participate in or choose to conduct, in its sole discretion, the defense of any such action. If information and assistance are furnished by the Commonwealth at the Grantee's written request, it shall be at the Grantee's expense, but the responsibility for such expense shall be only that within the Grantee's written authorization. The Grantee shall indemnify and hold the Commonwealth harmless from all damages, costs, and expenses, including attorney's fees that the Grantee or the Commonwealth may pay or incur by reason of any infringement or violation of the rights occurring to any holder of copyright, trademark, or patent interests and rights in any products provided or used in the performance of the Grant. If any of the products provided by the Grantee in such suit or proceeding are held to constitute infringement and the use is enjoined, the Grantee shall, at its own expense and at its option, either procure the right to continue use of such infringement products, replace them with non-infringement equal

performance products or modify them so that they are no longer infringing. If the Grantee is unable to do any of the preceding, the Grantee agrees to remove all the equipment or software which are obtained contemporaneously with the infringing product, or, at the option of the Commonwealth, only those items of equipment or software which are held to be infringing, and to pay the Commonwealth: 1) any amounts paid by the Commonwealth towards the purchase of the product, less straight line depreciation; 2) any license fee paid by the Commonwealth for the use of any software, less an amount for the period of usage; and 3) the pro rata portion of any maintenance fee representing the time remaining in any period of maintenance paid for. The obligations of the Grantee under this paragraph continue without time limit. No costs or expenses shall be incurred for the account of the Grantee without its written consent.

12. OWNERSHIP RIGHTS

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

13. ASSIGNMENT OF ANTITRUST CLAIMS

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

14. HOLD HARMLESS PROVISION

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

15. AUDIT PROVISIONS

The Commonwealth shall have the right, at reasonable times and at a site designated by the Commonwealth, to audit the books, documents and records of the Grantee to the extent that the books, documents and records relate to costs or pricing data for the Grant. The Grantee agrees to maintain records which will support the prices charged and costs incurred for the Grant. The Grantee shall preserve books, documents, and records that relate to costs or pricing data for the Grant for a period of three (3) years from date of final payment. The Grantee shall give full and free access to all records to the Commonwealth and/or their authorized representatives.

16. DEFAULT

a. The Commonwealth may, subject to the provisions of Paragraph 17, Force Majeure, and in addition to its other rights under the Grant, declare the Grantee in default by written notice thereof to the Grantee, and terminate (as provided in Paragraph 18, Termination Provisions) the whole or any part of this Grant for any of the following reasons:

1) Failure to begin work within the time specified in the Grant or as otherwise specified;
2) Failure to perform the work with sufficient labor, equipment, or material to insure the completion of the specified work in accordance with the Grant terms;
3) Unsatisfactory performance of the work;
4) Failure or refusal to remove material, or remove and replace any work rejected as defective or unsatisfactory;
5) Discontinuance of work without approval;
6) Failure to resume work, which has been discontinued, within a reasonable time after notice to do so;
7) Insolvency or bankruptcy;
8) Assignment made for the benefit of creditors;
9) Failure or refusal within 10 days after written notice by the Granting Officer, to make payment or show cause why payment should not be made, of any amounts due for materials furnished, labor supplied or performed, for equipment rentals, or for utility services rendered;
10) Failure to protect, to repair, or to make good any damage or injury to property; or
11) Breach of any provision of this Grant.

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

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

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

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

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

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

17. FORCE MAJEURE

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

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

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

18. TERMINATION PROVISIONS

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

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

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

availability and appropriation of funds. When funds (state and/or federal) are not appropriated or otherwise made available to support continuation of performance in a subsequent fiscal year period, the Commonwealth shall have the right to terminate the Grant. The Grantee shall be reimbursed for the reasonable value of any nonrecurring costs incurred but not amortized in the price of the supplies or services delivered under this Grant. Such reimbursement shall not include loss of profit, loss of use of money, or administrative or overhead costs. The reimbursement amount may be paid for any appropriations available for that purpose

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

19. GRANT CONTROVERSIES

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

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

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

20. ASSIGNABILITY AND SUBGRANTING

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

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

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

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

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

Grantee provided, however, that the term shall not apply to the sale or other transfer of stock of a publicly traded company.

f. Any assignment consented to by the Granting Officer shall be evidenced by a written assignment agreement executed by the Grantee and its assignee in which the assignee

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

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

21. NONDISCRIMINATION/SEXUAL HARASSMENT CLAUSE

During the term of the Grant, the Grantee agrees as follows:

a. In the hiring of any employee(s) for the manufacture of supplies, performance of work, or any other activity required under the grant agreement or any subgrant agreement, contract, or subcontract, the Grantee, a subgrantee, a contractor, a subcontractor, or any person acting on behalf of the Grantee shall not discriminate in violation of the Pennsylvania Human Relations Act (PHRA) and applicable federal laws against any citizen of this Commonwealth who is qualified and available to perform the work to which the employment relates.

b. The Grantee, any subgrantee, contractor or any subcontractor or any person on their behalf shall not in any manner discriminate in violation of the PHRA and applicable federal laws against or intimidate any of its employees.

c. The Grantee, any subgrantee, contractor or any subcontractor shall establish and maintain a written nondiscrimination and sexual harassment policy and shall inform their employees of the policy. The policy must contain a provision that sexual harassment will not be tolerated and employees who practice it will be disciplined. Posting this Nondiscrimination/Sexual Harassment Clause conspicuously in easily-accessible and well-lighted places customarily frequented by employees and at or near where the grant services are performed shall satisfy this requirement.

d. The Grantee, any subgrantee, contractor or any subcontractor shall not discriminate in violation of the PHRA and applicable federal laws against any subgrantee, contractor, subcontractor or supplier who is qualified to perform the work to which the grant relates.

e. The Grantee and each subgrantee, contractor and subcontractor represents that it is presently in compliance with and will maintain compliance with all applicable federal, state, and local laws and regulations relating to nondiscrimination and sexual harassment. The Grantee and each subgrantee, contractor and subcontractor further represents that it has filed a Standard Form 100 Employer Information Report ("EEO-1") with the U.S. Equal Employment Opportunity Commission ("EEOC") and shall file an annual EEO-1 report with the EEOC as required for employers subject to Title VII of the Civil Rights Act of 1964, as amended, that have 100 or more employees and employers that have federal government contracts or first-tier subcontracts and have 50 or more employees. The Grantee, any subgrantee, any contractor or any subcontractor shall, upon request and within the time periods requested by the Commonwealth, furnish all necessary employment documents and records, including EEO-1 reports, and permit access to their books, records, and accounts by the granting agency and the Bureau of Small Business Opportunities (BSBO), for the purpose of ascertaining compliance with the provisions of this Nondiscrimination/Sexual Harassment Clause.

f. The Grantee, any subgrantee, contractor or any subcontractor shall include the provisions of this Nondiscrimination/Sexual Harassment Clause in every subgrant agreement, contract or subcontract so that those provisions applicable to subgrantees, contractors or subcontractors will be binding upon each subgrantee, contractor or subcontractor.

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

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

22. CONTRACTOR INTEGRITY PROVISIONS

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

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

a. "Affiliate" means two or more entities where (a) a parent entity owns more than fifty percent of the voting stock of each of the entities; or (b) a common shareholder or group of shareholders owns more than fifty percent of the voting stock of each of the entities; or c) the entities have a common proprietor or general partner.

b. "Consent" means written permission signed by a duly authorized officer or employee of the Commonwealth, provided that where the material facts have been disclosed, in writing, by prequalification, bid, proposal, or contractual terms, the Commonwealth shall be deemed to have consented by virtue of the execution of this contract.

c. "Contractor" means the individual or entity, that has entered into this contract with the Commonwealth.

d. "Contractor Related Parties" means any affiliates of the Contractor and the Contractor's executive officers, Pennsylvania officers and directors, or owners of 5 percent or more interest in the Contractor.

e. "Financial Interest" means either:

(1) Ownership of more than a five percent interest in any business; or

(2) Holding a position as an officer, director, trustee, partner, employee, or holding any position of management.

f. "Gratuity" means tendering, giving, or providing anything of more than nominal monetary value including, but not limited to, cash, travel, entertainment, gifts, meals, lodging, loans, subscriptions, advances, deposits of money, services, employment, or contracts of any kind. The exceptions set forth in the *Governor's Code of Conduct, Executive Order 1980-18*, the *4 Pa. Code §7.153(b)*, shall apply.

g. "Non-bid Basis" means a contract awarded or executed by the Commonwealth with Contractor without seeking bids or proposals from any other potential bidder or offeror.

2. In furtherance of this policy, Contractor agrees to the following:

a. Contractor shall maintain the highest standards of honesty and integrity during the performance of this contract and shall take no action in violation of state or federal laws or regulations or any other applicable laws or regulations, or other requirements applicable to Contractor or that govern contracting or procurement with the Commonwealth.

b. Contractor shall establish and implement a written business integrity policy, which includes, at a minimum, the requirements of these provisions as they relate to the Contractor activity with the Commonwealth and Commonwealth employees and which is made known to all Contractor employees. Posting these Contractor Integrity Provisions conspicuously in easily-accessible and well-lighted places customarily frequented by employees and at or near where the contract services are performed shall satisfy this requirement.

c. Contractor, its affiliates, agents, employees and anyone in privity with Contractor shall not accept, agree to give, offer, confer, or agree to confer or promise to confer, directly or indirectly, any gratuity or pecuniary benefit to any person, or to influence or attempt to influence any person in violation of any federal or state law, regulation, executive order of the Governor of Pennsylvania, statement of policy, management directive or any other published standard of the Commonwealth in connection with performance of work under this contract, except as provided in this contract.

d. Contractor shall not have a financial interest in any other contractor, subcontractor, or supplier providing services, labor, or material under this contract, unless the financial interest is disclosed to the Commonwealth in writing and the Commonwealth consents to Contractor's financial interest prior to Commonwealth execution of the contract. Contractor shall disclose the financial interest to the Commonwealth at the time of bid or proposal submission, or if no bids or proposals are solicited, no later than Contractor's submission of the contract signed by Contractor.

e. Contractor certifies to the best of its knowledge and belief that within the last five (5) years Contractor or Contractor Related Parties have not:

(1) been indicted or convicted of a crime involving moral turpitude or business honesty or integrity in any jurisdiction;

(2) been suspended, debarred or otherwise disqualified from entering into any contract with any governmental agency;

(3) had any business license or professional license suspended or revoked;

(4) had any sanction or finding of fact imposed as a result of a judicial or administrative proceeding related to fraud, extortion, bribery, bid rigging, embezzlement, misrepresentation or anti-trust; and

(5) been, and is not currently, the subject of a criminal investigation by any federal, state or local prosecuting or investigative agency and/or civil anti-trust investigation by any federal, state or local prosecuting or investigative agency.

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

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

f. When Contractor has reason to believe that any breach of ethical standards as set forth in law, the Governor's Code of Conduct, or these Contractor Integrity Provisions has occurred or may occur, including but not limited to contact by a Commonwealth officer or employee which, if acted upon, would violate such ethical standards, Contractor shall immediately notify the Commonwealth contracting officer or the Office of the State Inspector General in writing.

g. Contractor, by submission of its bid or proposal and/or execution of this contract and by the submission of any bills, invoices or requests for payment pursuant to the contract, certifies and represents that it has not violated any of these Contractor Integrity Provisions in connection with the submission of the bid or proposal, during any contract negotiations or during the term of the contract, to include any extensions thereof. Contractor shall immediately notify the Commonwealth in writing of any actions for occurrences that would result in a violation of these Contractor Integrity Provisions. Contractor agrees to reimburse the Commonwealth for the reasonable costs of investigation incurred by the Office of the State Inspector General for investigations of the Contractor's compliance with the terms of this or any other agreement between the Contractor and the Commonwealth that results in the suspension or debarment of the Contractor. Contractor shall not be responsible for investigative costs for investigations that do not result in the Contractor's suspension or debarment.

h. Contractor shall cooperate with the Office of the State Inspector General in its investigation of any alleged Commonwealth agency or employee breach of ethical standards and any alleged Contractor non-

compliance with these Contractor Integrity Provisions. Contractor agrees to make identified Contractor employees available for interviews at reasonable times and places. Contractor, upon the inquiry or request of an Inspector General, shall provide, or if appropriate, make promptly available for inspection or copying, any information of any type or form deemed relevant by the Office of the State Inspector General to Contractor's integrity and compliance with these provisions. Such information may include, but shall not be limited to, Contractor's business or financial records, documents or files of any type or form that refer to or concern this contract. Contractor shall incorporate this paragraph in any agreement, contract or subcontract it enters into in the course of the performance of this contract/agreement solely for the purpose of obtaining subcontractor compliance with this provision. The incorporation of this provision in a subcontract shall not create privity of contract between the Commonwealth and any such subcontractor, and no third party beneficiaries shall be created thereby.

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

23. GRANTEE RESPONSIBILITY PROVISIONS

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

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

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

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

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

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

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

24. AMERICANS WITH DISABILITIES ACT

a. Pursuant to federal regulations promulgated under the authority of The Americans With Disabilities Act, 28 C.F.R. § 35.101 et seq., the Grantee understands and agrees that it shall not cause any individual with a disability to be excluded from participation in this Grant or from activities provided for under this Grant on the basis of the disability. As a condition of accepting this Grant, the Grantee agrees to comply with the "General Prohibitions Against Discrimination," 28 C.F.R. § 35.130, and all other regulations promulgated under Title II of The Americans With Disabilities Act which are applicable to all benefits, services, programs, and activities provided by the Commonwealth of Pennsylvania through Grants with outside Grantees.

b. The Grantee shall be responsible for and agrees to indemnify and hold harmless the Commonwealth of Pennsylvania from all losses, damages, expenses, claims, demands, suits, and actions brought by any party against the Commonwealth of Pennsylvania as a result of the Grantee's failure to comply with the provisions of subparagraph a above.

25. HAZARDOUS SUBSTANCES

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

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

1) Hazardous substances:

a) The chemical name or common name,

b) A hazard warning, and

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

2) Hazardous mixtures:

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

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

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

d) A hazard warning, and

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

3) Single chemicals:

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

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

4) Chemical Mixtures:

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

b) A hazard warning, if appropriate,

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

d) The chemical name or common name of either the top five substances by volume or those substances consisting of 5.0% or more of the mixture.

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

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

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

- NFPA 704, Identification of the Fire Hazards of Materials.
- National Paint and Coatings Association: Hazardous Materials Identification System.
- American Society for Testing and Materials, Safety Alert Pictorial Chart.
- American National Standard Institute, Inc., for the Precautionary Labeling of Hazardous Industrial Chemicals.

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

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

26. COVENANT AGAINST CONTINGENT FEES

The Grantee warrants that no person or selling agency has been employed or retained to solicit or secure the Grant upon an agreement or understanding for a commission, percentage, brokerage, or contingent fee, except bona fide employees or bona fide established commercial or selling agencies maintained by the Grantee for the purpose of securing business. For breach or violation of this warranty, the Commonwealth shall have the right to terminate the Grant without liability or in its discretion to

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

27. APPLICABLE LAW

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

28. INTEGRATION

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

deemed to modify, add to or detract from, or otherwise change or alter its terms and conditions. No negotiations between the parties, nor any custom or usage, shall be permitted to modify or contradict any of the terms and conditions of the Grant. No modifications, alterations, changes, or waiver to the Grant or any of its terms shall be valid or binding unless accomplished by a written amendment signed by both parties. All such amendments will be made using the appropriate Commonwealth form.

29. CHANGE ORDERS

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

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

30. RIGHT TO KNOW LAW 8-K-1580

a. Grantee or Subgrantee understands that this Grant Agreement and records related to or arising out of the Grant Agreement are subject to requests made pursuant to the Pennsylvania Right-to-Know Law, 65 P.S. §§ 67.101-3104, ("RTKL"). For the purpose of these provisions, the term "the Commonwealth" shall refer to the granting Commonwealth agency.

b. If the Commonwealth needs the Grantee's or Subgrantee's assistance in any matter arising out of the RTKL related to this Grant Agreement, it shall notify the Grantee or Subgrantee using the legal contact information provided in the Grant Agreement. The Grantee or Subgrantee, at any time, may designate a different contact for such purpose upon reasonable prior written notice to the Commonwealth.

c. Upon written notification from the Commonwealth that it requires Grantee's or Subgrantee's assistance in responding to a request under the RTKL for information related to this Grant Agreement that may be in Grantee's or Subgrantee's possession, constituting, or alleged to constitute, a public record in accordance with the RTKL ("Requested Information"), Grantee or Subgrantee shall:

    1. Provide the Commonwealth, within ten (10) calendar days after receipt of written notification, access to, and copies of, any document or information in Grantee's or Subgrantee's possession arising out of this Grant Agreement that the Commonwealth reasonably believes is Requested Information and may be a public record under the RTKL; and

    2. Provide such other assistance as the Commonwealth may reasonably request, in order to comply with the RTKL with respect to this Grant Agreement.

d. If Grantee or Subgrantee considers the Requested Information to include a request for a Trade Secret or Confidential Proprietary Information, as those terms are defined by the RTKL, or other information that Grantee or Subgrantee considers exempt from production under the RTKL, Grantee or Subgrantee must notify the Commonwealth and provide, within seven (7) calendar days of receiving the written notification, a written statement signed by a representative of Grantee or Subgrantee explaining why the requested material is exempt from public disclosure under the RTKL.

e. The Commonwealth will rely upon the written statement from Grantee or Subgrantee in denying a RTKL request for the Requested Information unless the Commonwealth determines that the Requested Information is clearly not protected from disclosure under the RTKL. Should the Commonwealth determine that the Requested Information is clearly not exempt from disclosure, Grantee or Subgrantee shall provide the Requested Information within five (5) business days of receipt of written notification of the Commonwealth's determination.

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

g. The Commonwealth will reimburse Grantee or Subgrantee for any costs associated with complying with these provisions only to the extent allowed under the fee schedule established by the office of Open Records or as otherwise provided by the RTKL if the fee schedule is inapplicable.

h. Grantee or Subgrantee may file a legal challenge to any Commonwealth decision to release a record to the public with the Office of Open Records, or in the Pennsylvania Courts, however, Grantee or Subgrantee shall indemnify the Commonwealth for any legal expenses incurred by the Commonwealth as a result of such a challenge and shall hold the Commonwealth harmless for any damages, penalties, costs, detriment or harm that the Commonwealth may incur as a result of Grantee's or Subgrantee's failure, including any statutory damages assessed against the Commonwealth, regardless of the outcome of such legal challenge. As between the parties, Grantee or Subgrantee agrees to waive all rights or remedies that may be available to it as a result of the Commonwealth's disclosure of Requested Information pursuant to the RTKL.

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

EXHIBIT E

DEPARTMENT OF HUMAN SERVICES ADDENDUM TO STANDARD GRANT TERMS AND CONDITIONS

A. **APPLICABILITY**

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

B. **CONFIDENTIALITY**

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

C. **INFORMATION**

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

D. **CERTIFICATION AND LICENSING**

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

E. **PROGRAM SERVICES**

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

F. **CHILD PROTECTIVE SERVICE LAWS**

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

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

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

H. **MEDICARE/MEDICAID REIMBURSEMENT**

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

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

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

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

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

I. **TRAVEL AND PER DIEM EXPENSES**

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

J. **INSURANCE**

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

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

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

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

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

K. **PROPERTY AND SUPPLIES**

1. Contractor agrees to obtain all supplies and equipment for use in the performance of this contract

at the lowest practicable cost and to purchase by means of competitive bidding whenever required by law.

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

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

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

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

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

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

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

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

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

L. <u>DISASTERS</u>

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

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

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

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

The contractor warrants that no person or selling agency has been employed or retained to solicit or secure this contract upon an agreement or understanding for a commission, percentage, brokerage or contingent fee (excepting bona fide employees or bona fide established commercial or selling agencies maintained by the contractor for the purpose of securing business). For breach or violation of this warranty, the

Department shall have the right to annul this contract without liability or, in its discretion, to deduct from the consideration otherwise due under the contract, or otherwise recover, the full amount of such commission, percentage, and brokerage or contingent fee.

O. CONTRACTOR'S CONFLICT OF INTEREST

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

P. INTEREST OF THE COMMONWEALTH AND OTHERS

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

Q. CONTRACTOR RESPONSIBILITY TO EMPLOY WELFARE CLIENTS

(Applicable to contracts $25,000 or more)

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

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

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

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

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

R. TUBERCULOSIS CONTROL

As recommended by the Centers for Disease Control and the Occupational Safety and Health

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

S. ACT 13 APPLICATION TO CONTRACTOR

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

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

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

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

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

T. LOBBYING CERTIFICATION AND DISCLOUSRE

(applicable to contracts $100,000 or more)

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

U. AUDIT CLAUSE

(applicable to contracts $100,000 or more) This contract is subject to audit in accordance with the Audit Clause attached hereto and incorporated herein.

EXHIBIT F

FAMILY PLANNING SERVICES PROCEDURES

Procedures Which May Be Included with a Family Planning Clinic Comprehensive Visit, a Family Planning Clinic Problem Visit or a Family Planning Clinic Routine Revisit:

- Insertion, implantable contraceptive capsules
- Implantation of contraceptives, including device (e.g. Norplant) (once every five years) (females only)
- Removal, Implantable contraceptive capsules
- Removal with reinsertion, Implantable contraceptive capsules (e.g., Norplant) (once per five years) (females only)
- Destruction of vaginal lesion(s); simple, any method (females only)
- Biopsy of vaginal mucosa; simple (separate procedure) (females only)
- Biopsy of vaginal mucosa; extensive, requiring suture (including cysts) (females only)
- Colposcopy (vaginoscopy); separate procedure (females only)[A]
- Colposcopy (vaginoscopy); with biopsy(s) of the cervix and/or endocervical curettage[A]
- Colposcopy (vaginoscopy); with loop electrosurgical excision(s) of the cervix (LEEP) (females only)[B]
- Intensive colposcopic examination with biopsy and or excision of lesion(s) (females only)[B]
- Biopsy, single or multiple or local excision of lesion, with or without fulguration (separate procedure) (females only)
- Cauterization of cervix; electro or thermal (females only)
- Cauterization of cervix; cryocaury, initial or repeat (females only)
- Cauterization of cervix; laser ablation (females only)

- Endometrial and/or endocervical sampling (biopsy), without cervical dilation, any method (separate procedure) (females only)
- Alpha-fetoprotein; serum (females only)
- Nuclear molecular diagnostics; nucleic acid probe, each
- Nuclear molecular diagnosis; nucleic acid probe, each
- Nuclear molecular diagnostics; nucleic acid probe, with amplification; e.g., polymerase chain reaction (PCR), each
- Fluorescent antibody; screen, each antibody
- Immunoassay for infectious agent antibody; quantitative, not elsewhere specified
- Antibody; HIV-1
- Antibody; HIV-2
- Treponema Pallidum, confirmatory test (e.g., FTA-abs)
- Culture, chlamydia
- Cytopathology, any other source; preparation, screening and interpretation
- Progestasert I.U.D. (females only)
- Depo-Provera injection (once per 60 days) (females only)
- ParaGuard I.U.D. (females only)
- Hemoglobin electrophoresis (e.g., A2, S, C)
- Microbial Identification, Nucleic Acid Probes, each probe used
- Microbial Identification, Nucleic Acid probes, each probe used; with amplification (PCR)

[A] Medical record must show a Class II or higher pathology.

[B] Medical record must show a documentation of a history of previous uterine cancer surgery or in-utero DES (diethylstilbestrol) exposure.

Procedures Which May Be Included with a Family Planning Clinic Problem Visit:

- Gonadotropin, chorionic, (hCG); quantitative
- Gonadotropin, chorionic, (hCG); qualitative
- Syphilis test; qualitative (e.g., VDRL, RPR, ART)
- Culture, bacterial, definitive; any other source
- Culture, bacterial, any source; anaerobic (isolation)
- Culture, bacterial, any source; definitive identification, each anaerobic organism, including gas chromatography
- Culture, bacterial, urine; quantitative, colony count
- Dark field examination, any source (e.g., penile, vaginal, oral, skin); without collection
- Smear, primary source, with interpretation; routine stain for bacteria, fungi, or cell types
- Smear, primary source, with interpretation; special stain for inclusion bodies or intracellular parasites (e.g., malaria, kala azar, herpes)
- Smear, primary source, with interpretation; wet mount with simple stain for bacteria, fungi, ova, and/or parasites
- Smear, primary source, with interpretation; wet and dry mount, for ova and parasites
- Cytopathology, smears, cervical or vaginal, the Bethesda System (TBS), up to three smears; screening by technician under physician supervision
- Level IV - Surgical pathology, gross and microscopic examination
- Antibiotics for Sexually Transmitted Diseases (course of treatment for 10 days) (two units may be dispensed per visit)
- Medication for Vaginal Infection (course of treatment for 10 days) (two units may be dispensed per visit)
- Breast cancer screen (females only)
- Mammography, bilateral (females only)
- Genetic Risk Assessment

Exhibit G

OPIOID USE DISORDER CENTERS OF EXCELLENCE

A. The PH-MCO must contract with all physical health Opioid Use Disorder Centers of Excellence (OUD-COE) identified by OMAP within the HealthChoices zones in which the PH-MCO operates, unless the PH-MCO demonstrates to OMAP's satisfaction that the PH-MCO is not able to reach a contractual agreement with the OUD-COE.

B. The PH-MCO must pay the Department's per-member-per-month (PMPM) rate for community-based care management services rendered by an OUD-COE when the OUD-COE has appropriately submitted a claim using procedure code G9012 (other specified case management service not elsewhere classified).

   The PH-MCO must pay a claim for procedure code G9012 when it determines that the OUD-COE has met the following requirements:

   1. During the first calendar month a Member is engaged with the OUD-COE, the OUD-COE has provided and documented one face-to-face community-based care management service and one service for the treatment of a condition associated with an ICD-10 diagnosis code related to OUD.

   2. During subsequent months a Member is engaged with the OUD-COE, the OUD-COE has provided and documented one face-to-face community-based care management service. If a Member does not receive a face-to-face care management service for two or more consecutive months, the OUD-COE must also provide a treatment service in addition to a face-to-face care management service to receive the PMPM for a subsequent month.

   3. Face-to-face community-based care management services for a Member include:

      a. Helping a Member with OUD navigate the health system and find community resources such as individual and group therapy, social services and recovery supports.

      b. Addressing a Member's individual treatment and non-treatment needs through evaluation of the Member's needs.

      c. Directly assisting a Member with and ongoing facilitation of needed physical and behavioral health services.

      d. Providing follow-up care for a Member and re-engaging a Member in care.

e. Referring a Member for housing, job training, transportation services, educational services, vocational services, food assistance, healthcare services, mental health services, pain management services, substance use disorder level of care evaluation, interpreter services, voter registration or self-help meetings.

f. Advocating on behalf of a Member.

g. Monitoring a Member's health status and achievement of goals within the Member's treatment plan.

h. Screening a Member's urine or blood.

i. Making initial contact with a Member where they present, including emergency departments, state prisons, county jails, and other medical or non-medical settings.

j. Facilitating a Member's initiation into OUD treatment from emergency departments, primary care physicians, criminal justice system, and other sources. Initiation is defined as a face-to-face level of care evaluation.

k. Facilitating a Member's admission to treatment within 14 Days of initiation with an OUD-COE, a treatment provider or other entities as appropriate and necessary.

l. Helping a Member transition from an inpatient level of care to ongoing engagement in outpatient treatment.

m. Creating an individualized support plan for a Member.

n. Motivating and encouraging a Members with OUD to stay engaged in both physical health and behavioral health treatments.

o. Facilitating recovery by helping a Member find stable housing and employment, and reestablishing family/community relationships.

4. The OUD-COE has documented the care management service encounter within the Member's electronic health record, including the following information:

   a. Date of encounter

   b. Location of encounter

   c. Identity of the individual employed by the OUD-COE with whom the Member met

d. Duration of encounter

e. Description of service provided during the encounter

f. Next planned activities that the OUD-COE and the Member will undertake

5. The community-based care management service for which the G9012 procedure code claim is being submitted is not duplicative, overlapping, or redundant of other care or case management services for which the BH-PH-MCO has already paid on a Member's behalf.

6. The OUD-COE has obtained written Member consent to share OUD related information with the Member's Physical HealthChoices PH-MCO (PH-MCO) or Community HealthChoices PH-MCO (CHC-PH-MCO) consistent with state and federal laws and regulations for the purpose of coordinating comprehensive services that address the Member's physical and behavioral needs and any needs related to social determinants of health.

The PH-MCO may not pay multiple claims using procedure code G9012 to an OUD-COE for the same Member in the same calendar month. The PH-MCO may require a claim using procedure code G9012 be submitted each time a Member receives a community-based care management service from an OUD-COE, but it may only pay one claim per month. The PH-MCO may pay the PMPM to more than one OUD-COE for services provided to an individual Member during the same calendar month only during the Member's first two months of engagement with an OUD-COE.

C. The PH-MCO may not require anything additional of the OUD-COEs in order to receive the PMPM, including data reporting. OUD-COEs will submit a data collection spreadsheet to DHS monthly. On a quarterly basis, DHS will transmit a report that includes all of the metrics submitted by the OUD-COEs on the data collection spreadsheet for each of the PH-MCO's individual members, sorted by OUD-COE, to the PH-MCO**.** This report will be transmitted via secure transfer by the end of the quarter following the quarter for which the data was reported.

The Department will provide the following data to the PH-MCO:

1. The Medical Assistance Identification numbers of each of the PH-MCO's members who received services from the OUD-COE during the preceding quarter.

2. The initial date of engagement for each of the PH-MCO's members who received services from the OUD-COE during the preceding quarter.

3. Duration measure - Duration of treatment is defined as the time of initial Member engagement until the last engagement with the Member in the calendar year. This measure will be reported as the percent engaged ≥ 90 days, ≥180 days, and ≥ 270 days. The numerator is the number of Members engaged at each of the above listed time intervals and the denominator is the number of Members who received a treatment or face-to-face care management service during the reporting period Engaged is defined as an initial billable face-to-face care management service for covered services by a licensed professional or facility related to OUD treatment.

4. Percentage of Members served by the OUD-COE who receive drug and alcohol counseling service in the calendar year. The numerator is the number of Members who received a drug and alcohol counseling service in the calendar year and the denominator is the number of Members who received a treatment or face-to-face care management service during the reporting period.

5. The number of months each Member served by the OUD-COE received at least one monthly counseling service in the past quarter.

6. Percentage of Members served by the OUD-COE receiving Medication-Assisted Treatment service during the calendar year. The numerator is the number of Members who received a Medication-Assisted Treatment service during the calendar year and the denominator is the number of Members who received a treatment or face-to-face care management service during the reporting period.

7. Percentage of Members served by the OUD-COE who have a mental health diagnosis and received a mental health outpatient service in the calendar year. The numerator is the number of Members with a mental health diagnosis who received a mental health outpatient service in the calendar year and the denominator is the number of Members with a mental health diagnosis who received a treatment or face-to-face care management service during the reporting period.

8. Percentage of Members served by the OUD-COE who received services from a primary care physician in the calendar year. The numerator is the number of Members who received services from a primary care physician in the calendar year and the denominator is the number of Members who received a treatment or face-to-face care management service during the reporting period.

9. Percentage of Members served by the OUD-COE who complete the Department's outcomes survey within 30 days of the date of the initial billable service. The numerator is the number of Members who completed the Department's outcomes survey within 30 days of the date of the initial billable service and the denominator is the number of Members who received a treatment or face-to-face care management service during the reporting period.

10. Percentage of Members served by the OUD-COE who complete the Department's outcomes survey within 180 days of the date of the initial billable service. The numerator is the number of Members who completed the Department's outcomes survey within 180 days of the initial billable service and the denominator is the number of Members who received a treatment or face-to-face care management service during the reporting period.

11. Percentage of Members served by the OUD-COE who screened negative for drug use. The numerator is the number of Members who received negative urine drug screening results and the denominator is the number of Members who received a treatment or face-to-face care management service during the reporting period.

12. The following information for inactive Members:

    a. The date that a Member who had previously been served by the OUD-COE was deemed inactive. A Member is deemed inactive on the date two months following the date of the most recent face-to-face care management encounter in the Member's record.

    b. The reason, if known, that the Member was deemed inactive.

    c. Duration measure prior to inactive status - Duration of treatment is defined as the time of initial Member engagement until the last engagement with the Member prior to the Member being deemed inactive.

13. The following information for each face-to-face care management encounter between an OUD-COE provider and a Member:

    a. Date of the encounter.

    b. Location of the encounter.

    c. Activity code description of the care management services performed during the encounter, as defined in the data collection spreadsheet.

    d. Name of provider who provided the care management service.

D. The PH-MCO will perform a claims analysis on an annual basis. The PH-MCO will identify OUD-COE clients as those members for whom a G9012 procedure code claim was submitted during the previous year and will analyze the additional claims submitted for those members, focusing on the metrics defined below. The purpose of this analysis will be to monitor COEs for adherence with the terms of their provider contracts and to ensure quality services are being provided to the PH-MCO's members.

The PH-MCO will analyze the following metrics through claims analysis:

1. Percentage of Members who received a service rendered by a primary care provider. The numerator is the number of Members who received a service rendered by a primary care provider and the denominator is the number of Members who received a treatment or face-to-face care management service during the reporting period.

2. Percentage of Members who received a pain management service. The numerator is the number of Members who received a pain management service and the denominator is the number of Members who received a treatment or face-to-face care management service during the reporting period.

3. Percentage of Members who were prescribed a benzodiazepine while prescribed buprenorphine. The numerator is the number of Members who were concurrently prescribed a benzodiazepine and buprenorphine and the denominator is the number of Members who received a treatment or face-to-face care management service during the reporting period.

4. Percentage of Members who were prescribed an opiate while prescribed buprenorphine. The numerator is the number of Members who were concurrently prescribed an opiate and buprenorphine and the denominator is the number of Members who received a treatment or face-to-face care management service during the reporting period.

5. Percentage of Members who received a urine drug screening. The numerator is the number of Members who received a urine drug screening and the denominator is the number of Members who received a treatment or face-to-face care management service during the reporting period.

6. Percentage of Members who are pregnant. The numerator is the number of Members who are or were pregnant and the denominator is the number of Members who received a treatment or face-to-face care management service during the reporting period.

7. Percentage of pregnant Members who received a timely prenatal initial visit. The numerator is the number of pregnant Members who received a timely prenatal initial visit as defined by HEDIS® and the denominator is the number of pregnant Members.

8. Percentage of pregnant Members who received a timely post-partum care visit. The numerator is the number of pregnant Members who received a timely post-partum care visit as defined by HEDIS® and the denominator is the number of pregnant Members.

9. Percentage of pregnant Members receiving post-partum contraception. The numerator is the number of pregnant Members receiving post-partum

contraception and the denominator is the number of pregnant Members who received a treatment or face-to-face care management service during the reporting period.

10. Percentage of children born to Members who have completed six well child visits in the first 15 months of life. The numerator is the number of children born to Members who have completed six well child visits in the first 15 months of life per the HEDIS® specifications and the denominator is the number of pregnant Members who received a treatment or face-to-face care management service during the reporting period.

11. Percentage of Members who received buprenorphine. The numerator is the number of Members who received buprenorphine and the denominator is the number of Members who received a treatment or face-to-face care management service during the reporting period.

12. Percentage of Members who received naltrexone. The numerator is the number of Members who received naltrexone and the denominator is the number of Members who received a treatment or face-to-face care management service during the reporting period.

13. Duration of medication-assisted treatment. Duration of medication-assisted treatment is defined as the time of initial dose until the last dose in the calendar year. This measure will be reported as the percent of Members receiving doses for periods of time ≥ 90 days, ≥180 days, and ≥ 270 days. The numerator is the number of Members receiving doses of buprenorphine or naltrexone at each of the above listed time intervals and the denominator is the number of Members who received a treatment or face-to-face care management service during the reporting period.

14. Percentage of Members screened for HIV. The numerator is the number of Members screened for HIV and the denominator is the number of Members who received a treatment or face-to-face care management service during the reporting period.

15. Percentage of Members screened for Hepatitis C. The numerator is the number of Members screened for Hepatitis C and the denominator is the number of Members who received a treatment or face-to-face care management service during the reporting period.

16. Percentage of female Members receiving contraception. The numerator is the number of female Members receiving contraception and the denominator is the number of female Members who received a treatment or face-to-face care management service during the reporting period.

17. Percentage of female Members who received long-acting reversible contraception. The numerator is the number of female Members who received long-acting reversible contraception and the denominator is the number of female Members who received a treatment or face-to-face care management service during the reporting period.

18. Percentage of Members with emergency department visits. The numerator is the number of Members who were seen in an emergency department and the denominator is the number of Members who received a treatment or face-to-face care management service during the reporting period.

19. Percentage of Members with inpatient acute stays, excluding drug and alcohol stays. The numerator is the number of Members who were admitted for an inpatient acute stay in a facility other than an inpatient drug and alcohol treatment facility and the denominator is the number of Members who received a treatment or face-to-face care management service during the reporting period.

EXHIBIT H

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

A. General Requirement

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

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

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

The Department defines prior authorization as a determination made by a PH-MCO to approve or deny payment for a Provider's request to provide a service or course of treatment of a specific duration and scope to a Member prior to the Provider's initiation or continuation of the requested service.

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

B. Guidelines for Review

1. Basic Requirements:

   a. The PH-MCO must identify individual service(s), medical item(s), and/or therapeutic categories of drugs to be Prior Authorized.

   b. If the Prior Authorization is limited to specific populations, the PH-MCO must identify all populations who will be affected by the proposal for Prior Authorization.

2. Medically Necessary Requirements:

   a. The PH-MCO must describe the process to validate medical necessity for:

      - covered care and services;
      - procedures and level of care;
      - medical or therapeutic items.

   b. The PH-MCO must identify the source of the criteria used to review the request for Prior Authorization of services. The criteria must be consistent with the HealthChoices contract definition for a service or benefit that is Medically Necessary. All criteria must be submitted to the Department for evaluation and approval under URCAP prior to implementation.

   c. For PH-MCOs, if the criteria being used are:

      - Purchased and licensed, the PH-MCO must identify the vendor;
      - Developed/recommended/endorsed by a national or state health care provider association or society, the PH-MCO must identify the association or society;

- Based on national best practice guidelines, the PH-MCO must identify the source of those guidelines;

- Based on the medical training, qualifications, and experience of the PH-MCO's Medical Director or other qualified and trained practitioners, the PH-MCO must identify the individuals who will determine if the service or benefit is Medically Necessary.

d. PH-MCO guidelines to determine medical necessity of all drugs that require prior authorization must be posted for public view on the PH-MCO's website. This includes, but is not limited to, guidelines to determine medical necessity of both specific drugs and entire classes of drugs that require prior authorization for health and safety reasons, non-formulary designations, appropriate utilization, quantity limits, or mandatory generic substitution. The guidelines must specify all of the conditions that the PH-MCO reviewers will consider when determining medical necessity including requirements for step therapy.

e. The PH-MCO must identify the qualification of staff that will determine if the service is Medically Necessary. Health Care Providers, qualified and trained in accordance with the CMS Guidelines, the RFP, the HealthChoices Agreement, and applicable legal settlements must make the determination of Medically Necessary services.

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

- That the prescriber did not make a good faith effort to submit a complete request, or

- That the service or item is not Medically Necessary, <u>after</u> making a reasonable effort to consult with the prescriber. The reasonable effort to consult must be documented in writing.

3. Administrative Requirements

a. The PH-MCO's written policies and procedures must identify the time frames for review and decisions and the PH-MCO must demonstrate that the time frames are consistent with the following required maximum time frames:

- Immediate: Inpatient Place of Service Review for emergency and urgent admissions.

- 24 hours: All drugs; and items or services which must be provided on an urgent basis.

- 48 hours: (following receipt of required documentation) Home Health Services.

- 21 days: All other services.

b. The PH-MCO's written policies and procedures must demonstrate how the PH-MCO will ensure adequate care management and overall continuity of care among all levels and specialty areas.

c. The PH-MCO's written policies and procedures must explain how Prior Authorization data will be incorporated into the PH-MCO's overall Quality Management plan.

4. Notification, Grievance, and DHS Fair Hearing Requirements

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

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

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

EXHIBIT J

EPSDT GUIDELINES

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

The PH-MCO must have written policies and procedures for providing all Medically Necessary Title XIX EPSDT services to all eligible individuals under the age of twenty-one (21) regardless of whether the service is included on the Medicaid State Plan. The PH-MCO must assist individuals in gaining access to necessary medical, social, education, and other services in accordance with the HealthChoices agreement.

1. Screening

The PH-MCO must ensure that periodic EPSDT screens are conducted by a process, including data collection format, approved by the Department, on all Members under age twenty-one (21) to identify health and developmental problems. These screens must be in accordance with the most current periodicity schedule developed by the Department and recommended pediatric immunization schedules, both of which are based on guidelines issued by the American Academy of Pediatrics (AAP) and the Centers for Disease Control and Prevention (CDC).

2. Diagnoses and Treatment

If a suspected problem is detected by a screening examination, the child must be evaluated as necessary for further diagnosis. This diagnosis is used to determine treatment needs. Following an EPSDT screen, if the screening Provider suspects developmental delay and the child is not receiving services at the time of screening, s/he is required to refer the child (not over five (5) years of age) through CONNECT, 1-800-692-7288, for referral for local Early Intervention Program services. The PH-MCO is also responsible to ensure that a child is referred to the county Intellectual Disabilities (ID) office for a determination of eligibility for home and community-based services. The Intellectual Developmental Disabilities County contacts are found at http://pafamiliesinc.org/understanding-systems/intellectual-disabilities/intellectual-developmental-disabilities-county-contact-information-for-pennsylvania.The PH-MCO is responsible for developing a system that tracks treatment needs as they are identified and ensures that appropriate follow-up is pursued and reflected in the medical record (see Section 3, Tracking, for all requirements).

OBRA '89 entitles individuals under the age of twenty-one (21) to receive all Medically Necessary health care services that are contained in Section 1905(a) of the Social Security Act and required to treat a condition diagnosed during any encounter with a Health Care Provider practicing within the scope of state law. Any Medically Necessary health care,

eligible under the federal Medicaid program, required to treat conditions detected during a visit must be covered by the PH-MCO, except Behavioral Health Services which will be covered through the BH-MCO. Even though the PH-MCO is not responsible for behavioral health treatment, it is still responsible for identifying Members who are in need of behavioral health treatment services, and for linking the Member with the appropriate BH-MCO.

The PH-MCO must have a system in place to address the need for and furnish expanded services. Such policies will be clearly communicated to Providers and Recipient through the Provider Manual and the Member Handbook. If a Health Care Provider prescribes services or equipment for an individual under the age of twenty-one (21), which is not normally covered by the MA Program, or for which the PH-MCO requires Prior Authorization, the PH-MCO must follow the Prior Authorization requirements outlined in Section V.B. and Exhibit H of the contract.

3. Tracking

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

- Initial visit for newborns. The initial EPSDT screen shall be the newborn physical exam in the hospital.

- EPSDT screen and reporting of all screening results.

- Diagnosis and/or treatment, or other referrals for children.

- Other tracking activities include: Number of comprehensive screens (reported by age); hearing and vision examinations; dental screens; age appropriate screens; complete age appropriate immunizations; blood lead screens; prenatal care for teen mothers; provision of eyeglasses to those in need of them; dental sealants; newborn home visits; referral of very low birth weight babies to early intervention; referral of Members under the age of five (5) with elevated blood lead levels to early intervention; routine evaluation for iron deficiencies; maternal depression screening; screenings for developmental delays and autism spectrum disorders; depression screenings; and timely identification and treatment of asthma.

4. Follow-ups and Outreach

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

- Written notification of upcoming or missed appointments within a set time period, taking into consideration language and literacy capabilities of Members.

- Telephone protocols to remind Members of upcoming visits and follow-up on missed appointments within a set time period.

- If requested, any necessary assistance with transportation to ensure that recipients obtain necessary EPSDT screening services. This assistance must be offered prior to each due date of a child's periodic examination.

- Protocols for conducting outreach with non-compliant Members, including home visits, as appropriate.

- A process for outreach and follow-up to Members under the age of twenty-one (21) with Special Needs, such as homeless children.

- A process for outreach and follow-up with County Children and Youth Agencies and Juvenile Probation Offices to assure that they are notified of all Members under the age of twenty-one (21) who are under their supervision and who are due to receive EPSDT screens and follow-up treatment.

- The PH-MCO may develop alternate processes for follow up and outreach subject to prior written approval from the Department.

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

Arranging for Medically Necessary follow-up care for health care services is an integral part of the Provider's continuing care responsibility after a screen or any other health care contact. In cases involving a Member under the age of twenty-one (21) with complex medical needs or serious or multiple disabilities or illnesses, case management services must be offered, consistent with the HealthChoices agreement and exhibits.

To assist the PH-MCO in provision of the above four (4) required services (Screening, Diagnosis and Treatment, Tracking and Follow-up and Outreach) to children in substitute care, the PH-MCO will be required to develop master lists of all enrolled children who are coded as such on the monthly membership files. The PH-MCO must assign specific staff to monitor the services provided to these children and to ensure that they receive comprehensive EPSDT screens and follow-up services. The assigned staff must contact the relevant agencies with custody of these Members or with jurisdiction over them (e.g., County Children and Youth Agency, Juvenile Probation Office) when a particular child has yet to receive an EPSDT screen or is not current with their EPSDT screen and/or immunizations and to ensure that an appointment for such service is scheduled.

Further, in addition to the EPSDT related Pennsylvania Performance Measures, the PH-MCO must submit to the Department, reports providing all data regarding children in substitute care (e.g., the number of children enrolled in substitute care who have received comprehensive EPSDT screens, the number who have received blood level assessments, etc.).

5. Interagency Teams for EPSDT Services for Children

For the ongoing coordination of EPSDT services for Members under the age of twenty-one (21) identified with Special Needs, the PH-MCO must appoint a PH-MCO representative who will ensure coordination with other health, education and human services systems in the development of a comprehensive individual/family services plan.

The goal is to develop and implement a comprehensive service plan through a collaborative interagency team approach, which ensures that children have access to appropriate, coordinated, comprehensive health care. To achieve this goal, The PH-MCO must ensure the following:

- Children have access to adequate pediatric care.
- The service plan is developed in coordination with the interagency team, including the child (when appropriate), the adolescent and family members and a PH-MCO representative.
- Development of adequate specialty Provider Networks.
- Integration of covered services with ineligible services.
- Prevention against duplication of services.
- Adherence to state and federal laws, regulations and court requirements relating to individuals with Special Needs.
- Cooperation of PH-MCO Provider Networks.
- Applicable training for PCPs and Providers including the identification of PH-MCO contact persons.

EXHIBIT L

MEDICAL ASSISTANCE TRANSPORTATION PROGRAM

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

- Non-emergency transportation to a medical service that is covered by the MA Program. This includes transportation for urgent care appointments.

- Transportation to another county to get medical care as well as advice on locating a train, the bus, and route information.

- Reimbursement for mileage, parking, and tolls with valid receipts, if the consumer used their own car or someone else's to get to the medical care provider.

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

EXHIBIT M(1)

QUALITY MANAGEMENT AND UTILIZATION MANAGEMENT PROGRAM REQUIREMENTS

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

A. Contain a written program description, work plan, evaluation and policies/procedures that meet requirements outlined in the agreement;

B. Allow for the development and implementation of an annual work plan of activities that focuses on areas of importance as identified by the PH-MCO in collaboration with the Department;

C. Be based on statistically valid clinical and financial analysis of Encounter Data, Member demographic information, HEDIS, CAHPS, Pennsylvania Performance Measures and other data that allows for the identification of prevalent medical conditions, barriers to care and racial/ethnic disparities to be targeted for quality improvement and disease management initiatives;

D. Allow for the continuous evaluation of its activities and adjustments to the program based on these evaluations;

E. Demonstrate sustained improvement for clinical performance over time; and

F. Allow for the timely, complete, and accurate reporting of Encounter Data and other data required to demonstrate clinical and service performance, including HEDIS and CAHPS as outlined in Exhibit M(4), Healthcare Effectiveness Data and Information Set (HEDIS).

G. Include processes for the investigation and resolution of individual performance or quality of care issues whether identified by the PH-MCO or the Department that:

   1. Allow for the tracking and trending of issues on an aggregate basis pertaining to problematic patterns of care;

   2. Allow for submission of improvement plans, as determined by and within time frames established by the Department. Failure by the PH-MCO to comply with the requirements and improvement actions requested by the Department may result in the application of penalties and/or sanctions as outlined in Section VIII.H, Sanctions, of the Agreement.

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

1. The PH-MCO must demonstrate evidence by submitting to the Department accreditation survey type and level, results of survey including recommendations actions and/or improvements, corrective action plans, and summaries of findings conducted by the accrediting national recognized organization.

2. The PH-MCO must submit to the Department an expiration of the accreditation and future accreditation surveys.

I. Attain NCQA Multicultural Health Care Distinction by meeting the requirement guidelines set forth by NCQA for multicultural health care. The PH-MCO must submit a workplan and timeline to the Department depicting their progress in achieving NCQA Multicultural Distinction at least annually.

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

A. Adhere to current Medicaid CMS guidelines.

B. Be developed and implemented by professionals with adequate and appropriate experience in QM/UM and techniques of peer review.

C. Ensure that all QM and UM activities and initiatives undertaken by the PH-MCO are based upon clinical and financial analysis of Encounter Data, Member demographic information, HEDIS, CAHPS, Pennsylvania Performance Measures and/or other identified areas.

D. Contain policies and procedures which provide for the ongoing review of the entire scope of care provided by the PH-MCO assuring that all demographic groups, races, ethnicities, care settings and types of services are addressed.

E. Contain a written program description that addresses all standards, requirements and objectives established by the Department and that describes the goals, objectives, and structure of the PH-MCO's QM and UM programs. The written program description must, at a minimum:

1. Include standards and mechanisms for ensuring the accessibility of primary care services, specialty care services, urgent care services, hospitals and Member services in accordance with timeframes outlined in Exhibit AAA, Provider Network Composition/Service Access of the Agreement.

2. Include mechanisms for planned assessment and analysis of the quality of care provided and the utilization of services against formalized standards, including but not limited to:

    a. Primary, secondary, and tertiary care;

    b. Preventive care and wellness programs;

    c. Acute and/or chronic conditions;

    d. Dental care;

    e. Care coordination; and

    f. Continuity of care.

3. Allow for the timely, accurate, complete collection and clinical and financial analysis of Encounter Data and other data including, but not limited to, HEDIS, CAHPS, and Pennsylvania Performance Measures.

4. Allow for systematic analysis and re-measurement of barriers to care, the quality of care provided to Members, and utilization of services over time.

F. Provide a comprehensive written evaluation, completed on at least an annual basis, that details all QM and UM program activities including, but not limited to:

    a. Studies and activities undertaken; including the rationale, methodology and results;

    b. Subsequent improvement actions; and

    c. Aggregate clinical and financial analysis of Encounter, HEDIS, CAHPS, Pennsylvania Performance Measures, Community Based Care Management, Diabetic Prevention Program and other data on the quality of care rendered to Members and utilization of services.

G. Include a work plan and timetable for the coming year which clearly identifies target dates for implementation and completion of all phases of all QM activities, including, but not limited to:

    a. Data collection and analysis;

    b. Evaluation and reporting of findings;

    c. Implementation of improvement actions where applicable; and

d. Individual accountability for each activity.

H. Provide for aggregate and individual analysis and feedback of Provider performance and PH-MCO performance in improving access to care, the quality of care provided to Members and utilization of services.

I. Include mechanisms and processes which ensure related and relevant operational components, activities, and initiatives from the QM and UM programs are integrated into activities and initiatives undertaken by other departments within the PH-MCO including, but not limited to, the following:

a. Special Needs;

b. Provider Relations;

c. Member Services; and

d. Management Information Systems

J. Include procedures for informing both physician and non-physician Providers about the written QM and UM programs, and for securing cooperation with the QM and UM programs in all physician and non-physician Provider agreements.

K. Include procedures for feedback and interpretation of findings from analysis of quality and utilization data to Providers, health professionals, PH-MCO staff, and MA Consumers/family members.

L. Include mechanisms and processes which allow for the development and implementation of PH-MCO wide and Provider specific improvement actions in response to identified barriers to care, quality of care concerns, and over-utilization, under-utilization and/or mis-utilization of services.

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

A. The Governing Body:

1. Has formally designated an accountable entity or entities, within the PH-MCO to provide oversight of QM and UM program activities or has formally decided to provide such oversight as a committee, e.g. Quality Management Committee.

2. Regularly receives written reports on the QM and UM program activities that describe actions taken, progress in meeting objectives and improvements made. The governing body formally reviews, on at least an annual basis, a written evaluation of the QM and UM program activities that includes studies undertaken, results of studies, and subsequent improvement actions taken.

The written evaluation must include aggregate clinical and financial analysis of quality and utilization data, including HEDIS, CAHPS, and Pennsylvania Performance Measures.

3. Documents actions taken by the governing body in response to findings from QM and UM program activities.

B. The Quality Management Committee (QMC):

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

   a. Demonstrate that the QMC has oversight responsibility and input, including review and approval, on all QM and UM program activities;

   b. Ensure membership on the QMC and active participation by individuals representative of the composition of the PH-MCO's Providers; and

   c. Provide for documentation of the QMC's activities, findings, recommendations, and actions.

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

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

D. The Medical Director:

1. Serves as liaison and is accountable to the governing body and Quality Management Committee for all QM and UM activities and initiatives;

2. Is available to the PH-MCO's medical staff for consultation on referrals, denials, Complaints and problems;

3. Is directly involved in the PH-MCO's recruiting and credentialing activities;

4. Is familiar with local standards of medical practice and nationally accepted standards of practice;

5. Has knowledge of due process procedures for resolving issues between participating Providers and the PH-MCO administration, including those related to medical decision making and utilization review;

6. Is available to review, advise and take action on questionable hospital admissions, Medically Necessary days and all other medical care and medical cost issues;

7. Is directly involved in the PH-MCO's process for prior authorizing or denying services and is available to interact with Providers on denied authorizations;

8. Has knowledge of current peer review standards and techniques;

9. Has knowledge of risk management standards;

10. Is directly accountable for all Quality Management and Utilization Management activities and

11. Oversees and is accountable for:

    a. Referrals to the Department and appropriate agencies for cases involving quality of care that have adverse effects or outcomes; and

    b. The processes for potential Fraud and Abuse investigation, review, sanctioning and referral to the appropriate oversight agencies.

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

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

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

    1. Written in measurable and accepted professional formats,

    2. Based on valid and reliable clinical and scientific evidence or a consensus of providers in the particular field; and

    3. Applicable to Providers for the delivery of certain types or aspects of health care.

B. The QM and UM programs must include clinical/quality Indicators in the form of written, professionally developed and adopted in consultation with contracting health professionals, with objective and measurable variables of a specified clinical or health services delivery area, which are updated periodically as appropriate and

reviewed over a period of time to screen delivered health care and/or monitor the process or outcome of care delivered in that clinical area.

C. Practice guidelines and clinical indicators must consider the needs of the PH-MCO Enrollees and must address the full range of health care needs of the populations served by the PH-MCO. (per 42 C.F.R. 438.236 (b)(2)).

D. The clinical areas addressed must include, but are not limited to:

1. Adult preventive care;

2. Pediatric and adolescent preventive care with a focus on EPSDT services;

3. Obstetrical care including a requirement that Members be referred to obstetricians or certified nurse midwives at the first visit during which pregnancy is determined;

4. Selected diagnoses and procedures relevant to the enrolled population;

5. Selected diagnoses and procedures relevant to racial and ethnic subpopulations within the PH-MCO's membership; and

6. Preventive dental care.

E. The PH-MCO QM and UM programs must disseminate practice guidelines, clinical indicators and medical record keeping standards to all affected Providers and appropriate subcontractors. This information must also be provided to Members or potential Enrollees upon request. (per 42 C.F.R 438.236 (c)).

F. The PH-MCO must develop methodologies for assessing performance of PCPs/PCP sites, high risk/high volume specialists, dental Providers, and Providers of ancillary services not less than every two years (e.g., medical record audits). These methodologies must, at a minimum:

1. Demonstrate the degree to which PCPs, specialists, and dental Providers are complying with clinical and preventive care guidelines adopted by the plan;

2. Allow for the tracking and trending of individual and PH-MCO wide Provider performance over time;

3. Include active mechanisms and processes that allow for the identification, investigation and resolution of quality of care concerns, including events such as Health Care-Associated Infections and medical errors; and

4. Include mechanisms for detecting instances of over-utilization, under-utilization, and mis-utilization.

G. The QM and UM program must have policies and procedures for implementing and monitoring improvement plans. These policies and procedures must include the following:

1. Processes that allow for the identification, investigation and resolution of quality of care concerns including Health Care-Associated Infections, medical errors, and unnecessary and/or ineffective care patterns;

2. Processes for tracking and trending problematic patterns of care;

3. Use of progressive sanctions as indicated;

4. Person(s) or body responsible for making the final determinations regarding quality problems; and

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

    a. Education;

    b. Follow-up monitoring and re-evaluation;

    c. Changes in processes, structures, forms;

    d. Informal counseling;

    e. Procedures for terminating the affiliation with the physician or other health professional or Provider;

    f. Assessment of the effectiveness of the actions taken; and

    g. Recovery of inappropriate expenditures (e.g., related to Health Care-Associated Infections, medical errors, and unnecessary and/or ineffective care).

H. The QM and UM programs must include methodologies that allow for the identification, verification, and timely resolution of inpatient and outpatient quality of care concerns, Member quality of care complaints, over-utilization, under-utilization, and/or mis-utilization, access/availability issues, and quality of care referrals from other sources;

I. The QM and UM programs must contain procedures for Member satisfaction surveys that are conducted on at least an annual basis including the collection of annual Member satisfaction data through application of the CAHPS instrument as outlined in Exhibit M(4), Healthcare Effectiveness Data and Information Set (HEDIS).

J. The QM and UM programs must contain procedures for Provider satisfaction surveys to be conducted on at least an annual basis. Surveys are to include PCPs, and specialists, dental Providers, hospitals, and Providers of ancillary services.

K. Each PH-MCO will be required to comply with requirements for Performance Improvement Projects (PIPs) as outlined in Exhibit M(2) External Quality Review.

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

A. Semi-annually, or more frequently as appropriate, the QM and UM programs must provide for production and distribution to Providers, (in either hard copy or web-based electronic formats) profiles comparing the average medical care utilization rates of the Members of each PCP to the average utilization rates of all PH-MCO Members. The PH-MCO must develop statistically valid methodologies for data collection regarding Provider profiling. Profiles shall include, but not be limited to:

    1. Utilization information on Member Encounters with PCPs;

    2. Specialty Claims;

    3. Prescriptions;

    4. Inpatient stays;

    5. Emergency room use;

    6. Clinical indicators for preventive care services (e.g., mammograms, immunizations, pap smear, etc.); and

    7. Clinical indicators for EPSDT requirements.

B. PH-MCO must submit to the department on an annual basis network provider profiles.

C. The PH-MCO must have mechanisms and processes for profiling physicians using risk adjusted diagnostic data for profiles.

D. The QM and UM programs must implement statistically valid methodologies for analysis and follow-up of semi-annual practitioner utilization profiles for patterns and instances of over-utilization, under-utilization, and mis-utilization across the continuum of care, as well as, trending of Provider utilization patterns over time. Follow up includes but is not limited to Provider education, Provider improvement plans, and Provider sanctions as necessary.

E. The QM and UM programs must at least annually, provide for verification of Encounter reporting rates and accuracy and completeness of Encounter information submitted by PCPs.

Standard V: The PH-MCO must develop mechanisms for integration of case/disease and health management programs that rely on wellness promotion, prevention of complications and treatment of chronic conditions for Members identified. Case/Disease and health management programs must:

A. Include mechanisms and processes that ensure the active collaboration and coordination of care and services for identified members.

B. Include mechanisms and processes that allow for the identification of conditions to be targeted for case/disease and health management programs and that allow for the assessment and evaluation of the effectiveness of these programs in improving outcomes for and meeting the needs of individuals with targeted conditions.

C. Include care guidelines and/or protocols for appropriate and effective management of individuals with specified conditions. These guidelines must be written in measurable and accepted professional formats and be based on scientific evidence.

D. Include performance indicators that allow for the objective measurement and analysis of individual and PH-MCO wide performance in order to demonstrate progress made in improving access and quality of care.

E. Include mechanisms and processes that lead to healthy lifestyles such as weight loss program memberships, gym memberships and asthma camps.

F. Include and refer members who are identified as pre-diabetic to programs that addresses prevention of diabetes mellitus. The programs must be recognized by the Centers for Disease Control (CDC) or be enrolled in the Medicare program as a Medicare Diabetes Prevention Program. Requirements for program recognition by the CDC are available at: https://www.cdc.gov/diabetes/prevention/requirements-recognition.htm

G. Include participation and membership in the Perinatal Collaborative being developed with the DHS and DOH.

H. Include collaboration with the Department to develop, adopt and disseminate a Social Determinants of Health assessment tool.

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

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

B. Other HealthChoices PH-MCOs;

D. The PH-MCO and HealthChoices BH-MCOs;

E. The PH-MCOs and the Department's Fee For Service Program; and

F. The PH-MCO and other third party insurers

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

A. Have a written description of the delegated activities, the delegate's accountability for these activities, and the frequency of reporting to the PH-MCO.

B. Have written procedures for monitoring and evaluating the implementation of the delegated functions and for verifying the actual quality of care being provided.

C. Document evidence of continuous and ongoing evaluation of delegated activities, including approval of quality improvement plans and regular specified reports.

D. Make available to the Department, and its authorized representatives, any and all records, documents, and data detailing its oversight of delegated QM and UM program functions.

E. Must ensure that delegated entities make available to the Department, and its authorized representatives, any and all records, documents and data detailing the delegated QM and UM program functions undertaken by the entity of behalf of the PH-MCO.

F. Compensation and payments to individuals or entities that conduct Utilization Management activities may not be structured so as to provide incentives for the individual or entity to deny, limit, or discontinue Medically Necessary services to any Member

Standard VIII: The QM/UM program must have standards for credentialing/ recredentialing Providers to determine whether physicians and other Health Care Providers, who are licensed by the Commonwealth and are under contract to the PH-MCO, are qualified to perform their services.

A. The PH-MCO must establish and maintain minimum credentialing and recredentialing criteria for all Provider types. Recredentialing activities must be conducted by the PH-MCO at least every three (3) years. Criteria must include, but

not be limited to, the following:

1. Appropriate license or certification as required by Pennsylvania state law;

2. Verification that Providers have not been suspended, terminated or entered into a settlement for voluntary withdrawal from the Medicaid or Medicare Programs;

3. Verification that Providers and/or subcontractors have a current Provider Agreement and an active PROMIS*e*™ Provider ID issued by the Department;

4. Evidence of malpractice/liability insurance;

5. A valid Drug Enforcement Agency (DEA) certification;

6. Adherence to the Principles of Ethics of the American Medical Association, the American Osteopathic Association or any appropriate professional organization involved in a multidisciplinary approach;

7. Consideration of quality issues such as Member Complaint and/or Member satisfaction information, sentinel events and quality of care concerns.

B. For purposes of credentialing and recredentialing, the PH-MCO must perform a check on all PCPs and other physicians by contacting the National Practitioner Data Bank (NPDB). If the PH-MCO does not meet the statutory requirements for accessing the NPDB, then the PH-MCO must obtain information from the Federation of State Medical Boards.

C. Appropriate PCP qualifications:

1. Seventy-five to 100% of the Network consists of PCPs who have completed an approved primary care residency in family medicine, osteopathic general medicine, internal medicine or pediatrics;

2. No more than 25% of the Network consists of PCPs without appropriate residencies but who have, within the past seven years, five years of post-training clinical practice experience in family medicine, osteopathic general medicine, internal medicine or pediatrics. Post-training experience is defined as having practiced at least as a 0.5 full-time equivalent in the practice areas described; and

3. No more than 10% of the Network consists of PCPs who were previously trained as specialist physicians and changed their areas of practice to primary care, and who have completed Department-approved primary care retraining programs.

4. A PCP must have the ability to perform or directly supervise the ambulatory primary care services of Members;

5. Membership of the medical staff with admitting privileges of at least one general hospital or an acceptable arrangement with a PCP with admitting privileges;

6. Demonstrate evidence of continuing professional medical education;

7. Attend at least one PH-MCO sponsored Provider education training session as outlined in Section V.R.2, Provider Education, of the Agreement.

D. Assurance that any CRNP, Certified Registered Midwife or physician's assistant, functioning as part of a PCP team, is performing under the scope of their respective licensure; and

E. As part of the Provider release form, the potential Provider must agree to release all MA records pertaining to sanctions and/or settlement to the PH-MCO and the Department.

F. The Department will recoup from the PH-MCO any and all payments made to a Provider who does not meet the enrollment and credentialing criteria for participation or is used by the PH-MCO in a manner that is not consistent with the Provider's licensure. In addition, the PH-MCO must notify its PCPs and all subcontractors of the prohibitions and sanctions for the submission of false Claims and statements.

G. The PH-MCO shall evaluate a Provider's professional qualifications through objective measures of competence and quality. Providers should be given the opportunity to have input on the PH-MCO's credentialing practices.

H. Any economic profiles used by the PH-MCOs to credential Providers should be adjusted to adequately account for factors that influence utilization independent of the Provider's clinical management, including Member age, Member sex, Provider case-mix and Member severity. The PH-MCO must report any utilization profile that it utilizes in its credentialing process and the methodology that it uses to adjust the profile to account for non-clinical management factors at the time and in the manner requested by the Department.

I. In the event that a PH-MCO renders an adverse credentialing decision, the PH-MCO must provide the affected Provider with a written notice of the decision. The notice should include a clear and complete explanation of the rationale and factual basis for the determination. The notice shall include any utilization profiles used as a basis for the decision and explain the methodology for adjusting profiles for non-clinical management factors. All credentialing decisions made by the PH-MCO are final and may not be appealed to the Department.

J. The PH-MCO must meet the following standards related to timeliness of processing new provider applications for credentialing.

1. The PH-MCO must begin its credentialing process upon receipt of a provider's credentialing application if the application contains all required information.

2. The PH-MCO may not delay processing the application if the provider does not have an MAID number that is issued by the DHS. However, the PH-MCO cannot complete its process until the provider has received its MAID number from DHS.

3. Provider applications submitted to the PH-MCO for credentialing must be completed within sixty (60) calendar days of the PH-MCO, Dental Benefit Manager (DBM) or Vision Benefit Manager (VBM) receipt of a complete application packet.

4. The PH-MCO, DBM or VBM must notify the provider of the status of their credentialing application as follows:

    a. First Correspondence: The PH-MCO, DBM or VBM must provide an Acknowledge of Application notification to the provider within ten (10) calendar days of receipt.

    b. Second Correspondence: The PH-MCO, DBM or VBM will send an Application Status to the provider within thirty (30) calendar days stating:

        i. Their application is clean and is being submitted through the credentialing process or;

        ii. Their application is not clean with a list of items needing to be addressed. If a provider's Medicaid ID (PROMISe) number is not in place at the time of this notification, it may be noted as an outstanding item.

    c. Third Correspondence: A Credentialing Approval/Denial notice will be sent within a maximum of sixty (60) calendar days. If the provider application is denied, the correspondence should include all of the requirements that were not met.

    d. The PH-MCO, DBM and VBM must also include language in the First and Second Correspondence reminding providers that credentialing

cannot be completed until their Medicaid Number (PROMISe ID) is in place.

e. The PH-MCO, DBM and VBM are encouraged to provide communications electronically to the provider.

5. Failure to comply will result in sanctions as per Section VIII. H. to include retrospective payments to the provider as directed by the Department.

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

A. The UM program must contain policies and procedures for Prospective, Concurrent, and Retrospective review determinations of medical necessity.

B. The UM program must allow for determinations of medical necessity that are consistent with the HealthChoices Program definition of Medically Necessary:

Determinations of medical necessity for covered care and services whether made on a Prior Authorization, Concurrent Review or Retrospective Review basis, shall be documented in writing. The PH-MCO shall base its determination on medical information provided by the Member, the Member's family/care taker and the PCP, as well as any other Providers, programs and agencies that have evaluated the Member. Medical necessity determinations must be made by qualified and trained Health Care Providers. A Health Care Provider who makes such determinations of Medical Necessity is not considered to be providing a health care service under this Agreement. Satisfaction of any one of the following standards will result in authorization of the service:

1. The service or benefit will, or is reasonably expected to, prevent the onset of an illness, condition or disability;

2. The service or benefit will, or is reasonably expected to, reduce or ameliorate the physical, mental or developmental effects of an illness, condition, injury or disability;

3. The service or benefit will, assist the Member to achieve or maintain maximum functional capacity in performing daily activities, taking into account both the functional capacity of the Member and those functional capacities that are appropriate for Members of the same age.

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

1. Meet the HealthChoices Program's definition of Medically Necessary;

2. Contain timeframes for decision making or cross reference policies on time frames for decision making that meet requirements outlined in Section V.B, Prior Authorization of Services, of the Agreement.

3. Contain language or cross reference policies and procedures of notifying Members of adverse decisions and how to file a Complaint/Grievance/DHS Fair Hearing;

4. Comply with state/federal regulations;

5. Comply with HealthChoices RFP and other contractual requirements;

6. Specify populations covered by the policy;

7. Contain an effective date; and

8. Be received under signature of individuals authorized by the plan.

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

1. Not contain any definition of medical necessity that differs from the HealthChoices definition of Medically Necessary;

2. Allow for determinations of medical necessity that are consistent with the HealthChoices Program definition of Medically Necessary;

3. Allow for the assessment of the individual's current condition and response to treatment and/or co-morbidities, psychosocial, environmental and/or other needs that influences care;

4. Provide direction to clinical reviewers on how to use clinical information gathered in making a determination to approve, deny, continue, reduce or terminate a service;

5. Be developed using a scientific based process;

6. Be reviewed at least annually and updated as necessary; and

7. Provide for evaluation of the consistency with which reviewers implement the criteria on at least an annual basis.

E. The PH-MCO must ensure that Prior Authorization and Concurrent review decisions:

1. Are supervised by a physician, dentist or Health Care practitioner with appropriate clinical expertise in treating the Member's condition or disease;

2. That result in a denial may only be made by a licensed physician;

3. Are made in accordance with established time-frames outlined in the Agreement for routine, urgent, or emergency care; and

4. Are made by clinical reviewers using the HealthChoices definition of medical necessity.

F. The PH-MCO agrees to provide twenty-four (24) hour staff availability to authorize weekend services, including but not limited to: home health care, pharmacy, DME, and medical supplies. The PH-MCO must have written policies and procedures that address how Members and Providers can make contact with the PH-MCO to receive instruction or Prior Authorization, as necessary

G. Additional Prior Authorization requirements can be found in Exhibit H, Prior Authorization Guidelines for Participating Managed Care Organizations in the HealthChoices Program.

H. The PH-MCO must ensure that utilization records document efforts made to obtain all pertinent clinical information and efforts to consult with the prescribing Provider before issuing a denial based upon medical necessity.

I. The PH-MCO must ensure that sources of utilization criteria are provided to Members and Providers upon request.

J. The UM program must contain procedures for providing written notification to Members of denials of medical necessity and terminations, reductions and changes in level of care or placement, which clearly document and communicate the reasons for each denial. These procedures and process must:

1. Meet requirements outlined in Exhibit GG, Complaints, Grievances, and DHS Fair Hearing Process.

2. Provide for written notification to Members of denials, terminations, reductions and changes in medical services at least ten (10) days before the effective date.

3. Include notification to Members of their right to file a Complaint, Grievance or DHS Fair Hearing as outlined in Exhibit GG, Complaints, Grievances, and DHS Fair Hearing Process.
4. Not allow for UM staff rendering an adverse determination of a denial to use Prior Authorization policy, Medical literature, PA codes and Federal regulations as a means of informing a member of a service or item denial.

K. The PH-MCO must agree to comply with the Department's utilization review monitoring processes, including, but not limited to:

1. Submission of a log of all denials issued using formats to be specified by the Department.

2. Submission of denial notices for review as requested by the Department.

3. Submission of utilization review records and documentation as requested by the Department.

4. Ensure that all staff who have any level of responsibility for making determinations to approve or deny services, for any reason have completed a utilization review training program.

5. Development of an internal quality assurance process designed to ensure that all denials issued by the plan and utilization review record documentation meet Department requirements. This process must be approved by the Department prior to implementation.

L. The PH-MCO must follow the Department's Technology Assessment Group (TAG) process and determinations when new and existing services or items are reviewed and added to the MA Program.

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

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

B. QM/UM sanctions

C. Adverse credentialing/recredentialing decisions

D. Provider Terminations

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

A. The QM and UM program must have procedures which describe how findings, conclusions, recommendations, actions taken and results of actions taken are documented and reported to individuals within the PH-MCO for use in conjunction with other related activities such as:

1. PH-MCO Provider Network changes;

2. Benefit changes;

3. Medical management systems (e.g., pre-certification); and

4. Practices feedback to Providers.

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

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

A. The PH-MCO must have written policies and procedures for the maintenance of medical records so that those records are documented accurately and in a timely manner, are readily accessible and permit prompt and systematic retrieval of information. Written policies and procedures must contain standards for medical records that promote maintenance of medical records in a legible, current, detailed, organized and comprehensive manner that permits effective patient care and quality review.

B. Medical record standards must meet or exceed medical record keeping requirements contained in 55 Pa. Code Section 1101.51(d)(e) of the MA Manual and medical record keeping standards adopted by DOH.

C. Additional standards for patient visit data must, at a minimum, include the following:

1. History and physical that is appropriate to the patient's current condition;

2. Treatment plan, progress and changes in treatment plan;

3. Diagnostic tests and results;

4. Therapies and other prescribed regimens;

5. Disposition and follow-up;

6. Referrals and results thereof;

7. Hospitalizations;

8. Reports of operative procedures and excised tissues; and

9. <u>All other aspects of patient care.</u>

D. The PH-MCO must have written policies and procedures to assess the content of medical records for legibility, organization, completion and conformance to its standards.

E. The PH-MCO must ensure access of the Member to his/her medical record at no charge and upon request. The Member's medical records are the property of the Provider who generates the record.

F. The Department and/or its authorized agents (i.e., any individual or corporation or entity employed, contracted or subcontracted with by the Department) shall be afforded prompt access to all Members' medical records whether electronic or paper. All medical record copies are to be forwarded to the requesting entity within 15 calendar days of such request and at no expense to the requesting entity. The Department is not required to obtain written approval from a Member before requesting the Member's medical record from the PCP or any other agency.

G. Medical records must be preserved and maintained for a minimum of five years from expiration of the PH-MCO's contract. Medical records must be made available in paper form upon request.

H. When a Member changes PCPs, the PH-MCO must facilitate the transfer of his/her medical records or copies of medical records to the new PCP within seven business days from receipt of the request. In emergency situations, the PH-MCO must facilitate the transfer of medical records as soon as possible from receipt of the request.

I. When a Member changes PH-MCOs, the PH-MCO must facilitate the transfer of his/her medical records or copies of medical records to the new PH-MCO within seven business days from the effective date of enrollment in the gaining PH-MCO. In emergency situations, the PH-MCO must facilitate the transfer of medical records as soon as possible from receipt of the request.

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

A. The PH-MCO must have a written policy that recognizes the following rights of Members:

1. To be treated with respect, and recognition of their dignity and need for privacy;

2. To be provided with information about the PH-MCO, its services, the practitioners providing care, and Members rights and responsibilities;

3. To be able to choose Providers, within the limits of the PH-MCO Network, including the right to refuse treatment from specific practitioners;

4. To participate in decision making regarding their health care, including the right to refuse treatment, and to express preferences about future treatment decisions;

5. To have a Health Care Provider, acting within the lawful scope of practice, discuss Medically Necessary care and advise or advocate appropriate care with or on behalf of the Member including; information regarding the nature of treatment options; risks of treatment; alternative therapies; and consultation or tests that may be self-administered; without any restriction or prohibition from the PH-MCO;

6. To file a Grievance about the PH-MCO or care provided;

7. To file a DHS Fair Hearing appeal with the Department;

8. To formulate advance directives including:

   a. Written policies and procedures that meet advance directive requirements in accordance with 42 C.F.R. 489, Subpart I

   b. Written policies and procedures concerning advance directives with respect to all adult Members receiving medical care by or through the PH-MCO

9. To have access to his/her medical records in accordance with applicable Federal and State laws and the right to request that they be amended or corrected as specified as in 45 C.F.R. Section 164.526.

B. The PH-MCO must have a written policy that addresses Member's responsibility for cooperating with those providing health care services. This written policy must address Member's responsibility for:

1. Providing, to the extent possible, information needed by professional staff in caring for the Member; and

2. Following instructions and guidelines given by those providing health care services.

   Members shall provide consent to managed care plans, Health Care Providers and their respective designees for the purpose of providing patient care management, outcomes improvement and research. For these purposes, Members will remain anonymous to the greatest extent possible.

C. The PH-MCO's policies on Member rights and responsibilities must be provided to all participating Providers.

D. Upon enrollment, Members must be provided with a written statement that includes information on the following:

   1. Rights and responsibilities of Members;

   2. Benefits and services included as a condition of membership, and how to obtain them, including a description of:

      a. Any special benefit provisions (for example, co-payment, higher deductibles, rejection of Claim) that may apply to services obtained outside the system; and

      b. The procedures for obtaining Out-of-Area Services;

      c. Charges to Members if applicable;

      d. Benefits and services excluded.

      e. Provisions for after-hours, urgent and emergency coverage;

      f. The PH-MCO's policy on referrals for specialty care;

      g. PH-MCO Procedures for notifying, in writing, those Members affected by denial, termination or change in any benefit or service including denials, terminations or changes in level of care or placement;

      h. Procedures for appealing decisions adversely affecting the Member's coverage, benefits or relationship to the PH-MCO;

      i. Information about OMAP's Hotline functions;

      j. Procedures for changing practitioners;

k. Procedures for disenrolling from the PH-MCO;

l. Procedures for filing Complaints and/or Grievances; DHS Fair Hearings; and

m. Procedures for recommending changes in policies and services.

E. The PH-MCO must have policies and procedures for resolving Member Complaints and Grievances that meet all requirements outlined in Exhibit GG, Complaints, Grievances, and DHS Fair Hearing Processes. These procedures must include mechanisms that allow for the review of all Complaints and Grievances to determine if quality of care issues exists and for appropriate referral of identified issues.

F. Opportunity must be provided for Members to offer suggestions for changes in policies and procedures.

G. The PH-MCO must take steps to promote accessibility of services offered to Members. These steps must include identification of the points of access to primary care, specialty care and hospital services. At a minimum, Members are given information about:

1. How to obtain services during regular hours of operation;

2. How to obtain after-hours, urgent and emergency care; and

3. How to obtain the names, qualifications, and titles of the Health Care Provider providing and/or responsible for their care.

H. Member information (for example, Member brochures, Member denials, announcements, and handbooks) must be written in language that is readable and easily understood.

I. The PH-MCO must make vital documents disseminated to English speaking members available in alternate languages, upon request of the member. Documents may be deemed vital if related to the access of LEP persons to programs and services.

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

A. The PH-MCO must document that it is monitoring the quality of care across all services, all treatment modalities, and all sub-populations according to its written QM and UM programs.

B. The PH-MCO must adhere to all systems requirements as outlined in Section V.O.7, Management Information Systems, and Section VIII.B, Systems Reporting, of the Agreement and in Management Information System and Systems Performance Review Standards provided by the Department on the HealthChoices Extranet.

C. The PH-MCO must adhere to all Encounter Data requirements as outlined in Section VIII.B.1, Encounter Data Reporting, of the Agreement.

EXHIBIT M(2)

EXTERNAL QUALITY REVIEW

External Quality Review (EQR) is a requirement under Title XIX of the Social Security Act, Section 1902(a), (30), (c) for states to obtain an independent, external review body to perform an annual review of the quality of services furnished under state contracts with Managed Care Organizations, including the evaluation of quality outcomes, timeliness and access to services. The requirements for EQR were further outlined in 42 C.F.R. Parts 433 and 438; External Quality Review of Medicaid Managed Care Organizations; Final Rule issued on May 6, 2016. EQR refers to the analysis and evaluation of aggregated information on timeliness, access, and quality of health care services furnished to Members. "Quality", as it pertains to EQR, means the degree to which a PH-MCO maintains or improves the health outcomes of its Members through its structural and operational characteristics and through the provision of services. The results of the EQR are made available, upon request, to specified groups and to interested stakeholders. This is one of many tools that facilitate achieving continuous quality improvement in the delivery of care, health care outcomes, and timeliness of care, access to services, quality and utilization management systems, and program oversight. The Department requires that the PH-MCOs:

A. Actively participate in planning and developing the measures to be utilized with the Department and the EQRO. The Medical Assistance Advisory Committee will be given an opportunity to provide input into the measures to be utilized.

B. Accurately, completely and within the required timeframe identify eligible Members to the EQRO.

C. Correctly identify and report the numerator and denominator for each measure.

D. Actively encourage and require Providers, including subcontractors, to provide complete and accurate Provider medical records within the timeframe specified by the EQRO.

E. Demonstrate how the results of the EQR are incorporated into the Plan's overall Quality Improvement Plan and demonstrate progressive improvements during the term of the contract.

F. Improve Encounter Data in an effort to decrease the need for extensive Provider medical record reviews.

G. Provide information to the EQRO as requested to fulfill the requirements of the mandatory and optional activities required in 42 C.F.R. Parts 433 and 438.

H. Ensure that data, clinical records and workspace located at the PH-MCO's work site are available to the independent review team and to the Department, upon request.

I. Participate in Performance Improvement Projects whose target areas are dictated by the Department to address key quality areas of focus for improvements. The PH-MCO will comply with the timelines as prescribed by the EQRO.

EXHIBIT M(4)

HEALTHCARE EFFECTIVENESS DATA AND INFORMATION SET (HEDIS®)

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

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

The Department requires that the PH-MCOs:

A. Must produce rates for all Medicaid reporting measures, with the exclusion of the behavioral health measures, unless otherwise specified by the Department.

B. Must follow NCQA specifications as outlined in the HEDIS® Technical Specifications clearly identifying the numerator and denominator for each measure.

C. Must have all HEDIS® results validated by an NCQA-licensed vendor. The Department currently contracts with an NCQA-licensed entity to validate the MCOs' HEDIS® results used in public reporting. The MCO may utilize these validation results for other purposes such as pursuit of accreditation. The Department may at some future date relinquish the direct contracting of NCQA validation activities.

D. Must assist with the HEDIS® validation process by the Department's NCQA licensed contractor.

E. Must demonstrate how HEDIS® results are incorporated into the MCO's overall Quality Improvement Plan.

F. Must submit validated HEDIS® results annually on June 15th unless otherwise specified by the Department.

Measures publicly reported in the HealthChoices Consumer Guide are based on the Department's NCQA-licensed organization's validated findings.

Consumer Assessment of Healthcare Providers and Systems (CAHPS®)

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

In addition to the Adult survey, HEDIS® incorporates a CAHPS® survey of parental experiences with their child's care. The separate survey is necessary because children's health care frequently requires different Provider Networks and addresses different consumer concerns (e.g. child growth and development).

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

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

1. C1. In the last 6 months, did you get care from a dentist's office or dental clinic?
   1) Yes
   2) No

2. C2. In the last 6 months, how many times did you go to a dentist's office or dental clinic?
   1) None (If None, the Adult dental questions are complete. Thank you.)
   2) 1
   3) 2
   4) 3
   5) 4
   6) 5 to 9
   7) 10 or more

3. C3. We want to know your rating of all your dental care from all dentists and other dental providers in the last 6 months. Using any number from 0 to 10, where 0 is the worst dental care possible and 10 is the best dental care possible, what number would you use to rate your dental care?

1) 0 Worst dental care possible
2) 1
3) 2
4) 3
5) 4
6) 5
7) 6
8) 7
9) 8
10) 9
11) 10 Best dental care possible

Additional Child CAHPS® dental questions:

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

1) Yes
2) No

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

1) None
2) 1
3) 2
4) 3
5) 4
6) 5 to 9
7) 10 or more

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

1) 0 Worst dental care possible
2) 1
3) 2
4) 3
5) 4
6) 5
7) 6
8) 7
9) 8
10) 9
11) 10 Best dental care possible

7. D4. Which of the following would help your child see the dentist more often?
   1) Help with transportation to the dentist
   2) Reminders to visit the dentist
   3) More dentists to choose from
   4) More convenient office hours
   5) Dentists that speak my language
   6) Help in finding a dentist
   7) Better communication about benefits from my child's health plan
   8) Education about good dental care
   9) None of the above. My child sees the dentist as often as I like.
   10) Other (write in)

D. Must forward CAHPS® data to the Department both electronically and hardcopy in an Excel file in the format determined by the Department.

E. Must submit validated CAHPS® results annually on June 15th unless otherwise specified by the Department.

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

EXHIBIT N

NOTICE OF DENIAL

A written notice of denial must be issued to the Member for the following:

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

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

c. The denial of a requested service because it is not a covered service for the Member.

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

Please refer to Templates N(1) through N(6) for denial notice templates and Template N(7) Request for Additional Information Letter template which are available in Docushare.

EXHIBIT O

DESCRIPTION OF FACILITIES AND RELATEDSERVICES

Intermediate Care Facility For Individuals with Intellectual Disabilities And Other Related Conditions (ICF/ID/ORCs)

The PH-MCO is responsible to provide the full range of Physical Health Services to Members residing in private ICF/ID/ORC, except that the PH-MCO is not responsible to provide services to a Member to the extent services are covered under the facility's per diem payment. The PH-MCO is also not responsible to provide any services determined to fall under the scope of Behavioral Health Services or are the responsibility of the BH-MCO.

Residential Treatment Facility (RTF)

The PH-MCO is responsible to provide the full range of Physical Health Services to Members residing in RTFs. The PH-MCO is not responsible to provide any services that are currently covered under the facility's per diem payment. The PH-MCO is also not responsible to provide any services determined to fall under the scope of Behavioral Health Services or are the responsibility of the BH-MCOs.

Extended Acute Psychiatric Facility

The PH-MCO is responsible to provide the full range of physical health services to Members residing in extended acute psychiatric facilities. The PH-MCO is not responsible to provide any services that are currently covered under the facility's per diem payment. The PH-MCO is also not responsible to provide any services that are determined to fall under the scope of Behavioral Health Services or are the responsibility of the BH-MCOs.

Non-Hospital Residential Detoxification, Rehabilitation, and Half-Way House Facilities for Drug/Alcohol Dependence/ Addiction

The PH-MCO is responsible to provide the full range of physical health services to Members admitted to non-hospital residential detoxification, rehabilitation and halfway house facilities for drug/alcohol dependence/addiction. The PH-MCO is not responsible to provide any services that are currently covered under the facility's per diem payment. The PH-MCO is also not responsible to provide any services that are determined to fall under the scope of Behavioral Health Services or are the responsibility of the BH-MCOs.

Functional Eligibility Determinations (FED) and Pre-admission Screening Requirements

A Functional Eligibility Determinations (FED) must be completed to assess an individual's need for Nursing Facility services. The PH-MCO must contact Aging Well PA to initiate the FED assessment. This must occur prior to a Member's admission to a Nursing Facility. The PH-MCO must abide by the decision of the FED assessment related to the need for Nursing Facility services. The PH-MCO is not responsible for providing or paying for the FED assessment.

The PH-MCO must also comply with pre-admission screening requirements contained in 42 U.S.C. Section 1396r(e)(7) and 42 C.F.R. 483.100-483.138 regarding individuals with Mental Retardation/Other Related Conditions or mental illness.

Members Admitted to Juvenile Detention Centers (JDCs)

Any child receiving MA benefits will continue to receive those benefits during placement in a JDC. Children enrolled in a PH-MCO prior to placement at a JDC either inside or outside the HealthChoices Zone will continue to be covered by the PH-MCO from the date of placement for a maximum of thirty-five (35) consecutive days. The child will be disenrolled from the PH-MCO after the thirty-fifth (35th) consecutive day of placement. During the thirty-five (35) consecutive days, MA eligible services provided to the child on-site at the JDC will be covered under the Medical Assistance Fee-for-Service Program. Any services that are covered by the PH-MCO and provided outside of the JDC site are the responsibility of the PH-MCO. Should a child either be voluntarily disenrolled from a PH-MCO or become ineligible for enrollment due to a change in status, coverage of the child will remain consistent with enrollment policies. If during the period of placement the child transfers from one PH-MCO to another, the child will receive benefits through the new PH-MCO from the new PH-MCO effective date through the thirty-fifth (35th) consecutive day of placement.

A child already residing in a JDC will not be permitted to newly enroll in a PH-MCO until after release from the JDC. All other applicable coverage rules will apply.
EPSDT screening results or other health care needs detected during the period of the JDC placement should be reported to the effective PH-MCO. Should a covered service be identified that cannot be provided at the JDC site, the JDC must contact the PH-MCO in order to arrange for the covered service to be provided.

Dual Eligibles (Medicare/Medicaid) Under the Age of Twenty-One (21)

Recipients, under the age of twenty-one (21) who receive both Medicare as their primary health care coverage and Medicaid (MA) as a supplemental coverage, will be required to enroll in the HealthChoices Program and choose both a PH-MCO and PCP within the PH-MCO. See Section V.F., Member Enrollment and Disenrollment, of the Agreement for enrollment information into HealthChoices Zone.

Due to their Medicare eligibility, many of these recipients may require special assistance with the coordination of their Medicare/Medicaid benefits. Therefore, these dually eligible Recipients are classified as having Special Needs and should fall under the guidelines outlined in Section V.P., Special Needs Unit (SNU), of the Agreement.

Recipients who are dually eligible are not required to go to their PH-MCO for services that are covered by Medicare. If appropriate, Recipients who are Dual Eligible are required to comply with the PH-MCO's referral and authorization requirements if they have exhausted their Medicare benefit for a Medicare covered service.

The PH-MCO is responsible to provide prescriptions written by Medicare Providers for a Member as long as the Member goes to a pharmacy within the PH-MCO's Provider Network.

Prescription coverage for Recipients who are dually eligible is subject to the PH-MCO's authorization protocols, with the exception of drugs covered by Medicare. In addition, the provisions outlined in Section V.B., Prior Authorization of Services, of this Agreement, will apply.

The PH-MCO's financial responsibility for Dual Eligibles is outlined in Section VII. of the Agreement.

EXHIBIT P

OUT-OF-PLAN SERVICES

Out of Plan Services include, but are not limited to:

A. Transitional Care Homes

The PH-MCO will only be responsible to provide medical services to children upon the child leaving the transitional care home to reside with family or other caretakers living within the HealthChoices Zone. The PH-MCO must ensure continuity of care, as well as coordination with necessary Providers and interagency teams once they are notified that the child has become enrolled in the PH-MCO.

B. Medical Foster Care Services

Medical foster care services are provided to children with special or chronic medical conditions or physical disabilities in the custody of the County Children and Youth Agency and placed in foster family care. Medical foster care services enable the child to be treated by a licensed practitioner on an outpatient rather than an inpatient or institutional basis. Medical foster care services include both supportive and supervisory activities as well as direct care of children. Such tasks include but are not limited to: medical management, nutritional care, hygiene and personal care and developmental education.

Medical foster care services are provided by both county and private children and youth social service agencies. The foster parents who are under contract with the agency provide direct care. The licensed foster care agency is enrolled as a Provider Type 40, Specialty 400, Medically Fragile Foster Care, and claims reimbursement is through the Medical Assistance Fee-for-Service Program according to the maximum daily fees for the four levels of medical foster care as established by the Office of Medical Assistance Programs. Even though the PH-MCO is responsible to provide Medically Necessary services to children residing in medical foster care homes, the PH-MCO is not responsible for the medical foster care services identified in the four levels of care. These four levels of medical foster care are described as Level(s) I - IV with each level progressively requiring increased care.

- Level I
    - The Child has one or more medical conditions or physical disabilities that can be relieved, alleviated, or controlled by a regimen of medical supervision and consistent non-specialized care. No life-threatening situations are anticipated.
    - Some specialized training may be required for the foster parent to care for the child, such as the preparation and control of special diets and the administration of non-oral medications.
    - Wheel chairs, ramps, and/or prostheses may be required but sophisticated technological equipment usually will not be necessary. Few special medical supplies are necessary.
    -

- Level II
    - The child has one or more acute medical conditions or physical disabilities that can be relieved, alleviated, or controlled by specialized intervention and a regimen of medical supervision and consistent care. No immediate life-threatening situations are anticipated.
    - Some special medical procedures training may be required for the foster parent for the management of tracheostomies, ileostomies, NG feeding tubes, catheters, etc.
    - Use of sophisticated technological equipment will be minimal. Some special medical supplies will be necessary.
    - The child will usually require special therapeutic interventions and special social, educational, and vocational planning.
- Level III
    - The child has a combination of acute temporary, chronic, or permanent medical conditions or physical disabilities which require intensive, home-based medical intervention on a constant basis to sustain life. Life threatening situations are anticipated.
    - Considerable special medical procedures training will be required for the foster parent.
    - Use of sophisticated technological equipment will be necessary. Special medical supplies will be necessary.
    - Because the child will usually be home-bound, all developmental areas will require special planning.
- Level IV
    - The child has a combination of acute, chronic, or permanent medical conditions or physical disabilities whose life can be sustained only by intensive, home-based medical intervention on a 24-hour basis. Life threatening situations are constantly present.
    - Extensive special medical procedures training will be required for the foster parent.
    - Use of a variety of sophisticated technological equipment will be necessary. Special medical supplies will be necessary.
    - Because the child will be home-bound, all developmental areas will require special planning.

When children in the custody of the County Children and Youth Agency are placed in medical foster care homes, the PH-MCO's Special Needs Unit must work with the medical foster care agency to ensure that necessary medical and ancillary services are provided in the amount and level that enable the child to be maintained in the foster care home and minimize hospitalization/institutionalization of the child.

C. Early Intervention Services

An infant or toddler may receive services under both the HealthChoices Program and the Early Intervention Program, but the services are separate and distinct. The HealthChoices Program consists of Medically Necessary services prescribed by the Primary Care Practitioner. Early intervention services consist of a range of family-centered habilitation services and supports as defined by each family's individualized family service plan.

D. OLTL/OBRA Waiver: The Home and Community Based Waiver Program

This program provides services to people with developmental physical disabilities to allow them to live in the community and remain as independent as possible.

The Department's Office of Long-Term Living, (OLTL) currently operates a Home and Community-Based Waiver that provides services to Pennsylvania residents age 18 and older with a severe developmental physical disability requiring an Intermediate Care Facility / Other Related Conditions (ICF/ORC) level of care. The disability must result in substantial functional limitations in three or more of the following major life activities: mobility, communication, self-care, self-direction, capacity for independent living, and learning.

Other related conditions (ORCs) include physical, sensory, or neurological disabilities which manifested before age 22, are likely to continue indefinitely, and result in substantial functional limitations in three or more of the following areas of major life activity: capacity for independent living, mobility, self-direction, learning, understanding and use of language, and self-care.

Recipients receiving these home and community based services through the OLTL/ OBRA Waiver will be enrolled in the HealthChoices Program. The PH-MCO is responsible for providing all medically necessary state plan services to these individuals PRIOR TO services being covered under the OLTL/ OBRA Waiver. The PH-MCO must coordinate with the waiver service providers to promote a seamless continuum of care. The PH-MCO is not responsible to provide any medical services that are determined to fall under the scope of Behavioral Health Services or is the responsibility of the Behavioral Health MCOs. A description of these services is addressed in the MA Eligibility Handbook.

E. Office of Developmental Programs (ODP) Waivers: Person/Family Directed Support Waiver (P/FDS), Consolidated Waiver and Community Living Waiver

The Home and Community Based Waiver Program for Persons with Intellectual Disabilities and Autism: The Department's Office of Developmental Programs currently operates Home and Community Based Services Waivers (P/FDS, Consolidated and Community Living) which provide services to individuals with intellectual disabilities and autism of any age and children with developmental disabilities from birth through age eight. The waivers are designed to help individuals with an intellectual disability, autism or developmental disability to live more independently in their homes and communities and to provide a variety of services that promote community living and family support. Eligibility determinations require a recommendation for an Intermediate Care Facilities (Intellectual Disabilities (ICF/ID) or Other Related Conditions (ICF/ORC)) level of care based on a medical evaluation.

Recipients receiving community based services through these waivers will be enrolled in the HealthChoices Program. The PH-MCO is responsible to ensure a family with a child who has or is at risk of a developmental delay is referred to the County Intellectual Disabilities office for a determination of eligibility for home and community based services. The PH-MCO is responsible for providing all medically necessary state plan services to these individuals PRIOR TO services being covered under the ODP Waivers. The PH-MCO must coordinate with the waiver service providers to promote a seamless continuum of care. The PH-MCO is also not responsible to provide any medical services that fall under the scope of Behavioral Health Services, or are the responsibility of the Behavioral Health MCOs. A description of these services is addressed in the MA Eligibility Handbook .

F. Community HealthChoices Waiver

The Community HealthChoices Waiver targets individuals 21 and over who require a Nursing Home Level of Care and are in need of long term services and supports (LTSS), and meet the other requirements of the waiver as determined by the Office of Long Term Living. HealthChoices members who qualify for the Community HealthChoices Waiver will be disenrolled from HealthChoices and enrolled into the Community HealthChoices program. The PH-MCO shall be required to provide assistance to these members in transitioning their care between the HealthChoices and the Community HealthChoices program as stated in section V.D of the agreement.

G. ODP Autism Waiver: The Home and Community Based Waiver program for Persons with Autism Spectrum Disorder.

The Adult Autism Waiver is a Home and Community Based Waiver program. The Office of Developmental Programs administrates this waiver which provides home and community based services specifically designed to help adults, 21 and older, who possess an autism spectrum disorder. The overriding goal of the Waiver is to aid the recipients with participation in their communities in the manners which they desire. Eligibility determinations require a recommendation for an Intermediate Care Facilities for Other Related Conditions (ICF/ORC) level of care based on a medical evaluation.

Recipients receiving community-based services through this waiver will be enrolled in the HealthChoices Program. The PH-MCO is responsible for providing all medically necessary state plan services to these individuals PRIOR TO services being covered under the Autism. The PH-MCO must coordinate with the waiver service providers to promote a seamless continuum of care. The PH-MCO is also not responsible to provide any medical services that fall under the scope of Behavioral Health Services, or are the responsibility of the Behavioral Health MCOs. A description of these services is addressed in the MA Eligibility Handbook.

EXHIBIT Q

SAMPLE MODEL AGREEMENT

This sample model Agreement is illustrative only and is designed for use by the county children and youth agencies, but can be adapted by other community agencies. Letters of Agreement must contain the information found in Exhibit S, Written Agreements Between PH-MCO and Service Providers.

[COUNTY AGENCY]/OFFICE

HEALTH SERVICES COORDINATION AGREEMENT

This County Office Health Services Coordination Agreement is entered into and effective this _____ day of _____, _____, by and between [Plan], a corporation, and the [County Agency] for _____ County, and the _____ Office of _____ County, Pennsylvania (collectively [County Agency]).

WHEREAS, [Plan], a licensed health maintenance organization in the Commonwealth of Pennsylvania, has entered into an agreement with the Pennsylvania Department of Human Services ("DHS") to furnish Medical Assistance-covered services ("covered services") to Medical Assistance (MA) recipients under the [Plan] Medical Assistance product (MA product"), in accordance with the Commonwealth's Medical Assistance programs, and in accordance with the agreements between [Plan] and DHS ("MA Agreements"); and

WHEREAS, [Plan] and [County Agency] wish to ensure that Medical Assistance recipients who are children in substitute care ("MA covered persons"), and served by the parties, receive the necessary and appropriate covered services; and

WHEREAS, since covered services can be delivered more efficiently and more timely if [County Agency] and [Plan] coordinate the identification and treatment of MA covered persons, DHS requires that [Plan] enter into agreements with county agencies] and county offices to set forth the terms on which they will coordinate the delivery of covered services to MA covered persons; and

WHEREAS, the parties explicitly acknowledge, understand and agree that the common purpose of this cooperative relationship is to ensure that access to covered services and the quality of covered services provided will not be diminished or compromised because of an MA covered person's placement in substitute care.

NOW, THEREFORE, in consideration of the mutual covenants and premises, and for other good and valuable consideration, and intending to be legally bound, the parties agree as follows:

1.0 DEFINITIONS

For the purposes of this Agreement, the following terms shall have the meanings set forth below:

1.1 **Covered Services** means those health care services MA covered persons are entitled to receive under the state and federal law. It also means those services that a PH-MCO is required to provide under its agreement with the Department of Human Services to MA covered persons.

1.2 **DOH** means the Pennsylvania Department of Health.

1.3 **DHS** means the Pennsylvania Department of Human Services.

1.4 **Emergency Medical Condition** means a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent lay person 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.

1.5 **EPSDT** means the Early and Periodic Screening, Diagnosis, and Treatment Program that provides medical services for individuals under the age of 21 administered under the Medical Assistance Program.

1.6 **MA Covered Person** means: (1) any Medical Assistance recipient that (a) is under the age of 18; or (b) over the age of 18 up to age 21 and under the jurisdiction of [County Agency] care and custody; <u>and</u> (2) for whom [Plan] and [County Agency] have agreed to coordinate the provision of covered services.

1.7 **Medical Assistance (MA)** means the Medical Assistance Program authorized by Title XIX of the federal Social Security Act, 42 U.S.C. §1396 *et seq*., and regulations promulgated thereunder, and Title 62, Chapter 1, Article 4 of the Pennsylvania Statutes and regulations promulgated thereunder.

1.8 **MA Agreements** means the contracts between [Plan] and DHS under any of Pennsylvania's Medical Assistance managed care programs, including DHS's HealthChoices Program, pursuant to which [Plan] arranges for the provision of certain services covered by Medical Assistance to MA covered persons.

1.9 **MA Product** means [Plan's] Medical Assistance HMO product.

1.10 **MA Recipient** means an individual eligible to receive services under Pennsylvania's MA Program, including the HealthChoices Managed Care Program, and is enrolled in the MA product.

1.11 **Medically Necessary** means that condition or procedure defined as medically necessary by DHS as delineated in DHS's HealthChoices Agreement between the [Plan] and DHS.

1.12 **PID** means the Pennsylvania Insurance Department.

Terms not defined hereinabove shall be given the meanings ascribed to them in the MA Agreements or the RFP.

2.0 MUTUAL [PLAN] AND [COUNTY AGENCY] OBLIGATIONS RELATIVE TO COORDINATION OF CARE

2.1 The parties, and their liaisons where applicable agree to communicate with the MA covered person's Primary Care Physicians (PCPs), coordinate services, exchange relevant enrollment and individual health-related information and services needs of MA covered persons, including the institution of a process to monitor such activity, and a process to monitor the quality management and utilization management responsibilities of each party.

2.2 The parties agree to develop policies, within 60 days of the effective date, on referral, collaboration, and coordination of diagnostic assessment and treatment, prescribing practices, continuity of care, and other treatment issues necessary for optimal health and disease prevention, including policies on coordination of specialized service plans for MA covered persons with special health needs.

2.3 The parties agree to interact with the PCPs for prompt treatment and coordination of care.

2.4 The parties agree to jointly monitor the quality of the covered services delivered.

2.5 The parties agree to work cooperatively to establish programmatic responsibility for each MA covered person.

2.6 The parties agree to serve on interagency teams, when requested by either of the parties hereto.

2.7 The parties agree to cooperate in the coordination of covered services with the applicable Behavioral Health Managed Care Organizations in the HealthChoices Zone (HC Zone), including Pharmacy Coordination, to the extent permitted by law**.**

2.8 Where the parties have identified an issue, the parties mutually agree to undertake intensive outreach efforts to MA covered persons identified as needing covered services.

2.9 To assure the effectiveness of this Agreement and the services provided hereunder, the parties will review the Agreement for accuracy at least [insert time frame] or, if necessary, more often. Additionally, the parties agree to set up a

forum to discuss opportunities to assess training needs, consultation, and sharing of information between the parties to facilitate the cost-effective use of resources. The parties also agree to meet [insert time frame], or as requested by either party, to resolve any outstanding issues existing between them.

2.10 The parties agree to assist, when appropriate, in the development of an adequate provider network to serve special needs populations.

2.11 The parties agree to develop and implement a work plan to address issues or actions so as to bring said issues and actions into compliance with the term(s) of this Agreement.

2.12 The parties agree to adhere to the Americans with Disabilities Act, as amended, and the Rehabilitation Act of 1973.

2.13 The parties agree to collaborate on identifying and reducing the frequency of fraud, abuse, over use, under use, and inappropriate or unnecessary medical care.

2.14 The parties will work cooperatively to develop processes to ensure that:

(i) The [County Agency] caseworker will contact a participating provider or attempt to contact the PCP, when the [County Agency] caseworker can identify the PCP, when admission or discharge physical examinations are required due to the initial placement or discharge of an MA covered person or if the MA covered person is relocated. When it is not possible to contact the PCP, the [County Agency] shall coordinate with the plan's Special Needs Unit to arrange to use other providers within the [Plan's] network. In cases of suspected abuse, [County Agency] shall contact the appropriate medical provider for the examination without having to obtain prior approval from the PCP or [Plan]. If the enrollment of the MA recipient cannot be determined at the time the exam is required, the exam may be performed in an emergency room or through a provider affiliated with [County Agency]. Within 24 hours, or as soon as it can be reasonably determined that the MA recipient is eligible for the MA Product and eligible to be an MA covered person, [County Agency] will notify [Plan's] Special Needs Unit and/or the PCP in order that necessary follow-up care can be coordinated.

(ii) Information related to suspected abuse cases obtained from a PCP or [Plan] provider, including diagnostic tests, is shared with [County Agency].

(iii) Physical assessments needed by the MA covered persons entering emergency shelters are being performed within the time frames established by law. The same procedure set forth in 2.14(i) above applies.

(iv) Medically necessary home health services are being provided to MA covered persons in medical foster care.

(v) [County Agency] will be notified by [Plan] of denial of services to MA covered persons, including explicit steps on how to file an appeal, which has the right to file, and how denials will be processed.

2.15 [Plan] and [County Agency] will work together to determine the post-discharge needs of any MA covered person placed in substitute care, and to develop a care plan that will maintain continuity of care through the MA covered person's transition from substitute care to home.

2.16 [Plan] and [County Agency] will work together to develop policies and procedures on the identification of individuals who have the authority to represent MA covered persons to request PCP selections and changes; receive MA covered person information including identification cards, MA covered person notices, or filing MA covered person complaints, grievances or appeals on behalf of the MA covered persons.

2.17 [Plan] and [County Agency] will work together to develop and implement joint education and training programs related to requirements of both. This training will be provided to [County Agency] caseworkers, staff, or private agencies and [Plan's] Special Needs Unit staff and participating providers throughout the implementation of HealthChoices and as specific needs are identified.

2.18 [Plan] and [County Agency] will cooperate in the identification of opportunities for improvement of processes or procedures identified in this Agreement and the need for additional processes or procedures. At a minimum, representatives from [Plan] and [County Agency] will meet to discuss identified opportunities and to establish a work plan to address those issues. This process will be coordinated through the designated contact persons.

2.19 [Plan] shall provide to [County Agency] at [County Agency's] address set forth hereinafter, any notification that [Plan] is required to provide to MA covered persons, in lieu of providing it to MA covered persons, and [County Agency] shall then be obligated to provide any such notification to MA covered persons, and MA covered persons' caretaker, provider, or guardian.

2.20 [County Agency] and [Plan] shall cooperate with each other and shall share medical information for children entering placement who are covered persons and if appropriate.

3.0. <u>[PLAN] OBLIGATIONS</u>

3.1 [Plan] will be responsible for the payment of physical health services as set forth in the RFP, including eye care, dental care, hearing exams, and immunizations. [Plan] shall not be obligated to pay for medical services currently covered by Fee-For-Service Medical Assistance and for which [County Agency] contracts directly with providers of medical care. [Plan] shall not be obligated to pay for medical services for children who are not MA covered persons. Medical services provided to children who are currently being evaluated for Medicaid eligibility

shall be paid for by DHS under Fee-For-Service Medical Assistance programs. [Plan] shall not be obligated to pay for inpatient hospital days that are not a medical necessity, as determined by [Plan], including the situation where [County Agency] is in the process of placing the child in a foster or similar home and is having difficulty doing so. [Plan] shall not be obligated to pay for psychological evaluations for any purpose whatsoever.

3.2 [Plan] shall be responsible to provide or arrange for the provision of medically necessary covered services to any MA covered person upon his or her discharge from substitute care to his/her family or other primary caretaker (i.e. legal guardian), provided that the MA covered person is discharged to a location in the HC Zone.

3.3 [Plan] has a Special Needs Unit that will deal, in a timely manner, with issues relating to MA covered persons with special needs.

3.4 [Plan] shall identify a contact person for coordination with [County Agency] and further shall define the roles and responsibilities of the contact person to address mass change situations such as enrollment and incorrect PCP designations, which affect all MA covered persons, and individual requirements such as emergency physical exams, PCP selections or change, or EPSDT screens that are due.

3.5 For MA covered persons with complex medical needs, the designated contact person at [Plan's] Special Needs Unit will coordinate requests for specialists to serve as PCP with the contact person at [County Agency]. The procedures will include a timeline for submission of requests, tracking of requests, and decisions on requests. The procedures will include the selection of an accessible PCP until a decision has been provided. If the request has been denied, any request for a change in PCP will be coordinated with the [County Agency] contact person.

3.6 [Plan] shall coordinate notification and scheduling of EPSDT screens that are due with the [County Agency] contact person or the appropriate foster parent if [County Agency] notifies [Plan's] Special Needs Unit of the foster parent. [Plan] shall provide [County Agency] with EPSDT data on MA covered persons on a mutually agreed upon reporting, time frame, and format.

3.7 [Plan] shall provide [County Agency] with its provider directories when they are produced on no less than an annual basis.

3.8 [Plan's] Special Needs Unit shall provide information in writing to [County Agency] describing [Plan's] operations, including the manner in which [County Agency] may contact [Plan] regarding benefit coverage rules and access to additional information or resources on behalf of an MA covered person placed in substitute care.

3.9 [Plan's] Special Needs Unit staff shall provide education to [County Agency] staff on the [Plan's] requests for accessing medically necessary services.

3.10 All denials by [Plan] of requests for services shall be provided to [County Agency] via telefax and regular mail.

4.0 [COUNTY AGENCY'S] OBLIGATIONS

4.1 Within four months after the implementation of this Agreement, and, at a minimum, quarterly as new providers are identified by [County Agency], [County Agency] shall provide to [Plan] the names of the health care providers [County Agency] uses for exams on an annual basis.

4.2 [County Agency] shall identify a contact person to [Plan], and further shall define the roles and responsibilities of the contact person, to address mass change situations such as enrollment, which affect all MA covered persons, and individual requirements such as emergency physical exams, PCP selection or change, or EPSDT screens which are due.

4.3 [County Agency] will attempt to determine a Medical Assistance recipient's eligibility including physical health plan enrollment by utilizing DHS's Eligibility Verification System (EVS). If EVS is not available in the [County Agency] office, [County Agency] will secure an EVS terminal or educate staff on how to contact DHS to verify eligibility.

4.4 [County Agency] shall arrange for the provision of any medically necessary physical health services by [Plan] contract providers unless the situation is an emergency. [County Agency] will arrange for the provision of any EPSDT screening exams, immunizations, tests or follow-up medical care with [Plan's] Special Needs Unit or PCP. [Plan] shall consider all DHS-required EPSDT services covered services as set forth in DHS's EPSDT guidelines.

4.5 [County Agency] shall advise [Plan] of all new placements or relocations of MA recipients within 15 days or as soon as it can be determined that the recipient is an MA covered person. [County Agency] will coordinate PCP selection or change with [Plan's] Special Needs Unit contact person upon notification of the MA covered person's need to timely access to a PCP.

4.6 [County Agency] will notify [Plan] within 15 days of new placements, changes in placement, or removals from placement of an MA covered person.

4.7 As appropriate, [Plan's] Special Needs Unit will contact [County Agency's] Managed Care Unit [or its equivalent] to request assistance in gathering medical information on the MA covered person. The medical information can include that collected as part of the [County Agency's] intake function or obtained from past medical records. The [County Agency's] Managed Care Unit and the Special Needs Unit [or its equivalent] will work together to obtain the necessary medical information and to share this information with [Plan's] participating provider as appropriate.

4.8 [County Agency] will assist in obtaining required consent-to-treat documents from the MA covered person's parent, legal guardian, or through the court system, if necessary.

4.9 [County Agency] will require any private contracted agencies to cooperate with [Plan]. [County Agency] will require each private contracted agency to identify a contact person to [Plan's] Special Needs Unit designated contact person. [County Agency] will coordinate training and education of private contracted agencies with [Plan].

5.0 SPECIAL NEEDS UNIT

5.1 [County Agency] shall notify [Plan's] Special Needs Unit of the planned transition for the MA covered person within 15 days of discharge from substitute care. Included in these arrangements will be the transfer of all relevant medical information/records to a [Plan] PCP to which the MA covered person will be assigned if different from the current PCP.

5.2 As part of the joint [County Agency] and [Plan] discharge planning, and based on the individual needs of the MA covered person, the [County Agency] case worker and the [Plan's] Special Needs Unit will identify those MA covered persons who could benefit from Special Needs Unit case management. [Plan] case managers will cooperate with the PCP and the [County Agency] caseworker in the development of an appropriate care plan. The [Plan] case manager will assist in the coordination of services required to meet the needs of the MA covered person including any non- MA covered services.

5.3 In the event that [Plan] does not receive notice of an MA covered person's discharge from substitute care until after the discharge has occurred, a care coordinator from [Plan's] Special Needs Unit will be assigned to the case upon [Plan's] receipt of such notification. This care coordination will then work with the MA covered person's PCP and a [County Agency] Managed Care Unit, or its equivalent liaison, to make appropriate arrangements for the MA covered person's care.

6.0 DATA COLLECTION/REPORTING/SHARING

6.1 The parties agree to develop procedures on the collection of information on the covered services delivered, which information shall be shared with DHS upon request.

6.2 The parties agree to develop provisions for the notification of reportable conditions experienced by any MA covered persons to the appropriate regulatory agency as required by law.

6.3 The parties agree to share necessary data to ensure delivery of appropriate covered services.

7.0 COORDINATION OF CARE

If an MA covered person is placed by [County Agency] outside the HC services area, the [County Agency] contact person will notify the DHS County Assistance Office. DHS shall disenroll the MA covered person from [Plan]. The MA covered person will then either be enrolled in another HealthChoices service area or covered by the Fee-For-Service Medical Assistance Program. The [County Agency] contact person will notify [Plan's] Special Needs Unit contact person of the placement outside of the HC service area. [Plan] and [County Agency] will coordinate the transfer of the medical information to the new HealthChoices health plan or selected PCP.

8.0 CONFIDENTIALITY

8.1 The parties recognize and acknowledge that performance of this Agreement may result in the disclosure to the other party of trade secrets, proprietary information, and confidential information (collectively referred to as "Confidential Information"). The non-disclosing party agrees that it and its employees, representatives, and agents shall treat confidential information as strictly confidential and shall: (i) protect the confidential information from unauthorized use or disclosure either directly or indirectly, and keep it confidential; (ii) use the confidential information only for purposes related to this Agreement; (iii) not disclose or otherwise permit any third person or party access to the confidential information without prior written authorization by the disclosing party; and (iv) limit disclosure to necessary individuals and ensure that individuals exposed to confidential information are advised of its confidential nature and their obligations hereunder.

8.2 This Section, (8.0 Confidentiality) shall survive termination of this Agreement. The parties agree that the breach or prospective breach of this provision will cause irreparable harm of which money damages may not be adequate. The parties agree that in addition to any other remedies, the non-breaching party shall be entitled to injunctive or other equitable relief to restrain the breach hereof.

9.0 MEDICAL RECORDS

9.1 The parties agree to obtain the appropriate releases necessary to share clinical information and provide health records to each other as requested, consistent with all applicable laws.

9.2 The parties agree to maintain the confidentiality of all covered persons' medical records in accordance with all applicable state and federal laws.

9.3 DHS and/or its authorized agents shall be afforded prompt access to all MA covered persons' medical records whether electronic or paper. All medical

record copies are to be forwarded to the requesting party within 15 calendar days of such request and at no expense to the requesting party. DHS is not required to obtain written approval from an MA covered person before requesting the MA covered person's medical record from the parties or any other agency.

10.0 EMERGENCY CARE

[County Agency] has the right to proceed in an emergency without obtaining prior authorization from [Plan]. An emergency will not require an authorization at any time. [County Agency] shall contact the PCP to authorize urgent care or any follow-up care related to the emergency.

11.0 TERM AND TERMINATION

11.1 This Agreement shall become effective on the later of the effective date set forth above or DHS's approval thereof, and shall continue in effect until ___Date_____, or until the earlier termination of the HealthChoices MA Agreement. This Agreement shall renew upon the mutual consent of the parties and the renewal of the HealthChoices MA Agreement for a term consistent with the HealthChoices MA Agreement.

11.2 Either party may terminate this Agreement for cause by giving the other party and DHS 90 days written notice of a breach of this Agreement. Any such termination shall be effective on the date stated in the notice of termination unless the other party cures the breach prior to the expiration of the 90-day notice period. In the event the breach is cured to the reasonable satisfaction of the other party, the Agreement shall not be so terminated, and DHS shall be notified of the same.

11.3 This Agreement may also be terminated by mutual agreement of both parties with notice to DHS, and by either party upon 120 days advance written notice to the other party and DHS.

12.0 IMPLEMENTATION AND REVIEW OF AGREEMENT

The parties will jointly develop an implementation plan for the coordination of covered services and will appoint representatives who will meet regularly to carry out such plan. To assure the effectiveness of this Agreement and the services to be provided hereunder, the parties will review the Agreement at least once each year, or more often if necessary.

13.0 DISPUTE RESOLUTION

Any controversy, dispute, or disagreement arising out of or relating to the Agreement, or breach thereof, that cannot be resolved at the meetings described in Section 2.9 above,

shall first be mediated, which shall be conducted in [enter appropriate county] County, Pennsylvania, in accordance with the American Health Lawyers' Association Alternative Dispute Resolution Service Rules of Procedure. In the event the parties cannot resolve their differences through mediation, the parties shall have the right to undertake proceedings in a court of proper jurisdiction. No regulatory order or requirement of DOH shall be subject to such mediation.

14.0 MISCELLANEOUS

14.1 **Compliance with Federal and State Laws.** Throughout the term of this Agreement, it shall be each party's responsibility to maintain compliance with all state and federal laws and regulations that affect its respective operations and the furnishing of covered services under this Agreement.

14.2 **Assignment.** This Agreement shall not in any manner be assigned, delegated, or transferred by either party without the prior written consent of the other party, provided, however, that [Plan] may assign this Agreement to another party that controls, is controlled by, or is under common control with [Plan].

14.3 **Notices.** Any notice required to be given pursuant to the terms and provisions hereof shall be in writing and if such notice relates to a modification to this Agreement or the MA product, it shall be sent by certified mail, return receipt requested, to the parties at the addresses set forth below, or personally delivered, delivered by facsimile, or regular or overnight mail. If mailed by regular mail, any such notice shall be deemed given on the fifth day following the date of mailing.

If to [Plan]
[Address]
[Fax #]

If to [County Agency]
_____ County _____ Agency
[Address]
Attention: _____

14.4 **Relationship of Parties.** The relationship between [Plan] and [County Agency] is that of independent contractors and neither shall be considered an agent or representative of the other for any purpose.

14.5 **Non-Exclusivity.** [County Agency] may enter into independent contracts with any payor or participate in other organizations that have purposes identical or similar to the purposes of [Plan].

14.6 **No Third Party Beneficiaries.** This Agreement shall be construed to give rights and place obligations solely upon the parties to this Agreement.

14.7 **Section Headings.** The headings and captions in this Agreement are for ease of reference only and shall not affect in any way the meaning or interpretation of this Agreement.

14.8 **Severability/Invalid Provisions.** The provisions of this Agreement are independent of and separate from each other. If any one provision is determined to be invalid or unenforceable, it shall not render any other provision invalid or unenforceable.

14.9 **Waiver/Compliance with Terms.** Waiver of any part of this Agreement shall not be considered a waiver of any other part of this Agreement. Failure to insist upon strict compliance with any terms of this Agreement (by way of waiver or breach) by either party hereto shall not be deemed to be a continuous waiver in the event of any future breach or waiver of any condition hereunder.

14.10 **Governing Law.** This Agreement shall be governed by and construed in accordance with the laws of the Commonwealth of Pennsylvania and all applicable federal laws.

14.11 **Inconsistencies.** In the event of any inconsistency between the provisions of this Agreement and the provisions of any MA Agreement or the RFP, or any exhibit thereto, the provisions of the HealthChoices MA Agreement or the RFP, respectively, shall govern.

14.12 **Entire Agreement and Amendments.** This Agreement, and all attachments and amendments hereto, constitute the entire understanding and agreement of the parties hereto and supersede any prior written or oral agreement pertaining to the subject matter hereof. This Agreement may be amended by the parties upon the written consent of both parties and DHS. In the event the parties are unable to agree to the content or the wording of an amendment, the proposed amendment and the facts related thereto shall be conveyed to DHS for guidance and direction on how to proceed.

IN WITNESS WHEREOF, the parties have caused their duly authorized representatives to affix their signatures to this Agreement as of the date written above.

_____County [County Agency]	[Plan]
By: _____	By: _____
Title: _____	Title: _____
Witness:	Witness:
By: _____	By: _____

Title: _____

Date: _____

Title: _____

Date: _____

[County/Agency] Primary Contact:

Name: _____

Address: _____

_____

Telephone: _____

Fax: _____

[Plan] Primary Contact

Name: _____

Address: _____

_____

Telephone: _____

Fax: _____

[County/Agency] Office

By: _____

Title: _____

Witness:

By: _____

Title: _____

Date: _____

EXHIBIT R

COORDINATION WITH BH-MCOS

The HealthChoices PH-MCOs and the BH-MCOs are required to develop and implement written agreements regarding the interaction and coordination of services provided to Recipients enrolled in the HealthChoices Program. These agreements must be submitted and approved by the Department. The PH-MCOs and BH-MCOs in the HealthChoices Zone are encouraged to develop uniform coordination agreements to promote consistency in the delivery and administration of services. A sample coordination agreement (which does not include all required procedures) can be found in Exhibit Q, Sample Model Agreement. Complete agreements, including operational procedures, must be available for review by the Department upon request. The agreements must be submitted for final review and approval to the Department at least thirty (30) days prior to the implementation of the HealthChoices Program. The written agreements must include, but not be limited to:

- 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 disease. The PH-MCO and the BH-MCO must collaborate in relation to the provision of emergency room services. Emergency services provided in general hospital emergency rooms are the responsibility of the Member's PH-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 is 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;

- Procedures, including Prior Authorization, which govern reimbursement by the BH-MCO to the PH-MCO for behavioral health service provided by the PH-MCO or vice versa and the resolution of any payment disputes for services rendered. Procedures must include provisions for differential diagnosis of persons with co-existing physical and behavioral health disorders, as well as provisions for cost-sharing when both Physical and Behavioral Health Services are provided to a Member by a service Provider;

- Procedures for the exchange of relevant enrollment and health-related information among the BH-MCO, the PH-MCO, and PCP and Behavioral and Physical Health Services Providers in accordance with federal and state confidentiality laws and regulations; (e.g., periodic treatment updates with identified primary and relevant specialty Providers);

- 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;

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

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

- Procedures for serving on interagency teams, as necessary;

- 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, Behavioral Health Service Provider(s) and the PH-MCO PCP for Members with special health needs (e.g., Behavioral Health Services for individuals under the age of twenty-one (21) in medical foster care and older adults with coexisting physical and behavioral health disorders);

- The BH-MCO is required to provide behavioral health crisis intervention and other necessary In-Plan Services to Members with behavioral health Emergency Conditions. The PH-MCO and BH-MCO must establish clear procedures for coordinating the transport and treatment of persons with behavioral health emergencies who initially present themselves at general hospital emergency rooms to appropriate behavioral health facilities;

- Procedures for the coordination and payment of emergency and non-emergency medically necessary ambulance transportation of Members. All emergency and non-emergency medically necessary ambulance transportation for both physical and behavioral health covered services is the responsibility of the Member's PH-MCO even for a behavioral health diagnosis.

- Procedures for the coordination of laboratory services;

- Mechanisms and procedures to ensure coordination between the BH-MCO service managers, Member services staff and BH-MCO network Providers with the PH-MCO's Special Needs Unit. The effectiveness of these mechanisms shall be included as an area for review by the BH-MCO's Quality Assurance Program and the PH-MCO's Quality Management Program;

- Procedures for the PH-MCO to provide physical examinations required for the delivery of Behavioral Health Services, within designated time frames for each service;

- Procedures for the interaction and coordination of pharmacy.

To ensure that there is support for the coordination of care between the PCP and the behavioral health Provider, appropriate county contacts can be found at the following Internet addresses:

County MH/ID Administrators:
https://www.hcsis.state.pa.us/hcsis-ssd/pgm/asp/PRCNT.ASP

Single County Authorities (SCA's):
https://apps.ddap.pa.gov/GetHelpNow/CountyServices.aspx

https://www.health.pa.gov/topics/programs/PDMP/Pages/Clinical.aspx

EXHIBIT S

WRITTEN COORDINATION AGREEMENTS BETWEEN PH-MCO AND SERVICE PROVIDERS

Any written coordination agreements entered into between the PH-MCO and service Providers must contain, at a minimum:

- Provisions for ongoing communications; exchange of relevant enrollment and individual health related information; service needs among the PH-MCO, PCP and the community Provider, including a process to monitor such activity; and the Quality Management and Utilization Management program responsibilities of each entity.

- Provisions which govern referral, collaboration and coordination of diagnostic assessment and treatment, prescribing practices and other treatment issues necessary for optimal health and disease prevention, including coordination of specialized service plans for Members with special health needs.

- Provisions for requiring interaction by the PCP for prompt treatment, coordination of care or referral of Members for other identified services that are not the responsibility of the community Provider.

- Provisions for jointly identifying the services to be delivered and monitoring by the PH-MCO to determine the quality of the service delivered.

- Provisions for the PH-MCO and the community Provider to work cooperatively to establish programmatic responsibility for each HealthChoices Member.

- Provisions for serving on interagency teams, when requested.

- Provisions for assisting, when appropriate, in the coordination of services with the BH-MCO, including Pharmacy Coordination, to the extent permitted by law.

- Provisions for mutual intensive outreach efforts to Members identified as needing service (processes to conduct outreach and the measurement of the outreach efforts must be documented in the procedures governing the execution of the written agreement).

- Provisions for a timely resolution of any disputes.

- Provisions for training and consultations between both parties to facilitate continuity of care and the cost-effective use of resources.

- Provisions for assisting, when appropriate, in the development of an adequate Provider Network to serve Special Needs populations.

- Provisions for obtaining the appropriate releases necessary to share clinical information and provide health records to each other as requested consistent with state and federal laws.

- Provisions for the designation of a PH-MCO representative who will function as the liaison between the PH-MCO and the community Provider, if appropriate.

- Provisions for the development and implementation of corrective action plans in the event the provisions of the agreement are not being met.

- Provisions for the adherence to the Americans with Disabilities Act (ADA) (42 U.S.C. Section 12101 et seq) and the Rehabilitation Act of 1973 (29 U.S.C. Section 701 et seq).

- Provisions for the maintenance and confidentiality of medical records and other information considered confidential, including provisions for resolving confidentiality problems.

- Provisions for the collection of information on the service(s) delivered to be shared with the Department, upon request.

- Provisions for collaboration on identifying and reducing the frequency of Fraud, Abuse, overuse, under use, inappropriate or unnecessary medical care.

- Provisions for the reporting of health related information to the appropriate regulatory agency, if necessary.

EXHIBIT U

BEHAVIORAL HEALTH SERVICES

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

Behavioral Health Services Excluded from PH-MCO Covered Services

The following services are not the responsibility of the PH-MCO, under the HealthChoices Program.

The BH-MCO will provide timely access to diagnostic, assessment, referral, and treatment services for members for the following benefits:

- Inpatient psychiatric hospital services, except when provided in a state mental hospital;
- Inpatient drug and alcohol detoxification;
- Psychiatric partial hospitalization services;
- Inpatient drug and alcohol rehabilitation;
- Non-hospital residential detoxification, rehabilitation and half-way house services for drug/alcohol dependence/addiction;
- Emergency room evaluations for voluntary and involuntary commitments pursuant to the Mental Health Procedures Act of 1976, 50 P.S. 7101 et seq.;
- Psychiatric outpatient clinic services, licensed psychologist, and psychiatrist services;
- Behavioral health rehabilitation services (BHRS) for individuals under the age of 21 with psychiatric, substance abuse or intellectual disability disorders;
- Residential treatment services for individuals under the age of 21 whether treatment is provided in facilities that are Joint Commission for the Accreditation for Healthcare Organizations [JCAHO] accredited and/or without JCAHO accreditation;
- Outpatient drug and alcohol services, including Methadone Maintenance Clinic;
- Methadone when used to treat narcotic/opioid dependency and dispensed by an in-plan drug and alcohol services provider;
- Laboratory studies ordered by behavioral health physicians and clozapine support services;

- Crisis intervention with in-home capability;
- Family-based mental health services for individuals under the age of 21;
- Targeted mental health case management (intensive case management and resource coordination)

In addition to the in-plan mental health, drug and alcohol and behavioral services covered, supplemental mental health and drug and alcohol services may be made available pursuant to coordination agreements between the BH-MCO and the county mental health, intellectual disability, and drug and alcohol authorities. Supplemental services are not part of the capitated, in-plan benefit package. The BH-MCO may, however, choose to purchase such services in lieu of or in addition to an in-plan service.

The supplemental benefits may include:

- Partial hospitalization for drug and alcohol dependence/addiction;
- Psychiatric Rehabilitation: Site Based, Clubhouse or Mobile
- Targeted drug and alcohol case management and Intensive Outpatient Services;
- Supported living services;
- Assistance in obtaining and retaining housing, employment, and income support services to meet basic needs;
- Continuous community based treatment teams;
- Adult residential treatment (including long term structured residences and residential treatment facilities for adults);
- Consumer operated/directed self-help programs; e.g., drop-in centers, 12-step programs, double trouble groups;
- Drug and alcohol prevention/intervention services, including student assistance programs;
- Support groups for individuals under the age of 21; e.g., ALATEEN, peer groups;
- Social rehabilitation and companion programs, e.g., Compeer;
- Drug and alcohol transitional housing; and
- Drug and alcohol drop-in centers.

Exhibit V

TELEPHONIC PSYCHIATRIC CONSULTATION TEAM SERVICES

The HealthChoices MCO has the responsibility to coordinate the care of children who require therapeutic interventions and medication to treat mental health conditions especially those children in foster care. In order to improve the quality of care for children that require psychotropic medication, the MCO will contract with a telephonic Psychiatric Consultation Team (PCT) that will provide real time telephonic consultative services to PCPs and other prescribers of psychotropic medications for children (referred to as PCPs throughout this document). **The MCO will work with all other BH and PH-MCOs within the HC region to collaboratively choose one PCT for each HC region.**

The PCT must consist of a team of staff including one (1) full-time equivalent child psychiatrist, one (1) full-time equivalent behavioral health therapist, and one (1) full-time equivalent care coordinator.

Qualifications and key responsibilities for team staff are listed below:

(i) Child Psychiatrist

The full-time equivalent position of child psychiatrist may consist of one or more individuals as follows- child psychiatrists must be Board certified or Board eligible and skilled in psychopharmacology. At least one child psychiatrist shall be on call providing continuous coverage from 9:00 a.m. to 5:00 p.m., Monday through Friday, and shall at all times while on call carry a pager and/or cell phone and be accessible to a caller within thirty (30) minutes. The on-call team member shall not be engaged in any activity from which he/she cannot be interrupted within thirty (30) minutes. A child psychiatrist team member shall make an on-site visit to high volume participating PCPs defined by the MCOs in the HC region at least once per year. One child psychiatrist will be designated as the PCT's lead medical director with responsibility to assure consistent quality of care, convene periodic team meetings, assure team productivity and timely regional coverage of PCPs, and participate in quarterly meetings with all BH and PH MCOs within the HC region.

(ii) Behavioral Health Therapist

The one (1) full-time equivalent position of behavioral health therapist may consist of one or more individuals as follows: licensed clinical social workers ("LCSW"), licensed mental health counselor, or licensed psychologists. The behavioral health therapist team member's activities must be limited to consultative or short-term transitional care. The therapist(s) must be knowledgeable of local behavioral health resources and work as a team with the care coordinator to match a specific youth/family with the most appropriate and available community resource.

(iii) Care Coordinator

The care coordinator supports the team members by coordinating and maintaining schedules, managing registration and billing of patients requiring face-to-face visits, arranging appointments with local behavioral health providers and oversees collection of any encounter data. The care coordinator must be in constant contact with the BH and PH MCOs.

The PCT will perform consultative services and provider outreach services as described below.

Consultation Services

The PCT will be available at all times between 9:00 a.m. to 5:00 p.m., Monday through Friday (excluding Provider's holidays), to PCPs and other designated providers in the HC region to provide immediate consultations by telephone concerning children and adolescent behavioral health matters. In the event that PCT is unable to consult with the PCP at the time of the PCP's initial inquiry, the PCT shall respond to the PCP within thirty (30) minutes of PCP's initial inquiry call. The telephone consultation will result in one of the following outcomes dependent upon the needs of the PCP's patient and patient's family- resolution of the PCP's inquiry to the satisfaction of the PCP; referral to the PCT care coordinator to assist the family in accessing routine local behavioral health services with such referral stating the average anticipated wait time for visits; referral to PCT's child psychiatrist for an acute psychopharmacological or diagnostic consultation within two (2) weeks or as agreed with the patient's family; or referral to the PCT's social worker to provide diagnostic consultation and/or transitional face-to-face care or telephonic support to the patient and family until the family can access routine local behavioral health services.

The PCT shall maintain an appropriate clinical setting for its staff to care for patients needing face-to-face consultative or transitional services.

The PCT shall maintain records on all consultations and maintain a single designated telephone number with paging ability or PCT person answering the telephone for PCPs to access consultation services.

For all encounters requiring the care coordinator to assist the family with access to routine local behavioral health services, the PCT will follow up with the family to ascertain whether the appointment was made and continue to assist the family as appropriate if the appointment was not made. The care coordinator will contact the BH-MCO to make it aware of any barriers to timely care.

The PCT will send to PCPs a written or electronic record of all face-to-face visits including results of any follow up contacts within 48 hours of the visit. The PCT is encouraged to provide verbal feedback to the PCP from all face-to-face visits requiring follow up. The

PCT will also send to PCPs a written or electronic record of all telephonic care coordination encounters including results or any follow up contact within 48 hours of encounter.

The PCT will generate quarterly reports detailing the activity of participating PCPs and identifying which PCPs are not utilizing the service. The PCT will outreach to engage PCPs who are not utilizing the service. This may include but is not limited to outreach by telephone, e-mail, continuing education sessions, or visits to the office. The quarterly reports will detail the number of telephonic and face to face encounters, the number of unique recipients using the service, the number referred for additional services with community BH providers, the number of recipients who showed up for referred services, the number of unique members discussed with the BH-MCO, and the number of unique members discussed with the PH MCO.

Provider Outreach Services

The PCT will sequentially contact PCPs and other targeted prescribers of psychotropic medications in the HC Region to inform them of the PCT program and encourage them to participate. The PCT will provide PCPs in the HC Region with training and behavioral health continuing education at PCP offices on how to access and use the consultation program, orientation to community behavioral health services, and guidelines for prescribing and monitoring side effects of common psychotropic medications.

EXHIBIT X

HEALTHCHOICES PH-MCO GUIDELINES FOR ADVERTISING, SPONSORSHIPS, AND OUTREACH

I. Overview

The PH-MCO must submit a plan for advertising, sponsorship, and outreach procedures to the Department for advance written approval in accordance with the guidelines outlined in this exhibit.

II. HealthChoices Outreach Procedures

HealthChoices (HC) Managed Care Organizations (MCOs) must adhere to the following guidelines and all the requirements specified in Section V.F.2, PH-MCO Outreach Materials, and V.F.3, PH-MCO Outreach Activities, of the Agreement when submitting outreach materials, policies and procedures to the Department.

A. Submission of PH-MCO Outreach Material

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

Objectives:

1. To assure that PH-MCO outreach materials are accurate.

2. To prevent the PH-MCO from distributing outreach materials that mislead, confuse or defraud either the Member or the Department.

Process:

1. The PH-MCO submits outreach materials to the Department for prior approval using the HealthChoices Educational Materials Approval Request form (form attached).

2. The Department's contract monitoring Core Team will review and forward to the PH-MCO a preliminary response within thirty (30) calendar days from date of receipt of the request form.

   Exception: Should the materials require comments or approval from offices outside the Department contract monitoring Core Team, the turnaround time would be as soon as possible.

3. The PH-MCO will submit a final copy of the outreach materials to the Department contract monitoring Core Team for a final written approval prior to circulating the materials.

4. The Department review agency will forward a final written approval to the PH-MCO within ten (10) business days.

5. Outreach material usage:

   a. Direct outreach materials will be used only by the HealthChoices Independent Enrollment Assistance Program personnel after final written approval is received by the PH-MCO from the Department.

   b. Indirect outreach materials, i.e. advertisements, may be utilized immediately after final written approval is received by the PH-MCO from the Department.

B. Criteria for Review of PH-MCO Outreach Material

Purpose: To assure that printed materials, advertising, promotional activities and new Member orientations coordinated through the HealthChoices Independent Enrollment Assistance Program are designed to enable the Medical Assistance consumer to make an informed choice.

Objectives:

1. To assure that the information complies with all federal and state requirements.

2. To determine if the information is grammatically correct and appropriate for Pennsylvania's Medical Assistance population.

3. To ensure that outreach materials are accurate and do not mislead, confuse, or defraud the Member or the Department with the assertion or statement that the Member must enroll in the PH-MCO in order to obtain Medical Assistance benefits, or in order to not lose Medical Assistance benefits.

4. To ensure that there are no assertions or statements that the PH-MCO is endorsed by CMS, the Federal or State government, or similar entity.

Process:

1. Receive a written overall outreach plan annually if the PH-MCO anticipates participation in outreach activities. Requests for specific indirect advertising must be submitted thirty (30) calendar days in advance for written Department approval.

2. Determine if approval is necessary from other offices.

3. Review the information with the following criteria:

   a. Is the PH-MCO identified?
   b. Does the information comply with all federal and state regulations?
   c. Is the information presented in grammatically correct, precise, appropriate and unambiguous language, easily understood by the target audience (e.g., age and language) and does it avoid the use of industry jargon?
   d. Is the information fair, relevant, accurate and not misleading or disparaging to competitors?
   e. Can the information be easily understood by a person with a sixth grade education?
   f. Does the information include symbols or pictures that are discriminating because of race, color, age, religion, sex, national origin, physical handicap or otherwise? and
   g. Does the information create a negative image of the traditional Fee-for-Service system?

4. The Department will forward a final written response to the PH-MCO within ten (10) business days.

C. HC PH-MCO Participating In or Hosting an Event

The PH-MCO may submit requests to sponsor or participate in health fairs or community events; the request should demonstrate that the PH-MCO will participate in such fairs or events through activities, including approved outreach activities that are primarily health-care related. The PH-MCO must receive advance written approval from the Department prior to the event date. All requests must be submitted to the Department at least thirty 30 calendar days in advance of the event, on the forms which are included as part of this attachment.

Purpose: To clarify for PH-MCOs that Pennsylvania laws and regulations prohibit certain kinds of offers or payments to consumers as inducements or incentives for consumers to use the PH-MCO's services.

Objectives:

1. To provide amenities that create an environment that is comfortable and convenient for Recipients but is not offered as an artificial outreach inducement or incentive.

2. To eliminate fraudulent, abusive and deceptive practices that may occur as incentives or inducements to obtain specific covered services from the PH-MCO.

Process:

1. The PH-MCO must submit a request, using the applicable HealthChoices PH-MCO Outreach Approval Request Form or the HealthChoices Education Materials Request Form, to the appropriate Department review agency to host an event thirty (30) calendar days in advance of the event (see attached). Should the event require approval from other offices, the approval process may extend beyond thirty (30) calendar days.

2. The Department review agency considers the request confidential information.

D. PH-MCO Outreach Request Form

1. HealthChoices PH-MCO Outreach Approval Request Form

E. Health Education Materials Request Form

1. HealthChoices Educational Materials Approval Request Form

HEALTHCHOICES EDUCATIONAL MATERIALS APPROVAL FORM

PH-MCO Name: _____ Tracking #: _____

Contact Person: _____ Date: _____

Request Received By DHS: _____

Subject:
_____

Who:
_____

What:
_____

When:
_____

Where:
_____

Any Fees:
_____

Confirmation Letter Attached: Yes ☐ No ☐

Discussion:

DHS USE ONLY:

Approved: ☐ Denied: ☐

Reviewer: _____ Final Approval Date: _____

HEALTHCHOICES PH-MCO OUTREACH APPROVAL FORM

PH-MCO Name: _____ Tracking #: _____

Contact Person: _____ Date: _____

Request Received By DHS: _____

Subject:
_____

Who:
_____

What:
_____

When:
_____

Where:
_____

Any Fees:
_____

Confirmation Letter Attached: Yes ☐ No ☐

Discussion:

DHS USE ONLY:

Approved: ☐ Denied: ☐

Reviewer: _____ Final Approval Date: _____

EXHIBIT Z

AUTOMATIC ASSIGNMENT

Any Consumer who does not select a physical health-managed care organization (PH-MCO) and is mandated into the HealthChoices Program will be subject to the auto-assignment process as described below. The auto-assignment process does not negate the Consumer's option to change his/her PH-MCO. An eligible Consumer who has not made a PH-MCO selection and who has a case record that also includes another active member in the case with an active PH-MCO record will be assigned to that same PH-MCO. These Consumers will not count toward the percentages designated for auto-assignment. Consumers in a family unit will be assigned together to a PH-MCO. All remaining eligible Consumers, who have not voluntarily selected a PH-MCO, will be considered in the pool of Consumers who will be equally auto-assigned to PH-MCOs. The formula will direct an equal distribution of the auto-assignment pool in all HealthChoices Zones monthly based on the number of PH-MCOs in the Zone. For example, if there are five PH-MCOs in the Zone, each PH-MCO would receive 20%.

A. Consumer Re-Assignment Following Resumption of Eligibility: Consumers who lose eligibility and regain it within six (6) months will automatically be re-enrolled in their previously selected PH-MCO, as long as the Consumer's eligibility status or geographical residence is still valid for participation in that same PH-MCO.

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

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

B. Continuing Enrollment When Moving Between Zones: Eligible Consumers who move from one HealthChoices Zone to another will remain in the PH-MCO in which they were enrolled prior to their move, if the PH-MCO is also operational in the Zone to which they move.

C. Continuing Enrollment When Transferring from a CHC-MCO: Consumers who transfer from a CHC-MCO and the affiliate PH-MCO is also contracted as a PH-MCO, and the consumer has not made a PH-MCO selection, the consumer will be enrolled in the affiliated PH-MCO.

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

EXHIBIT AA

MANAGED CARE DEFINITIONS FOR MEMBER COMMUNICATIONS

The 2016 CMS "Medicaid and Children's Health Insurance Program (CHIP) Programs; Medicaid Managed Care, CHIP Delivered in Managed Care, and Revisions Related to Third Party Liability" final rule established a requirement (42 C.F.R. § 438.10(c)(4)(i)) that mandated that all states which contract with MCOs for delivery of Medicaid services must develop standardized definitions for a set of managed care related terms to be utilized by MCOs in communications with Members. The state developed definitions were required to be written at no higher than a sixth-grade reading level and are to be utilized by PH-MCOs for communications with Members such as newsletters, informational pamphlets, Member handbooks, etc.

When using any of the terms below in communications to Members, PH-MCOs must utilize the terms with the same intent as defined by the state.

Managed Care Definitions

1) **Appeal-** To file a Complaint, Grievance, or request a Fair Hearing.

2) **Complaint**- When a Member tells an MCO that he or she is unhappy with the MCO or his or her provider or does not agree with a decision by the MCO.

3) **Co-Payment-** A co-payment is the amount a Member pays for some covered services. It is usually only a small amount.

4) **Durable Medical Equipment**- A medical item or device that can be used in a Member's home or in any setting where normal life activities occur and is generally not used unless a person has an illness or injury.

5) **Emergency Medical Condition**- An injury or illness that is so severe that a reasonable person with no medical training would believe that there is an immediate risk to a person's life or long-term health.

6) **Emergency Medical Transportation**- Transportation by an ambulance for an emergency medical condition.

7) **Emergency Room Care**- Services needed to treat or evaluate an emergency medical condition in an emergency room.

8) **Emergency Services**- Services needed to treat or evaluate an emergency medical condition.

9) **Excluded Services**- Term should not be used. MCO should use "Services That Are Not Covered" instead.

10) **Grievance**- When a Member tells an MCO that he or she disagrees with an MCO's decision to deny, decrease, or approve a service or item different than the service or item the Member requested because it is not medically necessary.

11) **Habilitation Services and Devices**- Term should not be used by MCO. MCO should define specific service.

12) **Health Insurance**- A type of insurance coverage that pays for certain health care services. (If used by MCO, should be used to refer only to private insurance.)

13) **Home Health Care**- Home health care is care provided in a Member's home and includes skilled nursing services; help with activities of daily living such as bathing, dressing, and eating; and physical, speech, and occupational therapy.

14) **Hospice Services**- Home and inpatient care that provides treatment for terminally ill Members to manage pain and physical symptoms and provide supportive care to Members and their families.

15) **Hospitalization-** Care in a hospital that requires admission as an inpatient.

16) **Hospital Outpatient Care**- Care provided by a hospital or hospital-based clinic that does not require admission to the hospital.

17) **Medically Necessary**- A service, item, or medicine that does one of the following:

- Will, or is reasonably expected to, prevent an illness, condition, or disability;
- Will, or is reasonably expected to, reduce or improve the physical, mental, or developmental effects of an illness, condition, injury or disability;
- Will help a [member][participant] get or keep the ability to perform daily tasks, taking into consideration both the Member's abilities and the abilities of someone of the same age.

18) **Network**- Contracted providers, facilities, and suppliers that provide covered services to MCO Members.

19) **Non-Participating Provider**- When referring to a provider that is not in the network, MCOs should use the term "Out-of-Network Provider."

20) **Physician Services**- Health care services provided or directed by a licensed medical physician (M.D. – Medical Doctor or D.O. – Doctor of Osteopathic Medicine).

21) **Plan**- A health care organization that provides or pays for the cost of services or supplies.

22) **Preauthorization or Prior Authorization**- Approval of a service or item before a Member receives the service or item.

23) **Participating Provider**- When referring to a provider that is in the network, MCOs should use “Network Provider.”

24) **Premium**- The amount a Member pays for health care coverage.

25) **Prescription Drug Coverage**- A benefit that pays for prescribed drugs or medications.

26) **Prescription Drugs**- Drugs or medications that require a prescription for coverage.

27) **Primary Care Physician**- A physician (M.D. – Medical Doctor or D.O. – Doctor of Osteopathic Medicine) who directly provides or coordinates a range of health care services for a patient.

28) **Primary Care Provider**- A doctor, doctors’ group, or certified registered nurse practitioner who provides and works with a Member’s other health care providers to make sure the Member gets the health care services the Member needs.

29) **Provider**- An individual or entity that delivers health care services or supplies.

30) **Rehabilitative Services and Devices**- Term should not be used by MCO. MCO should define specific service.

31) **Skilled Nursing Care**- Services provided by a licensed nurse.

32) **Specialist**- A doctor, a doctor’s group, or a certified registered nurse practitioner who focuses his or her practice on treating one disease or medical condition or a specific part of the body.

33) **Urgent Care**- Care for an illness, injury, or condition which if not treated within 24 hours, could rapidly become a crisis or an emergency medical condition.

34) **Network Provider**- A provider, facility, or supplier that has a contract with an MCO to provide services to Members.

35) **Out-of-Network Provider**- A provider that does not have a contract with an MCO to provide services to Members.

EXHIBIT BB

PH-MCO RECIPIENT COVERAGE DOCUMENT

This Recipient Coverage Document (RCD) includes descriptions of policies supported by the Department of Human Services (Department) data systems and processes. In cases in which policies expressed in this document conflict with another provision of the Managed Care Organization's (PH-MCO) Agreement, the Agreement will take precedence.

PH-MCO coverage as detailed in this document does not imply coverage under a BH-MCO, or CHC-MCO. Refer to the BH-MCO RCD for behavioral health coverage guidelines and CHC-MCO PCD for Community Health Choices coverage guidelines.

The Department will provide sufficient information to the PH-MCO in order for it to reconcile PH-MCO membership data and amounts paid to and recovered from the PH-MCO. The Department will only pay capitation to one PH-MCO per recipient per month.

Coverage Rules

A PH-MCO is responsible for a Member if coverage is determined by applying the general rules found in any of paragraphs A, B, or C below, subject to exceptions and clarifications found in paragraphs D, E, F, and G.

Refer to the HealthChoices Intranet site "HealthChoices" for additional information on Recipient coverage, clarifications, examples, and membership Enrollment/disenrollment procedures.

A. **Responsibility to Provide MA Benefits -** Unless otherwise specified, the PH-MCO is responsible to provide Medical Assistance (MA) benefits to Members in accordance with eligibility information included on the Daily 834 Eligibility File and/or the Monthly 834 Eligibility File, which is provided by the Department to each PH-MCO.

B. **Membership Files/Coverage Dates/Eligibility -** Daily and Monthly 834 Eligibility Files containing information and changes that apply to their Members are provided to each PH-MCO. The PH-MCO is responsible to provide services for each PH-MCO Member identified on the Daily or Monthly 834 Eligibility File from the first day of the calendar month or the PH-MCO coverage start date, whichever is later, through the last day of the calendar month, or the PH-MCO end-date, if any. The Department will pay the PH-MCO from the first day of coverage in a month through the last day of the calendar month, except when transferring to a CHC-MCO. If a PH-MCO member transfers to a CHC-MCO the Department will pay capitation to the PH-MCO only through the day prior to the CHC begin date. PH-MCO coverage dates beyond the last day of the month in which the Daily or Monthly 834 Eligibility File is created are preliminary information that is subject to change.

Members who become ineligible for MA and were active in a PH-MCO will retain their PH-MCO selection for six months. These Members will become the responsibility of the same PH-MCO if they regain MA eligibility during that six-month period, as long as their category of assistance and geographic location are valid for that PH-MCO. Upon regaining eligibility, their PH-MCO effective date will be their eligibility begin date or the date Client Information System (CIS) is updated with their coverage, whichever is later.

C. Benefit Packages - The Department has established two benefit packages based on age. The packages are Adult and Children's. The Adult package includes individuals with an age greater than or equal to 21 years old. The Children's package includes individuals with an age less than 21 years old. Refer to the Daily and Monthly 834 Eligibility Files to determine benefits during a month based on these criteria.

D. Exceptions and Clarifications - The Department will recover Capitation payments made for Members for whom it has been determined that the PH-MCO was not responsible to provide services.

The PH-MCO will not be responsible and will not be paid when the Department notifies the PH-MCO of Members for whom they are not responsible.

1. Errors in PH-MCO coverage identified from any source must be reported to the Department within forty-five (45) days of receipt of the Daily 834 Eligibility File in order for changes to be considered.

   If a Recipient is enrolled in a PH-MCO in error, that PH-MCO is responsible to cover the Recipient until the Department is notified and the correction is applied to the CIS eligibility record.

   If at the time of notification to the Department, the Recipient was disenrolled in error from a PH-MCO and the Recipient is enrolled in a different PH-MCO, the Recipient will be reenrolled in the previous PH-MCO effective the first of the next month. However, if at the time of notification the Recipient is covered by FFS, the Recipient will be reenrolled into the same PH-MCO effective the day following notification to the Department.

2. If CIS shows an exemption code or a facility/placement code that precludes PH-MCO coverage, the Recipient will not be enrolled in a PH-MCO.

3. If CIS shows Fee-For-Service (FFS) coverage that coincides with PH-MCO coverage, the Member may use either coverage and there will be no monetary adjustment between the Department and the PH-MCO. (This is subordinate to #7 below.)

4. If a PH-MCO has actual knowledge that a Member is deceased, and if such Member shows on either the Monthly 834 Eligibility or the Daily 834 Eligibility file as active, the PH-MCO is required to notify the County

Assistance Office (CAO) and the Department. The Department will recover Capitation payments made for up to eighteen (18) months after the service month in which the date of death occurred.

5. The Department will recover Capitation payments for Members who were later determined to be ineligible for PH-MCO coverage or who were placed in settings that result in the termination of PH-MCO coverage by the Department. The Department will recoup payments back to the month following the month in which the termination of coverage occurred, for up to twelve (12) months afterwards (e.g., today's date is 9/18/11 and central office staff end date managed care coverage 9/30/10 – payments are recouped for 10/10 through 9/11. See Section F for examples of placements that result in termination of coverage).

6. The Department is not responsible to make a Capitation payment for a month in which a Member aged twenty-one through sixty-four (21 – 64) resides in a free-standing IMD at least sixteen (16) days in that calendar month and effective July 1, 2018, the Member's condition is not related to Substance Used Disorder (SUD). This is effective January 1, 2018 and applies without regard to the number of days in the month in which the Member is enrolled in the PH-MCO. Effective January 1, 2020, recovery of capitation payments that meet these criteria is limited to 18-months. Additionally, effective January 1, 2020, the Department will make a separate payment to the PH-MCO for the days the Member does not reside in the freestanding IMD during a calendar month as noted in Section VII.E.13.

7. A newborn is the responsibility of the PH-MCO that covered the mother on the newborn's date of birth. Where CIS does not reflect this, the PH-MCO must notify the Department to correct coverage. The Department will generate Capitation payments as appropriate. Limitations in Sections E-2 and E-3 applicable to the mother will apply to the newborn.

   Exception #1: If mother is in a PH-MCO and C&Y assumes custody of the newborn at birth and places the child in a county within the same HC zone as the mother, the child's coverage will mirror the mother's PH-MCO coverage.

   Exception #2: If mother is in a PH-MCO and C&Y assumes custody of the newborn at birth and places the child in a county outside of the same HC zone where the mother resides, the child will be FFS until auto assignment or selected PH-MCO is effective in the new HC County.

8. Movement out of a PH-MCO's service area does not necessarily eliminate the PH-MCO's responsibility to provide MA benefits. It is the PH-MCO's responsibility to inform the CAO of the address change upon receipt of information that a Member is residing outside the PH-MCO service area.

9. Pursuant to the rules outlined in the RCD, a lack of MA eligibility indicated on CIS for a certain date does not necessarily eliminate the PH-MCO's responsibility to provide MA benefits. (Refer to Section E, Coverage During Inpatient Hospital Stays, for rules regarding the PH-MCO's responsibility for hospital stays when a Recipient loses MA eligibility during the stay.)

10. Dual Eligibles who are enrolled in Medicare Part D, and who turn 21 years of age will be identified by the Department on the first Friday of each month, and will be disenrolled from the PH-MCO, effective the end of the month in which the Department identifies that the Member turned 21 years of age. In addition, newly identified Dual Eligibles age 21 and over will be disenrolled the end of the month following the month in which Medicare Part D is posted to their eligibility record. The PH-MCO remains responsible for these Members through the disenrollment date.

11. The Department reserves the right to intercede in requests for expedited enrollments when Medically Necessary. The Department's determination for the expedited enrollment will be final. The Capitation rate will be retroactively adjusted for each PH-MCO based on the effective date of the expedited enrollment.

12. A Member who is attending a college or university in a state other than Pennsylvania remains the responsibility of the PH-MCO. However, at the sole discretion of the Department, the Member may be disenrolled from the PH-MCO and enrolled in FFS. The Department will take into consideration such factors as distance from Pennsylvania, the intensity and duration of medically required services, whether the PH-MCO has a business presence nearby, etc.

E. Change in PH-MCO Coverage During Inpatient Hospital Stays - When an MA Recipient has managed care coverage during part of a hospital stay, payment responsibility is as documented in Section E, Coverage During Inpatient Hospital Stays.

Note: One or more of the rules documented in the following sections may apply during a hospital stay.

RULE: E-1.	
Condition	**A Recipient who is covered by FFS when admitted to a hospital assumes PH-MCO coverage while still in the hospital.**
PH-MCO Coverage Responsibility	As of the begin date of PH-MCO coverage, the PH-MCO is responsible for physician, DME and all other covered services not included in the hospital bill.
MA FFS Coverage Responsibility	The FFS program is responsible for the hospital bill through the date of discharge. Note: If the Recipient is discharged from the initial hospital to another hospital (acute or rehabilitation) after the PH-MCO begin date, FFS is only responsible for the stay in the initial hospital through the date of discharge. The PH-MCO is responsible for the stay in the subsequent hospital upon admission.

RULE: E-2.	
Condition	**A Recipient who is covered by a PH-MCO when admitted to a hospital loses PH-MCO coverage and assumes FFS coverage while still in the hospital.**
PH-MCO Coverage Responsibility	The PH-MCO is responsible for the hospital stay with the following exceptions. EXCEPTION #1: If the Recipient is still in the hospital on the FFS coverage begin date, and the Recipient's FFS coverage begin date is the first day of the month, the PH-MCO is financially responsible for the stay through the last day of that month. Example: If a Recipient covered by the PH-MCO is admitted to a hospital on June 21 and the FFS coverage begin date is July 1, the FFS program assumes payment responsibility for the stay on August 1. The PH-MCO remains financially responsible for the stay through July 31. EXCEPTION #2: If the Recipient is still in the hospital on the FFS coverage begin date, and the Recipient's FFS coverage begin date is any day other than the first day of the month, the PH-MCO is financially responsible for the stay through the last day of the following month. Example: If a Recipient covered by a PH-MCO is admitted to a hospital on June 21 and the FFS program coverage begin date is July 15, the FFS program assumes payment responsibility for the stay on September 1. The PH-MCO program remains financially responsible for the stay through August 31.
MA FFS Coverage Responsibility	Starting with the FFS begin date, FFS is responsible for physician, DME and other bills not included in the hospital bill. EXCEPTION #1: The FFS program is financially responsible for the stay beginning on the first day of the next month. EXCEPTION #2: The FFS program is financially responsible for the stay beginning on the first day of the month following the next month.

RULE: E-3.	
Condition	**A Recipient covered by a PH-MCO when admitted to a hospital transfers to another PH-MCO while still in the hospital.**
PH-MCO Coverage Responsibility	The losing PH-MCO is responsible for the hospital stay with the following exceptions. Starting with the gaining PH-MCO's begin date, the gaining PH-MCO is responsible for the physician, DME and all other covered services not included in the hospital bill. EXCEPTION #1: If the Recipient is still in the hospital on the gaining PH-MCO coverage begin date, and the Recipient's gaining PH-MCO coverage begin date is the first day of the month, the losing PH-MCO is financially responsible for the stay through the last day of the month. The gaining PH-MCO is financially responsible for the stay beginning on the first day of the next month. Example: If a Recipient is admitted to a hospital on June 21 and the gaining PH-MCO coverage begin date is July 1, the gaining PH-MCO assumes payment responsibility for the stay on August 1. The losing PH-MCO remains financially responsible for the stay through July 31. EXCEPTION #2: If the Recipient is still in the hospital on the gaining PH-MCO coverage begin date, and the Recipient's gaining PH-MCO coverage begin date is any day other than the first day of the month, the losing PH-MCO is financially responsible for the stay through the last day of the following month. The gaining PH-MCO is financially responsible for the stay beginning on the first day of the month following the next month. Example:

	If a Recipient is admitted to a hospital on June 21 and the gaining PH-MCO coverage begin date is July 15, the gaining PH-MCO assumes payment responsibility for the stay on September 1. The losing PH-MCO remains financially responsible for the stay through August 31.
MA FFS Coverage Responsibility	There is no FFS coverage in this example.

RULE: E-4a.	
Condition	**A Recipient covered by a PH-MCO when admitted to a hospital loses and regains MA eligibility while in the hospital (Recipient is not discharged), resulting in a break in PH-MCO coverage. The Department's Division of Managed Care Systems Support (DMCSS) becomes aware of the break in PH-MCO coverage by the end of the month following the month in which it is lost.**
PH-MCO Coverage Responsibility	DMCSS will reopen the Recipient's PH-MCO coverage retroactive to the day it was end-dated on CIS and adjust the Capitation payment accordingly. The PH-MCO continues to be financially responsible for the stay including the physician, DME, and all other covered services. Example: A Recipient who is admitted to the hospital on March 10 loses MA eligibility effective March 22 and regains it on April 9 retroactive to March 22. The PH-MCO coverage on CIS shows the Recipient was end-dated March 31 and reopened in the PH-MCO with a new PH-MCO begin date of April 9. On April 25, DMCSS becomes aware of the situation. Because DMCSS is aware of the loss of MA eligibility within the month following the month in which it was lost, DMCSS reopens the PH-MCO coverage retroactive to April 1, the day after the PH-MCO end-date is posted on CIS (March 31). The PH-MCO continues to be financially responsible for the stay including the physician, DME, and all other covered services.
MA FFS Coverage Responsibility	There would be no FFS coverage in this example.

RULE: E-4b.	
Condition	**A Recipient covered by a PH-MCO when admitted to a hospital loses and regains MA eligibility while in the hospital (Recipient is not discharged), resulting in a break in PH-MCO coverage. DMCSS does not become aware of the break in PH-MCO coverage by the end of the month following the month in which it is lost.**
PH-MCO Coverage Responsibility	Example: Same as in RULE: E-4a except, because DMCSS is not aware of the break in PH-MCO coverage by the end of the month following the month in which it was lost, the PH-MCO coverage is not reopened retroactive to the day it was end-dated on CIS (March 31). The PH-MCO is only responsible to cover the Recipient through the end of March.
MA FFS Coverage Responsibility	FFS is responsible effective April 1.

RULE: E-4c.	
Condition	**A Recipient covered by a PH-MCO when admitted to a hospital loses MA eligibility while in the hospital (Recipient is not discharged). The Recipient regains MA eligibility retroactively after the month following the month in which the MA eligibility was ended, regardless of when DMCSS became aware of the action.**
PH-MCO Coverage Responsibility	Example: A Recipient who is admitted to the hospital on March 10 loses MA eligibility effective March 22. The Recipient regains MA eligibility on May 15 retroactive to March 22. The PH-MCO coverage on CIS shows the Recipient was end-dated March 31 and reopened in the PH-MCO with a new begin date of May 15. Because the MA eligibility was not reopened within the month following the month in which it was lost, the PH-MCO coverage is not reopened retroactive to the day it was end-dated on CIS (March 31). The PH-MCO is only responsible to cover the Recipient through the end of March.

MA FFS Coverage Responsibility	FFS is responsible effective April 1.

RULE: E-4d.	
Condition	**A Recipient covered by a PH-MCO when admitted to a hospital loses MA eligibility <u>while in the hospital</u>. The Recipient <u>is discharged</u> from the hospital after the month in which the MA eligibility was lost but <u>before</u> the MA eligibility is regained by the Recipient and reopened retroactively, regardless of when DMCSS became aware of the situation.**
PH-MCO Coverage Responsibility	Example: A Recipient who is admitted to the hospital on March 10 loses MA eligibility effective March 22. The Recipient is discharged from the hospital April 3. The Recipient regains MA eligibility on April 22 retroactive to March 22. The PH-MCO coverage on CIS shows the Recipient was end-dated March 31 and reopened in the PH-MCO with a new begin date of April 22. Because the Recipient <u>was discharged</u> from the hospital before the MA eligibility was reopened, which resulted in a 3-day period of FFS coverage on CIS, DMCSS does not reopen the PH-MCO coverage retroactive to April 1. The PH-MCO is only responsible for the stay through the end of March.
MA FFS Coverage Responsibility	FFS is responsible effective April 1.

RULE: E-4e.	
Condition	**A hospitalized Recipient never regains MA eligibility.**
PH-MCO Coverage Responsibility	If the Recipient is never determined retroactively eligible for MA, the PH-MCO is only responsible to cover the Recipient through the end of the month in which MA eligibility ended.
MA FFS Coverage Responsibility	FFS is not responsible for coverage since the Recipient has not regained MA eligibility.

RULE: E-5.	
Condition	**A Recipient who is covered by PH-MCO when admitted to a hospital loses PH-MCO and assumes CHC-MCO while still in the hospital.**
PH-MCO Coverage Responsibility	The losing PH-MCO is responsible for the hospital stay with the following exceptions. Starting with the gaining CHC-MCO's coverage begin date, the gaining CHC-MCO is responsible for the physician, DME and all other Covered Services not included in the hospital bill. EXCEPTION #1: If the Recipient is still in the hospital on the gaining CHC-MCO coverage begin date, and the Recipient's gaining CHC-MCO coverage begin date is the first (1st) day of the month, the losing PH-MCO is financially responsible for the stay through the last day of the month. The gaining CHC-MCO is financially responsible for the stay beginning on the first day of the next month. Example: If a Recipient is admitted to a hospital on June 21 and the gaining CHC-MCO coverage begin date is July 1, the gaining CHC-MCO assumes payment responsibility for the stay on August 1. The losing PH-MCO remains financially responsible for the stay through July 31. EXCEPTION #2: If the Recipient is still in the hospital on the gaining CHC-MCO coverage begin date, and the Recipient's gaining CHC-MCO coverage begin date is any day other than the first day of the month, the losing PH-MCO is financially responsible for the stay through the last day of the following month. The gaining CHC-MCO is financially responsible for the stay beginning on the first day of the month following the next month. Example: If a Recipient is admitted to a hospital on June 21 and the gaining CHC-MCO coverage begin date is July 15, the gaining CHC-MCO assumes payment responsibility for the stay on

	September 1. The losing PH-MCO remains financially responsible for the stay through August 31.
MA FFS Coverage Responsibility	There is no FFS coverage in this example.

RULE: E-6.	
Condition	**Recipient who is covered by CHC-MCO when admitted to a hospital loses CHC-MCO and assumes PH-MCO while still in the hospital.**
PH-MCO Coverage Responsibility	The losing CHC-MCO is responsible for the hospital stay with the following exceptions. Starting with the gaining PH-MCO's coverage begin date, the gaining PH-MCO is responsible for the physician, DME and all other Covered Services not included in the hospital bill. EXCEPTION #1: If the Recipient is still in the hospital on the gaining PH-MCO coverage begin date, and the Recipient's gaining PH-MCO coverage begin date is the first (1st) day of the month, the losing CHC-MCO is financially responsible for the stay through the last day of the month. The gaining PH-MCO is financially responsible for the stay beginning on the first day of the next month. Example: If a Recipient is admitted to a hospital on June 21 and the gaining PH-MCO coverage begin date is July 1, the gaining PHC-MCO assumes payment responsibility for the stay on August 1. The losing CHC-MCO remains financially responsible for the stay through July 31. EXCEPTION #2: If the Recipient is still in the hospital on the gaining PH-MCO coverage begin date, and the Recipient's gaining PH-MCO coverage begin date is any day other than the first day of the month, the losing CHC-MCO is financially responsible for the stay through the last day of the following month. The gaining PH-MCO is financially responsible for the stay beginning on the first day of the month following the next month. Example: If a Recipient is admitted to a hospital on June 21 and the gaining PH-MCO coverage begin date is July 15, the gaining PH-MCO assumes payment responsibility for the stay on September 1. The losing CHC-MCO remains financially responsible for the stay through August 31.
MA FFS Coverage Responsibility	There is no FFS coverage in this example.

F. Other Causes for Coverage Termination and Involuntary Disenrollment - If a condition described in the following sections occurs, the PH-MCO must notify the Department. In accordance with Department's disenrollment guidelines, DMCSS will take action to disenroll the Member. The Department will recoup payments back to the month following the month in which the termination of coverage occurred, for up to twelve (12) months afterwards (e.g., today's date is 9/18/11 and central office staff end date managed care coverage 9/30/10 – payments are recouped for 10/10 through 9/11).

If a Recipient is placed in a setting listed in these sections, and is under FFS prior to the PH-MCO's begin date, PH-MCO coverage will be voided and adjustments will be processed for any Capitation payments made.

The PH-MCO must notify the Department within sixty (60) days following the satisfaction of the Department's disenrollment guidelines in order for DMCSS to end-date the member's enrollment. Failure on the part of the PH-MCO to notify DMCSS within the sixty (60) days **will** result in the end-date being delayed, thereby

extending the PH-MCO's responsibility for covering the Recipient. The PH-MCO should not hold and then later submit the notifications.

RULE: F-1a.	
Condition	
PH-MCO Coverage Responsibility	
MA FFS Coverage Responsibility	

RULE: F-1a.	
Condition	**A Member who is covered by a PH-MCO when admitted to a Nursing Facility transfers to a CHC-MCO.**
PH-MCO Coverage Responsibility	Residence in a nursing facility is not cause for disenrollment from a PH-MCO. If CIS provides a CHC start date, and if the PH-MCO's responsibility to provide benefits absent this information continues up to the date prior to the CHC start date or an earlier date in the month of the CHC start date, or a later date, the last day of the PH-MCO's responsibility to provide benefits is the date prior to the CHC start date. Refer to the Agreement, Section VII., E.12.
MA FFS Coverage Responsibility	FFS is not responsible for coverage.

RULE: F-1b.	
Condition	**A Member who is covered by a PH-MCO when admitted to a Nursing Facility transfers to another PH-MCO.**
PH-MCO Coverage Responsibility	The losing PH-MCO is responsible for the Nursing Facility stay with the following exceptions. Starting with the gaining PH-MCO's begin date, the gaining PH-MCO is responsible for the physician, DME and all other covered services not included in the Nursing Facility bill. EXCEPTION #1: If the Recipient is still in the Nursing Facility on the gaining PH-MCO coverage begin date, and the Recipient's gaining PH-MCO coverage begin date is the first day of the month, the losing PH-MCO is financially responsible for the stay through the last day of the month. The gaining PH-MCO is financially responsible for the stay beginning on the first day of the next month. Example: If a Recipient is admitted to a Nursing Facility on June 21 and the gaining PH-MCO coverage begin date is July 1, the gaining PH-MCO assumes payment responsibility for the stay on August 1. The losing PH-MCO remains financially responsible for the stay through July 31.
MA FFS Coverage Responsibility	FFS is not responsible for coverage.

RULE: F-1d.

Condition	**A Member is admitted to an out of state Nursing Facility (regardless of who places the Member in the facility).**
PH-MCO Coverage Responsibility	The PH-MCO is not responsible for Members who are placed in a Nursing Facility outside of Pennsylvania. A Member who is placed in an out of state Nursing Facility is disenrolled from the PH-MCO the day before the admission date.
MA FFS Coverage Responsibility	FFS is not responsible for coverage in an out of state Nursing Facility.

RULE: F-1e.	
Condition	
PH-MCO Coverage Responsibility	
MA FFS Coverage Responsibility	

RULE: F-1f.	
Condition	**A member is admitted to a Veteran's Home (MA provider type/specialty 03/042).**
PH-MCO Coverage Responsibility	The PH-MCO is not responsible for Members who are admitted to a Veteran's Home. A Member who is admitted to a Veteran's Home is disenrolled from the PH-MCO the day before the admission date.
MA FFS Coverage Responsibility	FFS coverage is effective on the admission date.

RULE: F-1g.	
Condition	**A member is placed into Hospice care while in a Nursing Facility.**
PH-MCO Coverage Responsibility	If Hospice care begins during the Nursing Facility placement, the member would remain the responsibility of the PH-MCO.
MA FFS Coverage Responsibility	FFS is not responsible for coverage.

RULE: F-2a.	
Condition	**A Member is enrolled in the CHC Waiver.**
PH-MCO Coverage Responsibility	If CIS provides a CHC start date, and if the PH-MCO's responsibility to provide benefits absent this information continues up to the date prior to the CHC start date or an earlier date in the month of the CHC start date, or a later date, the last day of the PH-MCO's responsibility to provide benefits is the date prior to the CHC start date.
MA FFS Coverage Responsibility	FFS is not responsible for coverage.

RULE: F-3.	
Condition	**A Member is admitted to a State Facility (MA Provider Type/Specialty Codes 01/23 - Public Psychiatric Hospital and 03/37 - State LTC Unit located at State Mental Hospitals).**
PH-MCO Coverage Responsibility	The PH-MCO is not responsible for Members in a state facility. A Member admitted to a state facility is disenrolled from the PH-MCO the day before the admission date.
MA FFS Coverage Responsibility	FFS coverage is effective on the admission date.

RULE: F-4.	
Condition	**A Member is incarcerated in a Penal Facility, Correctional Institution (including work release), or Youth Development Center.**

PH-MCO Coverage Responsibility	The PH-MCO is not responsible for coverage since the Member is no longer eligible for MA upon placement in a correctional facility. The Member is disenrolled from the PH-MCO effective the day before incarceration in the facility or institution.
MA FFS Coverage Responsibility	FFS is not responsible for coverage since the Member is no longer eligible for MA upon placement in a correctional facility, except for inpatient hospital services.
NOTE:	This rule is based upon section 392.2 of the MA Eligibility Handbook which states, "For purposes of MA eligibility, other than eligibility for inpatient hospital services, the needs of an inmate in a correctional institution are the responsibility of the governmental authority exercising administrative control over the facility."

RULE: F-5.	
Condition	**A Member is placed in a Juvenile Detention Center (JDC).**
PH-MCO Coverage Responsibility	During the first thirty-five (35) days of a Member's placement in a JDC, the PH-MCO is responsible for all covered services that are provided to the Member *outside* of the JDC site. A Member who is placed in a JDC is disenrolled from the PH-MCO after thirty-five (35) days.
MA FFS Coverage Responsibility	Services provided to the Member *on-site* at the JDC during the first thirty-five (35) days will be covered under the MA FFS Program. FFS coverage is effective on the 36th day.

RULE: F-6.	
Condition	**A Member becomes eligible for the Health Insurance Premium Payment Program (HIPP).**
PH-MCO Coverage Responsibility	A Member determined to be HIPP eligible (Employer Group Health Plan) is disenrolled from the PH-MCO. Additionally, HIPP eligible MA Members are prevented from enrolling in PH-MCOs.
MA FFS Coverage Responsibility	FFS benefits with HIPP insurance coverage begin the day after the disenrollment date.

RULE: F-7.	
Condition	**A Member is enrolled in the Living Independence for the Elderly Program (LIFE) (MA Provider Type/Specialty Code 07/70 – LIFE)** **LIFE is Pennsylvania's managed care demonstration for Nursing Facility eligibles. It provides for long term care needs of frail elderly Recipients who wish to remain independent in their community but require intensive, integrated primary and psychosocial care to do so.**
PH-MCO Coverage Responsibility	A Member enrolled in LIFE is disenrolled from the PH-MCO effective the day before the begin date of LIFE.
MA FFS Coverage Responsibility	LIFE Coverage begins the day after the disenrollment date.

G. Other Facility Placement Coverage - Refer to the following sections for rules concerning PH-MCO coverage of Recipients placed in other facilities.

RULE: G-1.	
Condition	**A Member is admitted to a state ICF-ID (MA Provider Type/Specialty Code 03/38 – State Intellectual Disability Center).**
PH-MCO Coverage Responsibility	A Member admitted to a state ICF-ID is disenrolled from the PH-MCO the day before the admission date.
MA FFS Coverage Responsibility	FFS coverage is effective on the admission date.

RULE: G-2.

Condition	**A Member is admitted to a private ICF-ID/ICF-ORC (MA Provider Type/Specialty Code 03/32 – ICF/ID 8 Beds or Less, 03/33 – ICF/ID 9 Beds or More, and 03/39 – ICF/ORC).**
PH-MCO Coverage Responsibility	A Member admitted to a private ICF-ID or an ICF-ORC facility will continue to be covered by their selected PH-MCO for all covered physical health services with the exception of those services that the ICF-ID or ICF-ORC has historically and customarily provided to residents of the facility or those services that are covered under the facilities per diem payment. The residential/treatment costs that are the responsibility of the ICF-ID or ICF-ORC under its agreement with DHS are not the responsibility of the BH-MCO. All other Behavioral Health Services are the responsibility of the BH-MCO.
MA FFS Coverage Responsibility	FFS is responsible for the residential/treatment costs. DHS will make direct payments to the ICF-ID or ICF-ORC facility to cover room, board, ID-specific non-MA services, and physical and behavioral health services to the extent these services have been customarily and historically provided to residents of the facility.

RULE: G-3.	
Condition	**A. A Member is admitted to a JCAHO approved Residential Treatment Facility (RTF) (MA Provider Type/Specialty Code 01/13 – Residential Treatment Facility (JCAHO Certified) Hospital).** **B. A Member is admitted to a non-JCAHO approved Residential Treatment Facility (RTF)** (MA Provider Type/Specialty Code 56/560 – Residential Treatment Facility (Non-JCAHO Certified)**.**
PH-MCO Coverage Responsibility	**A.** With the exception of Children in Substitute Care who are placed in residential facilities by another government agency that has responsibility for these children, a Member placed in a JCAHO approved RTF (MA Provider Type/Specialty Code 01/13 – Residential Treatment Facility (JCAHO Certified) Hospital) remains covered by their selected PH-MCO for all covered physical health services. The BH-MCO is responsible for the residential/treatment costs. **B.** A Member placed in a non-JCAHO approved RTF (MA Provider Type/Specialty Code 56/560 – Residential Treatment Facility (Non-JCAHO Certified) remains covered by their selected PH-MCO for all covered physical health services. The BH-MCO is responsible for the MA per diem. The Room & Board per diem can be the responsibility of the BH-MCO, Children and Youth or another agency depending on medical necessity and who places the Recipient.
MA FFS Coverage Responsibility	**A.** FFS is responsible for the residential/treatment costs. **B.** FFS is responsible for the facility's per diem payment.

RULE: G-4.	
Condition	**A Member is admitted to an Extended Acute Psychiatric Care Hospital (MA Provider Type/Specialty Code 01/18 – Extended Acute Psych Inpatient Unit).**
PH-MCO Coverage Responsibility	A Member admitted to an extended acute psychiatric hospital remains covered by the selected PH-MCO for all covered physical health services. If the Recipient is placed in the facility by the BH-MCO, then the BH-MCO is responsible for the residential/treatment costs.
MA FFS Coverage Responsibility	FFS is responsible for the residential/treatment costs.

RULE: G-5.	
Condition	**A Member is admitted to an Inpatient Private Psychiatric Facility (MA Provider Type/Specialty Code 01/11 – Private Psychiatric Hospital and 01/22 – Private Psychiatric Unit).**

PH-MCO Coverage Responsibility	A Member admitted to a private psychiatric hospital remains covered by the selected PH-MCO for all covered physical health services. The BH-MCO is responsible for the residential/treatment costs.
MA FFS Coverage Responsibility	FFS is responsible for the residential/treatment costs.

EXHIBIT FF

PCP, DENTISTS, SPECIALISTS AND PROVIDERS OF ANCILLARY SERVICES DIRECTORIES

A. PCP and Dentist Directories

The PH-MCO shall be required to provide its Members with PCP and Dentist directories upon request, which include, at a minimum, the following information:

- The names, addresses, and telephone numbers of participating PCPs.
- The hospital affiliations of the PCP.
- Identification of whether the PCP is a Doctor of Medicine or Osteopathy, and whether the PCP is a Pediatrician.
- Identification of whether PCPs are Board-certified and, if so, in what area(s).
- Identification of PCP Teams which include physicians, Certified Registered Nurse Practitioners (CRNPs), Certified Nurse Midwives and physicians' assistants.
- Indication of whether dentist is DDS or DMD, and whether dentist is a periodontist.
- Identification of whether dentists possess anesthesia certificates.
- Identification of whether the dentist is able to serve adults with developmental disabilities.
- Identification of languages spoken by Health Care Providers at the primary care and dental sites.
- Identification of sites which are wheelchair accessible.
- Identification of the days of operation and the hours when the PCP or dentist office is available to Members.

The PH-MCO, at the request of the PCP or dentist, may include the PCP's or dentist's experience or expertise in serving individuals with particular conditions.

B. Specialist and Providers of Ancillary Services Directories

The specialist and providers of ancillary services directories shall include, at a minimum, the following information:

- The names, addresses and telephone numbers of specialists and their hospital affiliations.
- Identification of the specialty area of each specialist's practice.
- Identification of whether the specialist is Board-certified and, if so, in what area(s).
- Experience or expertise in serving individuals with particular conditions.

EXHIBIT GG

COMPLAINT, GRIEVANCE, AND FAIR HEARING PROCESSES

A. General Requirements

1. The PH-MCO must obtain the Department's prior written approval of its Complaint, Grievance, and Fair Hearing policies and procedures.

2. The PH-MCO must have written policies and procedures for registering, responding to, and resolving Complaints and Grievances as they relate to the MA population and must make these policies and procedures available to Members upon request.

3. The PH-MCO policies and procedures resolving Complaints and Grievances as they relate to the MA population should outline expectations that providers secure and submit all documentation available at the time of request for service or item.

4. The PH-MCO must maintain an accurate written record of each Complaint and Grievance and the actions taken by the PH-MCO to resolve each Complaint and Grievance. The record must include at least the following:
    a. The name of the Member on whose behalf the Complaint or Grievance was filed;
    b. The date the Complaint or Grievance was received;
    c. A description of the reason for the Complaint or Grievance;
    d. The date of each review or review meeting;
    e. The date of resolution of the Complaint or Grievance and how the Complaint or Grievance was resolved; and
    f. A copy of any documents or records reviewed.

    The PH-MCO must provide the record of each Complaint and Grievance and the actions taken by the PH-MCO to resolve each Complaint and Grievance to the Department and CMS upon request.

5. The PH-MCO must submit a log of all Complaint and Grievance decisions in a format specified by the Department and must include review of the Complaint and Grievance processes in its QM and UM programs as outlined in Exhibit M(1) Quality Management and Utilization Management Program Requirements.

6. The PH-MCO must have a data system to process, track, and trend all Complaints and Grievances. This system must be updated and maintained to assure accurate accountability.

7. The PH-MCO must designate and train sufficient staff as reported in the Operating Procedures Report (OPS) 11 Provider Education, to be responsible for receiving, processing, and responding to Member Complaints and Grievances in accordance with the requirements specified in this Exhibit. To ensure a seamless transference of information, the PH-MCO will notify and update all changes to correspondence upon receipt of change by email and phone call.

8. PH-MCO staff performing Complaint and Grievance reviews must have the necessary orientation, clinical training, and experience to make an informed, accurate and impartial determination regarding issues assigned to them.

9. The PH-MCO must provide information about the Complaint and Grievance process to all Providers and Subcontractors when the PH-MCO enters into a contract or agreement with the Provider or Subcontractor. The PH-MCO is held accountable for the actions and outcomes from their Providers and Subcontractors. Accountability measures must be submitted to these partners in writing annually and will be reviewed and validated upon request by the Complaints, Grievances and Fair Hearings supervisor or designee.

10. The PH-MCO may not use the time frames or procedures of the Complaint or Grievance process to avoid the medical decision process or to discourage or prevent a Member from receiving Medically Necessary care in a timely manner.

11. The PH-MCO must require that anyone who participates in making the decision on a Complaint or Grievance was not involved in and is not a subordinate of an individual who was involved in any previous level of review or decision-making on the issue that is the subject of the Complaint or Grievance.

12. The PH-MCO may not charge Members a fee for filing a Complaint or a Grievance.

13. The PH-MCO must allow the Member and the Member's representative to have access to all relevant documentation, available in alternative formats if requested, pertaining to the subject of the Complaint or Grievance free of charge and sufficiently in advance of the time frame for resolution of the Complaint or Grievance outlined in this Exhibit.

14. The PH-MCO must maintain the following information in the Member's case file:
    a. Medical records;
    b. Any documents or records relied upon or generated by the PH-MCO in connection with the Complaint or Grievance, including any Medical Necessity guidelines used to make a decision or information on coverage limits relied upon to make a decision; and
    c. Any new or additional evidence considered, relied upon, or generated by the PH-MCO in connection with the Complaint or Grievance.

15. The PH-MCO must provide language interpreter services at no cost when requested by a Member.

16. The PH-MCO must accept Complaints and Grievances from individuals with disabilities which are in alternative formats including: TTY/TDD for telephone inquiries and Complaints and Grievances from Members who are deaf or hearing impaired; Braille; tape; computer disk; and other commonly accepted alternative forms of communication. The PH-MCO must make its employees who receive telephone Complaints and Grievances aware of the speech limitations of Members with disabilities or language barriers, so they treat these individuals with patience, understanding, and respect.

17. The PH-MCO must provide Members with disabilities assistance in presenting their case at Complaint or Grievance reviews at no cost to the Member. This includes but is not limited to:
    a. Providing qualified sign language interpreters for Members who are deaf or hearing impaired;
    b. Providing information submitted on behalf of the PH-MCO at the Complaint or Grievance review in an alternative format accessible to the Member or Member's representative, filing the Complaint or Grievance. The alternative format version must be supplied to the Member at or before the review, so the Member can discuss and/or refute the content during the review; and
    c. Providing personal assistance to a Member filing the Complaint or Grievance who has other physical limitations in copying and presenting documents and other evidence.

18. The PH-MCO must offer Members the assistance of a PH-MCO staff member trained and updated in the Complaints and Grievances process throughout the Complaint and Grievance processes at no cost to the Member.

19. The PH-MCO must provide Members with a toll-free number to file a Complaint or Grievance, request information about the Complaint or Grievance process, and ask any questions the Member may have about the status of a Complaint or Grievance.

20. The PH-MCO must, at a minimum, hold in-person reviews of Complaints and Grievances at one location within each of its zones of operation. If a Member requests an in-person review, the PH-MCO must notify the Member of the location of the review and who will be present at the review, using the template specified by the Department.

21. The PH-MCO must ensure that any location where it will hold in-person reviews is physically accessible for persons with disabilities.

22. The PH-MCO must notify the Member when the PH-MCO fails to decide a first level Complaint or a Grievance within the time frames specified in this Exhibit, using the template specified by the Department. The PH-MCO must mail this notice to the Member one (1) day following the date the decision was to be made not to exceed 30 calendar days.

23. The PH-MCO must notify the Member when it denies payment after a service or item has been delivered because the service or item was provided without authorization by a Provider not enrolled in the MA Program, using the template specified by the Department. The PH-MCO must mail this notice to the Member on the day the decision is made to deny payment.

24. The PH-MCO must notify the Member when it denies payment after a service or item has been delivered because the service or item provided is not a covered service for the Member, using the template specified by the Department. he PH-

MCO must mail this notice to the Member on the day the decision is made to deny payment.

25. The PH-MCO must notify the Member when it denies payment after a service or item has been delivered because the PH-MCO determined that the service or item was not Medically Necessary, using the template specified by the Department. The PH-MCO must mail this notice to the Member on the day the decision is made to deny payment.

26. The PH-MCO must notify the Member when it denies the Member's request to dispute a financial liability, including cost sharing, copayments, premiums, deductibles, coinsurance, and other enrollee financial liabilities, using the template specified by the Department. The PH-MCO must mail this notice to the Member on the day the decision is made to deny payment.

27. The PH-MCO must use all templates specified by the Department, which are available in Docushare.

B. Complaint Requirements

Complaint: A dispute or objection regarding:

- a denial because the requested service or item is not a covered service; this does not include BLE.
- the failure of the PH-MCO to provide a service or item in a timely manner, as defined by the Department;
- the failure of the PH-MCO to decide a Complaint within the specified time frames;
- a denial of payment by the PH-MCO after a service or item has been delivered because the service or item was provided without authorization by a Provider not enrolled in the MA Program;
- a denial of payment by the PH-MCO after a service or item has been delivered because the service or item provided is not a covered service for the Member; or
- a denial of a Member's request to dispute a financial liability, including cost sharing, copayments, premiums, deductibles, coinsurance, and other Member financial liabilities.

These types of complaints must be filed within sixty (60) calendar days from the date of the incident complained of or the date the Member receives written notice of a decision.

A Complaint **without** an adverse benefit determination: is an expression of dissatisfaction about any matter other than an adverse benefit determination.

Complaints may include, but are not limited to, the quality of care of services provided, and aspect of interpersonal relationships such as rudeness of a provider or employee, or failure to respect the enrollee's right regardless of whether remedial actions is requested. Complaint includes an enrollee's right to dispute an extension of time proposed by the MCO to make an authorization decision. These types of complaints do not have a filing timeframe.

The term does not include a Grievance.

1. First Level Complaint Process

a. A PH-MCO must permit a Member or Member's representative, which may include the Member's Provider, with proof of the Member's written authorization for the representative to be involved and/or act on the Member's behalf, to file a first level Complaint either in writing or verbally. The PH-MCO must commit oral requests to writing if not confirmed in writing by the Member and should provide the written Complaint to the Member or Member's representative for signature.

- If the requestor is the Member's representative, the signature may be obtained at any point in the process, and failure to obtain a signed consent may not delay the Complaint process.

- If the requestor is the Member's Provider, the written consent must be obtained prior to the onset of this process. If written consent from the member or Member's representative has not been obtained by the Provider, the Provider should proceed using the Provider Appeal Process.

b. If the first level Complaint disputes one of the following, the Member must file a Complaint within sixty (60) calendar days from the date of the incident complained of or the date the Member receives written notice of a decision:

- a denial because the service or item is not a covered service;

- the failure of the PH-MCO to provide a service or item in a timely manner, as defined by the Department;

- the failure of the PH-MCO to decide a Complaint within the specified time frames;

- a denial of payment after the service or item has been delivered because the service or item was provided without authorization by a Provider not enrolled in the MA Program;

- a denial of payment after the service or item has been delivered because the service or item provided is not a covered service for the Member; or

- a denial of a Member's request to dispute a financial liability, including cost sharing, copayments, premiums, deductibles, coinsurance, and other Member financial liabilities,

For all other Complaints, there is no time limit for filing a first level Complaint.

c. A Member who files a first level Complaint to dispute a decision to discontinue, reduce, or change a service or item that the Member has been receiving on the basis that the service or item is not a covered service must continue to receive the disputed service or item at the previously authorized level pending resolution of the first level Complaint, if the first level Complaint is made verbally, hand delivered, or post-marked within ten (10) calendar days from the mail date on the written notice of decision.

d. Upon receipt of the Complaint, the PH-MCO must send the Member and Member's representative, if the Member has designated one in writing, a first level Complaint acknowledgment letter, using the template specified by the Department.

e. The first level Complaint review for all complaints must be conducted by a first level Complaint review committee, which must include one or more employees of the PH-MCO who were not involved in and are not the subordinates of an individual involved in any previous level of review or decision-making on the issue that is the subject of the Complaint. For the aforementioned six objections in section B. Complaint Requirements, the first level Complaint review committee must include a licensed physician or dentist in the same or similar specialty that typically manages or consults on the service or item in question. Other appropriate Providers may participate in the review, but the licensed physician must decide the first level Complaint.

f. A committee member who does not personally attend the first level Complaint review meeting may not be part of the decision-making process unless that committee member actively participates in the review by telephone or videoconference and has the opportunity to review all information presented during the review.

g. The PH-MCO must afford the Member or Member's representative, a reasonable opportunity to present evidence and testimony and make legal and factual arguments, in person as well as in writing.

h. The PH-MCO must give the Member at least ten (10) calendar days advance written notice of the first level Complaint review date, using the template specified by the Department. The PH-MCO must be flexible when scheduling the review to facilitate the Member's attendance. If the Member cannot appear in person at the review, the PH-MCO must provide an opportunity for the Member to communicate with the first level Complaint review committee by telephone or videoconference.

i. The Member may elect not to attend the first level Complaint review meeting, but the meeting must be conducted with the same protocols as if the Member was present.

j. If a Member requests an in-person first level Complaint review, at a minimum, a member of the first level Complaint review committee must be physically present at the location where the first level Complaint review is held and the other members of the first level Complaint review committee must participate in the review through the use of videoconferencing.

k. The decision of the first level Complaint review committee must take into account all comments, documents, records, and other information submitted by the Member or the Member's representative without regard to whether such information was submitted or considered in the initial determination of the issue.

l. The testimony taken by the Complaint review committee (including the Member's comments) must be tape-recorded, transcribed verbatim and maintained as part of the Complaint record.

m. The first level Complaint review committee must complete its review of the Complaint as expeditiously as the Member's health condition requires.

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

o. The PH-MCO must send a written notice of the first level Complaint decision, using the template specified by the Department, to the Member, Member's representative, if the Member has designated one in writing, service Provider and prescribing Provider, if applicable, within thirty (30) calendar days from the date the PH-MCO received the Complaint unless the time frame for deciding the Complaint has been extended by up to fourteen (14) calendar days at the request of the Member.

p. If the Complaint disputes one of the following, the Member may file a request for a Fair Hearing, a request for an external review, or both a request for a Fair Hearing and a request for an external review:

- a denial because the service or item is not a covered service;
- the failure of the PH-MCO to provide a service or item in a timely manner, as defined by the Department;
- the failure of the PH-MCO to decide the Complaint or Grievance within the specified time frames;

- a denial of payment by the PH-MCO after the service or item has been delivered because the service or item was provided by a Provider not enrolled in the MA Program;

- a denial of payment by the PH-MCO after the service or item has been delivered because the service or item provided is not a covered service for the Member; or

- a denial of a Member's request to dispute a financial liability, including cost sharing, copayments, premiums, deductibles, coinsurance, and other Member financial liabilities.

The Member or Member's representative may file a request for a Fair Hearing within one hundred and twenty (120) calendar days from the mail date on the written notice of the PH-MCO's first level Complaint decision.

The Member or Member's representative, which may include the Member's Provider, with proof of the Member's written authorization for the representative to be involved and/or act on the Member's behalf, may file a request for an external review in writing with either DOH or PID within fifteen (15) calendar days from the date the Member receives written notice of the PH-MCO's first level Complaint decision.

For all other Complaints, the Member or Member's representative, which may include the Member's Provider, with proof of the Member's written authorization for the representative to be involved and/or act on the Member's behalf, may file a second level Complaint either in writing or verbally within forty-five (45) calendar days from the date the Member receives written notice of the PH-MCO's first level Complaint decision.

2. Second Level Complaint Process

a. A PH-MCO must permit a Member or Member's representative, which may include the Member's Provider, with proof of the Member's written authorization for the representative to be involved and/or act on the Member's behalf, to file a second level Complaint either in writing or verbally for any Complaint unless it is one of the following as they are eligible for a Fair Hearing and/or an external review with the Department of Health.

- a denial because the service or item is not a covered service;

- the failure of the PH-MCO to provide a service or item in a timely manner, as defined by the Department;

- the failure of the PH-MCO to decide the Complaint within the specified time frames;

- a denial of payment by the PH-MCO after the service or item has been delivered because the service or item was provided by a Provider not enrolled in the MA Program;

- a denial of payment by the PH-MCO after the service or item has been delivered because the service or item provided is not a covered service for the Member; or

- a denial of a Member's request to dispute a financial liability, including cost sharing, copayments, premiums, deductibles, coinsurance, and other Member financial liabilities.

b. Upon receipt of the second level Complaint, the PH-MCO must send the Member and Member's representative, if the Member has designated one in writing, a second level Complaint acknowledgment letter, using the template specified by the Department.

c. The second level Complaint review for all other complaints not eligible for a Fair Hearing must be conducted by a second level Complaint review committee made up of three (3) or more individuals who were not involved in and are not the subordinates of an individual involved in any previous level of review or decision-making on the issue that is the subject of the Complaint. For the aforementioned six objections listed in section B. Complaint Requirements, the second level Complaint review committee must include a licensed physician or dentist in the same or similar specialty that typically manages or consults on the service or item in question. Other appropriate Providers may participate in the review, but the licensed physician must decide the second level Complaint.

d. At least one-third of the second level Complaint review committee members may not be employees of the PH-MCO or a related subsidiary or Affiliate.

e. A committee member who does not personally attend the second level Complaint review meeting may not be part of the decision-making process unless that committee member actively participates in the review by telephone or videoconference and has the opportunity to review all information presented during the review.

f. The PH-MCO must afford the Member a reasonable opportunity to present evidence and testimony and make legal and factual arguments, in person as well as in writing.

g. The PH-MCO must give the Member at least fifteen (15) calendar days advance written notice of the second level Complaint review date, using the template specified by the Department. The PH-MCO must be flexible when scheduling the review to facilitate the Member's attendance. If the Member cannot appear in person at the review, the PH-MCO must provide an opportunity for the Member to communicate with the second level Complaint review committee by telephone or videoconference.

h. The Member may elect not to attend the second level Complaint review meeting, but the meeting must be conducted with the same protocols as if the Member was present.

i. If a Member requests an in-person second level Complaint review, at a minimum, a member of the second level Complaint review committee must be physically present at the location where the second level Complaint review is held and the other members of the second level Complaint review committee must participate in the review through the use of videoconferencing.

j. The decision of the second level Complaint review committee must take into account all comments, documents, records, and other information submitted by the Member or the Member's representative without regard to whether such information was submitted or considered previously. The decision of the second level Complaint review committee must be based solely on the information presented at the review.

k. The testimony taken by the second level Complaint review committee (including the Member's comments) must be tape-recorded, transcribed verbatim and maintained as part of the Complaint record. The Complaint review committee must prepare a verbatim written transcription of the issues presented and decisions made, which must be maintained as part of the Complaint record

l. The second level Complaint review committee must complete its review of the second level Complaint as expeditiously as the Member's health condition requires.

m. The PH-MCO must send a written notice of the second level Complaint decision, using the template specified by the Department, to the Member, Member's representative, if the Member has designated one in writing, service Provider, and prescribing Provider, if applicable, within forty-five (45) calendar days from the date the PH-MCO received the second level Complaint.

n. The Member or the Member's representative, which may include the Member's Provider, with proof of the Member's written authorization of the representative to be involved and/or act of the Member's behalf, may file in writing a request for an external review of the second level Complaint decision with either DOH or PID within fifteen (15) calendar days from the date the Member receives the written notice of the PH-MCO's second level Complaint decision.

3. External Complaint Process

a. If a Member files a request directly with PID or DOH for an external review of a Complaint decision that disputes a decision to discontinue, reduce, or

change a service or item that the Member has been receiving on the basis that the service or item is not a covered service, the Member must continue to receive the disputed service or item at the previously authorized level pending resolution of the external review, if the request for external review is hand-delivered or post-marked within ten (10) calendar days from the mail date on the written notice of the PH-MCO's first or second level Complaint decision.

b. Upon the request of either DOH or PID, the PH-MCO must transmit all records from the PH-MCO's Complaint review to the requesting department within thirty (30) calendar days from the request in the manner prescribed by that department. The Member, the Provider, or the PH-MCO may submit additional materials related to the Complaint.

c. DOH and PID will determine the appropriate agency for the review.

4. Expedited Complaint Process

a. The PH-MCO must conduct expedited review of a Complaint if the PH-MCO determines that the Member's life, physical or mental health, or ability to attain, maintain, or regain maximum function would be placed in jeopardy by following the regular Complaint process or if a Member or Member's representative, with proof of the Member's written authorization for the representative to be involved and/or act on the Member's behalf, provides the PH-MCO with a certification from the Member's Provider that the Member's life, physical or mental health, or ability to attain, maintain, or regain maximum function would be placed in jeopardy by following the regular Complaint process. The certification is only required if the Managed Care Organization cannot make a determination based on the information provided and must include the Provider's signature.

b. A request for an expedited review of a Complaint may be filed in writing, by fax, verbally, or by email.

c. Upon receipt of an oral or written request for expedited review, the PH-MCO must inform the Member of the right to present evidence and testimony and make legal and factual arguments in person as well as in writing and of the limited time available to do so.

d. If the Provider certification is not included with the request for an expedited review and the PH-MCO cannot determine based on the information provided that the Member's life, physical or mental health, or ability to attain, maintain, or regain maximum function would be placed in jeopardy by following the regular Complaint process, the PH-MCO must inform the Member that the Provider must submit a certification as to the reasons why the expedited review is needed. The PH-MCO must make a reasonable effort to obtain the certification from the Provider. If the Provider certification is not received within seventy-two (72) hours of the Member's request for expedited review, the PH-MCO must decide the Complaint within the

standard time frames as set forth in this Exhibit, unless the time frame for deciding the Complaint has been extended by up to fourteen (14) calendar days at the request of the Member. If the PH-MCO decides that expedited consideration within the initial or extended time frame is not warranted, the PH-MCO must make a reasonable effort to give the Member prompt oral notice that the Complaint is to be decided within the standard time frame and send a written notice within two (2) business days of the decision to deny expedited review, using the template specified by the Department.

e. A Member who files a request for expedited review of a Complaint that disputes a decision to discontinue, reduce, or change a service or item that the Member has been receiving on the basis that the service or item is not a covered service must continue to receive the disputed service or item at the previously authorized level pending resolution of the Complaint, if the request for expedited review is made verbally, hand delivered, faxed, emailed, or post-marked within ten (10) calendar days from the mail date on the written notice of decision.

f. Expedited review of a Complaint must be conducted by a Complaint review committee that includes a licensed physician or dentist in the same or similar specialty that typically manages or consults on the service or item in question. Other appropriate Providers may participate in the review, but the licensed physician must decide the Complaint. The members of the expedited Complaint review committee may not have been involved in and may not be the subordinates of an individual involved in any previous level of review or decision-making on the issue that is the subject of the Complaint.

g. The PH-MCO must prepare a summary of the issues presented and decisions made, which must be maintained as part of the expedited Complaint record.

h. The PH-MCO must issue the decision resulting from the expedited review in person or by phone to the Member, the Member's representative, if the Member has designated one in writing, service Provider and prescribing Provider, if applicable, within either forty-eight (48) hours of receiving the Provider certification or seventy-two (72) hours of receiving the Member's request for an expedited review, whichever is shorter, unless the time frame for deciding the expedited Complaint has been extended by up to fourteen (14) calendar days at the request of the Member.. In addition, the PH-MCO must mail written notice of the decision to the Member, the Member's representative, if the Member has designated one in writing, the service Provider, and prescribing Provider, if applicable, within two (2) business days of the decision, using the template specified by the Department.

i. The Member or the Member's representative may file a request for a Fair Hearing within one hundred and twenty (120) calendar days from the mail date on the written notice of the PH-MCO's expedited Complaint decision.

j. The Member, or the Member's representative, which may include the Member's Provider, with proof of the Member's written authorization for the representative to be involved and/or act on the Member's behalf, may file a request for an expedited external Complaint review with the PH-MCO within two (2) business days from the date the Member receives the PH-MCO's expedited Complaint decision. A Member who files a request for an expedited Complaint review that disputes a decision to discontinue, reduce, or change a service or item that the Member has been receiving must continue to receive the disputed service or item at the previously authorized level pending resolution of the request for expedited Complaint review.

k. A request for an expedited external Complaint review may be filed in writing, by fax, verbally, or by email.

l. The PH-MCO must follow DOH guidelines relating to submission of requests for expedited external Complaint reviews.

m. The PH-MCO may not take punitive action against a Provider who requests expedited resolution of a Complaint or supports a Member's request for expedited review of a Complaint.

C. Grievance Requirements

- **Grievance:** A request to have a PH-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 PH-MCO's decision to 1) deny, in whole or in part, payment for a service or item; 2) deny or issue a limited authorization of a requested service or item, including a determination based on the type or level of service or item; 3) reduce, suspend, or terminate a previously authorized service or item; 4) deny the requested service or item but approve an alternative service or item 5) deny a request for a BLE and 6) decide a Grievance within the specified time frames.

The term does not include a Complaint.

1. Grievance Process

a. A PH-MCO must permit a Member or Member's representative, which may include the Member's Provider, with proof of the Member's written authorization for the representative to be involved and/or act on the Member's behalf, to file a Grievance either in writing or verbally. The PH-MCO must commit oral requests to writing if not confirmed in writing by the Member and should provide the written Grievance to the Member or the Member's representative for signature.

- If the requestor is the Member representative, the signature may be obtained at any point in the process, and the failure to obtain a signed consent may not delay the Grievance process.

- If the requestor is the Member's Provider, the written consent must be obtained prior to the onset of this process. If written consent from the member or Member's representative has not been obtained by the Provider, the Provider should proceed using the Provider Appeal Process

b. A Member must file a Grievance within sixty (60) calendar days from the date the Member receives written notice of decision.

c. A Member who files a Grievance that disputes a decision to discontinue, reduce, or change a service or item that the Member has been receiving must continue to receive the disputed service or item at the previously authorized level pending resolution of the Grievance, if the Grievance is made verbally, hand delivered, or post-marked within ten (10) calendar days from the mail date on the written notice of decision.

d. Upon receipt of the Grievance, the PH-MCO must send the Member and Member's representative, if the Member has designated one in writing, a Grievance acknowledgment letter, using the template specified by the Department.

e. A Member who consents to the filing of a Grievance by a Provider may not file a separate Grievance. The Member may rescind consent throughout the process upon written notice to the PH-MCO and the Provider.

f. In order for the Provider to represent the Member in the conduct of a Grievance, the Provider must obtain the written consent of the Member and submit the written consent with the Grievance. A Provider may obtain the Member's written permission at the time of treatment. The PH-MCO must assure that a Provider does NOT require a Member to sign a document authorizing the Provider to file a Grievance as a condition of treatment. The written consent must include:

    - The name and address of the Member, the Member's date of birth and identification number;

    - If the Member is a minor, or is legally incompetent, the name, address, and relationship to the Member of the person who signed the consent;

    - The name, address, and PH-MCO identification number of the Provider to whom the Member is providing consent;

    - The name and address of the PH-MCO to which the Grievance will be submitted;

- An explanation of the specific service or item which was provided or denied to the Member to which the consent will apply;

- The following statement: “The Member or the Member’s representative may not submit a Grievance concerning the service or item listed in this consent form unless the Member or the Member’s representative rescinds consent in writing. The Member or the Member’s representative has the right to rescind consent at any time during the Grievance process.”;

- The following statement: “The consent of the Member or the Member’s representative shall be automatically rescinded if the Provider fails to file a Grievance or fails to continue to prosecute the Grievance through the review process.”;

- The following statement: “The Member or the Member’s representative, if the Member is a minor or is legally incompetent, has read, or has been read, this consent form, and has had it explained to his/her satisfaction. The Member or the Member’s representative understands the information in the Member’s consent form.”; and

- The dated signature of the Member, or the Member’s representative, and the dated signature of a witness.

g. The Grievance review must be conducted by a Grievance review committee made up of three (3) or more individuals who were not involved in and are not the subordinates of an individual involved in any previous level of review or decision-making on the issue that is the subject of the Grievance.

h. At least one-third of the Grievance review committee may not be employees of the PH-MCO or a related subsidiary or Affiliate.

i. The Grievance review committee must include a licensed physician or dentist in the same or similar specialty that typically manages or consults on the service or item in question. Other appropriate Providers may participate in the review, but the licensed physician must decide the Grievance.

j. A committee member who does not personally attend the Grievance review may not be part of the decision-making process unless that committee member actively participates in the review by telephone or videoconference and has the opportunity to review all information introduced during the review.

k. The PH-MCO must afford the Member or Member’s representative a reasonable opportunity to present evidence and testimony and make legal and factual arguments, in person as well as in writing.

l. The PH-MCO must give the Member at least ten (10) calendar days advance written notice of the review date, using the template specified by the Department. The PH-MCO must be flexible when scheduling the review to facilitate the Member's attendance. If the Member cannot appear in person at the review, the PH-MCO must provide an opportunity for the Member to communicate with the Grievance review committee by telephone or videoconference.

m. The Member may elect not to attend the Grievance review meeting, but the meeting must be conducted with the same protocols as if the Member was present.

n. If a Member requests an in-person Grievance review, at a minimum, a member of the Grievance review committee must be physically present at the location where the Grievance review is held and the other members of the Grievance review committee must participate in the review through the use of videoconferencing.

o. The decision of the Grievance review committee must take into account all comments, documents, records, and other information submitted by the Member or the Member's representative without regard to whether such information was submitted or considered in the initial determination of the issue. The decision of the Grievance review committee must be based solely on the information presented at the review.

p. The testimony taken by the Grievance review committee (including the Member's comments) must be tape-recorded, transcribed verbatim and a written transcription prepared and maintained as part of the Grievance record.

q. The Grievance review committee must complete its review of the Grievance as expeditiously as the Member's health condition requires.

r. The PH-MCO must send a written notice of the Grievance decision, using the template specified by the Department, to the Member, Member's representative, if the Member has designated one in writing, service Provider and prescribing Provider, if applicable, within thirty (30) calendar days from the date the PH-MCO received the Grievance, unless the time frame for deciding the Grievance has been extended by up to fourteen (14) calendar days at the request of the Member.

s. The Member may file a request for a Fair Hearing, a request for an external review, or both a request for a Fair Hearing and a request for an external review.

   The Member or Member's representative may file a request for a Fair Hearing within one hundred and twenty (120) calendar days from the mail date on the written notice of the PH-MCO's Grievance decision.

The Member or Member's representative, which may include the Member's Provider, with proof of the Member's written authorization for a representative to be involved and/or act on the Member's behalf, may file a request with the PH-MCO for an external review of a Grievance decision by a certified review entity (CRE) appointed by DOH. The request must be filed in writing or verbally within fifteen (15) calendar days from the date the Member receives the written notice of the PH-MCO's Grievance decision.

2. External Grievance Process:

a. The PH-MCO must process all requests for external Grievance review. The PH-MCO must follow the protocols established by DOH in meeting all time frames and requirements necessary in coordinating the request and notification of the decision to the Member, Member's representative, if the Member has designated one in writing, service Provider, and prescribing Provider.

b. A Member who files a request for an external Grievance review that disputes a decision to discontinue, reduce, or change a service or item that the Member has been receiving must continue to receive the disputed service or item at the previously authorized level pending resolution of the external Grievance review, if the request for external Grievance review is made verbally, hand delivered, or post-marked within ten (10) calendar days from the mail date on the written notice of the PH-MCO's Grievance decision.

c. Within five (5) business days of receipt of the request for an external Grievance review, the PH-MCO must notify the Member, the Member's representative, if the Member has designated one in writing, the Provider if the Provider filed the request for the external Grievance review, and DOH that the request for external Grievance review has been filed.

d. The external Grievance review must be conducted by a CRE not affiliated with the PH-MCO.

e. Within two (2) business days from receipt of the request for an external Grievance review, DOH will randomly assign a CRE to conduct the review and notify the PH-MCO and assigned CRE of the assignment.

f. If DOH fails to select a CRE within two (2) business days from receipt of a request for an external Grievance review, the PH-MCO may designate a CRE to conduct a review from the list of CREs approved by DOH. The PH-MCO may not select a CRE that has a current contract or is negotiating a contract with the PH-MCO or its Affiliates or is otherwise affiliated with the PH-MCO or its Affiliates.

g. The PH-MCO must forward all documentation regarding the Grievance decision, including all supporting information, a summary of applicable issues, and the basis and clinical rationale for the Grievance decision, to

the CRE conducting the external Grievance review. The PH-MCO must transmit this information within fifteen (15) calendar days from receipt of the Member's request for an external Grievance review.

h. Within fifteen (15) calendar days from receipt of the request for an external Grievance review by the PH-MCO, the Member or the Member's representative, or the Member's Provider, may supply additional information to the CRE conducting the external Grievance review for consideration. Copies must also be provided at the same time to the PH-MCO so that the PH-MCO has an opportunity to consider the additional information.

i. Within sixty (60) calendar days from the filing of the request for the external Grievance review, the CRE conducting the external Grievance review must issue a written decision to the PH-MCO, the Member, the Member's representative, and the Provider (if the Provider filed the Grievance with the Member's consent) that includes the basis and clinical rationale for the decision. The standard of review must be whether the service or item is Medically Necessary and appropriate under the terms of this Agreement.

j. The external Grievance decision may be appealed by the Member, the Member's representative, or the Provider to a court of competent jurisdiction (Commonwealth Court) within sixty (60) calendar days from the date the Member receives notice of the external Grievance decision.

3. Expedited Grievance Process

a. The PH-MCO must conduct expedited review of a Grievance if the PH-MCO determines that the Member's life, physical or mental health, or ability to attain, maintain, or regain maximum function would be placed in jeopardy by following the regular Grievance process or if a Member or Member representative, with proof of the Member's written authorization for a representative to be involved and/or act on the Member's behalf, provides the PH-MCO with a certification from the Member's Provider that the Member's life, physical or mental health, or ability to attain, maintain, or regain maximum function would be placed in jeopardy by following the regular Grievance process. The certification is only required if the Managed Care Organization cannot make a determination based on the information provided and must include the Provider's signature.

b. A request for expedited review of a Grievance may be filed in writing, by fax, by email, or verbally.

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

d. Upon receipt of an oral or written request for expedited review, the PH-MCO must inform the Member of the right to present evidence and testimony and

make legal and factual arguments in person as well as in writing and of the limited time available to do so.

e. If the Provider certification is not included within the request for an expedited review and the PH-MCO cannot determine based on the information provided that the Member's life, physical or mental health, or ability to attain, maintain, or regain maximum function would be placed in jeopardy by following the regular Grievance process, the PH-MCO must inform the Member that the Provider must submit a certification as to the reasons why the expedited review is needed. The PH-MCO must make a reasonable effort to obtain the certification from the Provider. If the Provider certification is not received within seventy-two (72) hours of the Member's request for expedited review, the PH-MCO must decide the Grievance within the standard time frames as set forth in this Exhibit, unless the time frame for deciding the Grievance has been extended by up to fourteen (14) calendar days at the request of the Member. If the PH-MCO decides that expedited consideration with the initial or extended time frame is not warranted, the PH-MCO must make a reasonable effort to give the Member prompt oral notice that the Grievance is to be decided within the standard time frame and send a written notice within two (2) business days of the decision to deny expedited review, using the template specified by the Department.

f. A Member who files a request for expedited review of a Grievance that disputes a decision to discontinue, reduce, or change a service or item that the Member has been receiving must continue to receive the disputed service or item at the previously authorized level pending resolution of the Grievance, if the request for expedited review of a Grievance is made verbally, hand delivered, or post-marked within ten (10) calendar days from the mail date on the written notice of decision.

g. Expedited review of a Grievance must be conducted by a Grievance review committee made up of three (3) or more individuals who were not involved in and are not the subordinates of an individual involved in any previous level of review or decision-making on the issue that is the subject of the Grievance.

h. At least one-third of the expedited Grievance review committee may not be employees of the PH-MCO or a related subsidiary or Affiliate.

i. The expedited Grievance review committee must include a licensed physician or dentist in the same or similar specialty that typically manages or consults on the service or item in question. Other appropriate Providers may participate in the review, but the licensed physician must decide the Grievance.

j. The PH-MCO must prepare a summary of the issues presented and decisions made, which must be maintained as part of the expedited Grievance record.

k. The PH-MCO must issue the decision resulting from the expedited review in person or by phone to the Member, the Member's representative, if the Member has designated one in writing, service Provider, and prescribing Provider, if applicable, within either forty-eight (48) hours of receiving the Provider certification or seventy-two (72) hours of receiving the Member's request for an expedited review, whichever is shorter, unless the time frame for deciding the expedited Grievance has been extended by up to fourteen (14) calendar days at the request of the Member. In addition, the PH-MCO must mail written notice of the decision to the Member, the Member's representative, if the Member has designated one in writing, service Provider, and prescribing Provider, if applicable, within two (2) business days of the decision, using the template specified by the Department.

l. The Member or the Member's representative may file a request for a Fair Hearing within one hundred and twenty (120) calendar days from the mail date on the written notice of the PH-MCO's expedited Grievance decision.

m. The Member, or Member's representative, which may include the Member's Provider, with proof of the Member's written authorization for the representative to be involved and/or act on the Member's behalf, may file a request for an expedited external Grievance review with the PH-MCO within two (2) business days from the date the Member receives the PH-MCO's expedited Grievance decision. A Member who files a request for an expedited external Grievance review that disputes a decision to discontinue, reduce, or change a service or item that the Member has been receiving must continue to receive the disputed service or item at the previously authorized level pending resolution of the request for expedited Grievance review.

n. A request for an expedited external Grievance review may be filed in writing, by fax, orally, or by email.

o. The PH-MCO must follow DOH guidelines relating to submission of requests for expedited external Grievance reviews.

p. The PH-MCO may not take punitive action against a Provider who requests expedited resolution of a Grievance or supports a Member's request for expedited review of a Grievance.

D. Department's Fair Hearing Requirements

Fair Hearing: A hearing conducted by the Department's Bureau of Hearings and Appeals (BHA) or a Department designee.

1. Fair Hearing Process

a. A Member or Member's representative, with proof of the Member's written authorization for the representative to be involved and/or act on the Member's behalf, must file a Complaint or Grievance with the PH-MCO and

receive a decision on the Complaint or Grievance before filing a request for a Fair Hearing. If the PH-MCO fails to provide written notice of a Complaint or Grievance decision within the time frames specified in this Exhibit, the Member is deemed to have exhausted the Complaint or Grievance process and may request a Fair Hearing.

b. The Member or the Member's representative may request a Fair Hearing in writing, signed by the member or Member's representative, with proof of the Member's written authorization for the representative to be involved and/or act on the Member's behalf, within one hundred and twenty (120) calendar days from the mail date on the written notice of the PH-MCO's first level Complaint decision or Grievance decision for any of the following:

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

   ii. the denial of a requested service or item because the service or item is not a covered service;

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

   iv. the denial of a requested service or item but approval of an alternative service or item;

   v. the failure of the PH-MCO to provide a service or item in a timely manner, as defined by the Department;

   vi. the failure of a PH-MCO to decide a Complaint or Grievance within the specified time frame;

   vii. the denial of payment after a service or item has been delivered because the service or item was provided by a Provider not enrolled in the MA Program;

   viii. the denial of payment after a service or item has been delivered because the service or item is not a covered service for the Member;

   ix. the denial of a Member's request to dispute a financial liability, including cost sharing, copayments, premiums, deductibles, coinsurance, and other Member financial liabilities.

c. The request for a Fair Hearing must include a copy of the written notice of decision that is the subject of the request unless the PH-MCO failed to provide written notice of the Complaint or Grievance decision within the time frames specified in this Exhibit.

d. A Fair Hearing may be requested as follows:
   i. Fax: 1-717-772-6328

ii. Mail: Department of Human Services
OMAP – HealthChoices Program
Complaint, Grievance and Fair Hearings
P.O. Box 2675
Harrisburg, Pennsylvania 17105-2675

e. A Member who files a request for a Fair Hearing that disputes a decision to discontinue, reduce, or change a service or item that the Member has been receiving must continue to receive the disputed service or item at the previously authorized level pending resolution of the Fair Hearing, if the request for a Fair Hearing is hand delivered, faxed, or post-marked within ten (10) calendar days from the mail date on the written notice of decision.

f. Upon receipt of the request for a Fair Hearing, BHA or the Department's designee will schedule a hearing. The Member and the PH-MCO will receive notification of the hearing date by letter at least ten (10) calendar days before the hearing date, or a shorter time if requested by the Member. The letter will outline the type of hearing, the location of the hearing (if applicable), and the date and time of the hearing.

g. The PH-MCO is a party to the hearing and must be present. The PH-MCO, which may be represented by an attorney, must be prepared to explain and defend the issue on appeal. BHA's decision is based solely on the evidence presented at the hearing. The absence of the PH-MCO from the hearing will not be reason to postpone the hearing.

h. The PH-MCO must provide Members, at no cost, with records, reports, and documents relevant to the subject of the Fair Hearing.

i. BHA will issue an adjudication within ninety (90) calendar days of the date the Member filed the first level Complaint or the Grievance with the PH-MCO, not including the number of days before the Member requested the Fair Hearing. If BHA fails to issue an adjudication within ninety (90) calendar days of receipt of the initial request of the first level complaint or grievance, less the time it took the member to request a Fair Hearing, the PH-MCO must comply with the requirements at 55 Pa. Code § 275.4 regarding the provision of interim assistance upon the request for such by the Member. When the Member is responsible for delaying the hearing process, it will be extended by the length of the delay attributed to the Member.

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

2. Expedited Fair Hearing Process

a. A Member or the Member's representative may file a request for an expedited Fair Hearing with the Department either in writing or orally.

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

c. BHA will conduct an expedited Fair Hearing if a Member or a Member's representative provides the Department with a signed written certification from the Member's Provider that the Member's life, physical or mental health, or ability to attain, maintain, or regain maximum function would be placed in jeopardy by following the regular Fair Hearing process or if the Provider provides testimony at the Fair Hearing which explains why using the usual time frames would place the Member's life, physical or mental health, or ability to attain, maintain, or regain maximum function in jeopardy.

d. A Member who files a request for an expedited Fair Hearing that disputes a decision to discontinue, reduce, or change a service or item that the Member has been receiving must continue to receive the disputed service or item at the previously authorized level pending resolution of the Fair Hearing, if the request for an expedited Fair Hearing is made orally, hand delivered, or post-marked within ten (10) calendar days from the mail date on the written notice of decision.

e. Upon the receipt of the request for an expedited Fair Hearing, BHA or the Department's designee will schedule a hearing.

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

g. The PH-MCO must provide the Member, at no cost, with records, reports, and documents relevant to the subject of the Fair Hearing.

h. BHA will issue an adjudication within three (3) business days from receipt of the Member's oral or written request for an expedited review.

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

E. Provision of and Payment for Service or Item Following Decision

1. If the PH-MCO, BHA, or the Secretary reverses a decision to deny, limit, or delay a service or item that was not furnished during the Complaint, Grievance, or Fair Hearing process, the PH-MCO must authorize or provide the disputed service or item as expeditiously as the Member's health condition requires but no later than seventy-two (72) hours from the date it receives notice that the decision was reversed. If the PH-MCO requests reconsideration, the PH-MCO must authorize or provide the disputed service or item pending reconsideration unless the PH-MCO requests a stay of the BHA decision and the stay is granted.

2. If the PH-MCO, BHA, or the Secretary reverses a decision to deny authorization of a service or item, and the Member received the disputed service or item during the Complaint, Grievance, or Fair Hearing process, the PH-MCO must pay for the service or item that the Member received.

EXHIBIT II

REQUIRED CONTRACT TERMS FOR ADMINISTRATIVE SUBCONTRACTORS

All subcontracts must be in writing and must include, at a minimum, the following provisions:

- The specific activities and report responsibilities delegated to the subcontractor;
- A provision for revoking delegation or imposing other sanctions if the subcontractor's performance is inadequate;
- All subcontractors shall comply with all applicable requirements of the Agreement between the PH-MCO and the Department concerning the HealthChoices Program;
- Meet the applicable requirements of 42 C.F.R. Subsection 434.6;
- Include nondiscrimination provisions;
- Include the provisions of the Americans with Disabilities Act (42 U.S.C. Section 12101 et seq);
- Contain a provision in all subcontracts with any individual firm, corporation or any other entity which provides medical services and receives reimbursement from the PH-MCO either directly or indirectly through capitation, that data for all services provided will be reported timely to the PH-MCO. Penalties and sanctions will be imposed for failure to comply. The data is to be included in the utilization and encounter data provided to the Department in the format required;
- Contain a provision in all subcontracts with any individual, firm, corporation or any other entity which provides medical services to HealthChoices members, that the subcontractor will report all new third party resources to the PH-MCO identified through the provision of medical services, which previously did not appear on the Department's recipient information files provided to the PH-MCO;
- Contain a hold harmless clause that stipulates that the PH-MCO subcontractor agrees to hold harmless the Commonwealth, all Commonwealth officers and employees and all PH-MCO members in the event of nonpayment by the PH-MCO to the subcontractor. The subcontractor shall further indemnify and hold harmless the Commonwealth and their agents, officers and employees against all injuries, death, losses, damages, claims, suits, liabilities, judgments, costs and expenses which may in any manner accrue against the Commonwealth or their agents, officers or employees, through the intentional conduct, negligence or omission of the subcontractor, its agents, officers, employees or the PH-MCO;
- Contain a provision in all subcontracts that the subcontractor agrees to comply with all applicable Medicaid, federal and state laws and regulations; including sub-regulatory guidance;

- Contain provisions in all subcontracts with any individual firm, corporation or any other entity which provides medical services to HealthChoices members, that prohibits gag clauses which limit the subcontractor from disclosure of medical necessary or appropriate health care information or alternate therapies to members, other health care professionals or the Department;

- Contain provisions in all employee contracts prohibiting gag clauses which limit said employees from the disclosure of information pertaining to the HealthChoices Program; and

- Contain provisions in all subcontracts with any individual, firm, corporation or any other entity which provides medical services to HealthChoices members, that limits incentives to those permissible under the applicable Federal regulation.

The PH-MCO shall require as a written provision in all subcontracts that the Department has ready access to any and all documents and records of transactions pertaining to the provision of services to Medical Assistance consumers.

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

The PH-MCO and its subcontractor(s) and the subcontractor's contractor(s) shall, at their own expense, make all books, records, contracts, computers, or other electronic systems available for audit, review, evaluation or inspection by the Commonwealth, its designated representatives, CMS, the HHS Inspector General, the Comptroller General or their designees. Access must be granted either on-site, electronically or through the mail at the discretion of the reviewing entity. The right to audit exists for ten (10) years from the final date of the contract period; or from the date of completion of any audit, whichever is longer. The PH-MCO must fully cooperate with any and all reviews and/or audits by state or federal agencies or their agents, such as the Independent Assessment Contractor, by assuring that appropriate employees and involved parties are available for interviews relating to reviews or audits. All records to be sent by mail shall be sent to the requesting entity in the form of accurate, legible paper copies, unless otherwise indicated, within fifteen (15) calendar days of such request and at no expense to the requesting entity. Such requests made by the Commonwealth shall not be unreasonable.

If the Commonwealth, CMS, or the HHS Inspector General or their designees determine that there is a reasonable possibility of fraud or similar risk, the Commonwealth, CMS, or the HHS Inspector General may inspect, evaluate, and audit the subcontractor at any time.

The PH-MCO and its subcontractor(s) shall maintain books, records, documents and other evidence pertaining to all revenues, expenditures and other financial activity pursuant to this contract as well as to all required programmatic activity and data pursuant to this

contract. Records other than medical records may be kept in an original paper state or preserved on micro media or electronic format. Medical records shall be maintained in a format acceptable by the Department. These books, records, documents and other evidence shall be available for review, audit or evaluation by authorized Commonwealth personnel or their representatives during the contract period and ten (10) years thereafter, except if an audit is in progress or audit findings are yet unresolved, in which case, records shall be kept until all tasks are completed.

The PH-MCO and its subcontractor(s) must agree to retain the source records for its data reports for a minimum of ten (10) years and must have written policies and procedures for storing this information.

The PH-MCO shall require, as a written provision in all subcontracts that the subcontractor recognize that payments made to the subcontractor are derived from federal and state funds. Additionally, the PH-MCO shall require, as a written provision in all contracts for services rendered to Recipient, that the subcontractor shall be held civilly and/or criminally liable to both the PH-MCO and the Department, in the event of nonperformance, misrepresentation, fraud, or abuse. The PH-MCO shall notify its PCPs and all subcontractors of the prohibition and sanctions for the submission of false claims and statements.

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

The PH-MCO shall monitor the subcontractor's performance on an on-going basis and subject it to formal review according to a periodic schedule established by the Department, consistent with industry standards or State laws and regulations. If the PH-MCO identifies deficiencies or areas needing improvement, the PH-MCO and the subcontractor must take corrective action.

EXHIBIT KK

REPORTING SUSPECTED FRAUD AND ABUSE TO THE DEPARTMENT

The following requirements are adapted from 55 PA Code §1101, General Provisions for the Medical Assistance Program, specifically 55 PA Code §1101.75(a) and (b), Provider Prohibited Acts, which are directly adapted from the 62 PS §1407, (also referred to as Act 105 of 1980, Fraud and Abuse Control Act) and Federal Regulations 42 C.F.R. §§438.608(a)(7-8) and 455.23(a).The basis for Recipient referrals is 55 PA Code §1101.91 and §1101.92, Recipient Misutilization and Abuse and Recipient Prohibited Acts. For information on these regulations, go to http://www.pacode.com.

Reporting Requirements:

PH-MCOs are required to report to the Department any act by Providers/Recipients/Caregivers/Employees that may affect the integrity of the HealthChoices Program under the Medical Assistance Program. Specifically, if the PH-MCO suspects that either Fraud, Abuse or Waste (as discussed in Section V.O.4, Fraud and Abuse, of the Agreement) may have occurred, the PH-MCO must report the issue to the Department's Bureau of Program Integrity (BPI). In addition to referrals to the Department, the PH-MCO is required to simultaneously submit fraud referrals to the Pennsylvania Office of Attorney General Medicaid Fraud Control Section in accordance with 42 C.F.R. §438.608(a)(7). The referrals shall be submitted \ using the Department's PH-MCO Referral Form. Fraud referrals submitted to the Department using the PH-MCO Referral Form will be automatically sent to the Pennsylvania Office of Attorney General's Medicaid Fraud Control Section. The PH-MCO must have a process to notify BPI of any adverse actions and/or provider disclosures taken during the credentialing/re-credentialing process. Depending on the nature or extent of the problem, it may also be advisable to place the individual Provider on prepayment review or suspend payments to avoid unnecessary expenditures during the review process.

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

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

All Fraud, Abuse, Waste or quality referrals must be made within thirty (30) days of the identification of the problem/issue. The PH-MCO must conduct a preliminary investigation to the level of an indication of indicia of fraud. The PH-MCO may informally consult with other state agencies or law enforcement to reach this determination. The PH-MCO must send to BPI all relevant documentation collected to support the referral. Such

information includes, but is not limited to, the materials listed on the "Checklist of Supporting Documentation for Referrals" located at the end of this exhibit. The Fraud and Abuse Coordinator, or the responsible party completing the referral, should check the appropriate boxes on the "Checklist of Supporting Documentation for Referrals" form to indicate the supporting documentation that is sent with each referral. A copy of the completed checklist and all supporting documentation should accompany each referral. Any egregious situation or act (e.g. those that are causing or imminently threaten to cause harm to a Member or significant financial loss to the Department or its agent) must be referred immediately to the Department's Bureau of Program Integrity for further investigation.

Failure to comply with the requirements of Exhibit KK will result in sanctions and or corrective action as stated in the HealthChoices Agreement. The Department must suspend all Medicaid payments to a provider after a determination that there is a credible allegation of fraud for which an investigation is pending against an individual or entity unless the Department has good cause not to suspend payments or to suspend payments in part. (42 C.F.R. 455.23 (a)). Upon notification from the Department of the imposition of a payment suspension, the PH-MCO, at a minimum, must also suspend payments to the provider.

The following processes are required for Provider/Caregiver and Employee referrals, unless prior approval is received from BPI. Reports must be submitted online using the PH-MCO Referral Form. Fraud allegations will result in an automatic dual referral to the Office of Attorney General and the Department. The instructions and form templates are located at http://www.dhs.pa.gov/hc-extranet/hc/managedcareprogram/fraudandabuse/index.htm

Once completed, the form must be submitted electronically to BPI. The following information must be submitted to BPI electronically using DocuShare:

- Checklist of Supporting Documentation for Referrals, accessible on the PH-MCO Referral Form,
- A copy of the confirmation page which will appear after the “Submit” button is clicked, submitting the PH-MCO Referral Form, and
- All supporting documentation. Referrals will not be processed but will be returned for further development if they are received without all supporting documentation.

If DocuShare is inaccessible for any reason, the PH MCO will notify the BPI contract monitor, then mail the supporting information above to the below address:

Department of Human Services
Bureau of Program Integrity – DPPC/DPR
P.O. Box 2675
Harrisburg, PA 17105-2675

All suspected member fraud, abuse and/or waste should be reported directly to the Bureau of Program Integrity’s Recipient Restriction Section by the PH-MCO’s Recipient Restriction Coordinator using the established restriction referral process.

In the event member fraud is suspected but the criteria for restriction is not met, the PH-

MCO's Restriction Coordinator should forward all supporting documentation, including a narrative description of the alleged fraud, to the Department's Recipient Restriction Section.

All subsequent information should also be sent to the Recipient Restriction Section at:

Department of Human Services
Bureau of Program Integrity
Recipient Restriction Program
P.O. Box 2675
Harrisburg, PA 17105-2675
717-772-4627 (office)
717- 214-1200 (fax)

Checklist of Supporting Documentation for Referrals

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

Example of materials for provider, caregiver or staff person referrals –

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

Example of materials for pharmacy referrals –

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

Example of materials for RTF referrals –

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

Example of materials for behavioral health referrals –

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

Example of materials for DME referrals –

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

EXHIBIT LL

GUIDELINES FOR SANCTIONS REGARDING FRAUD, WASTE AND ABUSE

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

To maintain the integrity of the HealthChoices Program and to ensure that PH-MCOs comply with pertinent provisions and related state and federal policies, including rules and regulations involving Fraud, Waste and Abuse issues, the Department will impose sanctions on the PH-MCOs as deemed appropriate where there is evidence of violations involving Fraud, Waste and Abuse issues in the HealthChoices Program. To that end, program compliance and improvement assessments, including financial assessments payable to BPI, will be applied by BPI for the PH-MCO's identified program integrity compliance deficiencies. Note that the Department also retains discretion to impose additional remedies available under applicable law and regulations.

FRAUD, WASTE AND ABUSE ISSUES WHICH MAY RESULT IN SANCTIONS

The Department may impose sanctions, for non-compliance with Fraud, Waste and Abuse requirements which include, but are not limited to, the following:

A. Failure to implement, develop, monitor, continue and/or maintain the required compliance plan and policies and procedures directly related to the detection, prevention, investigation, referral or sanction of Fraud, Waste and Abuse by providers, caregivers, members or employees.

B. Failure to cooperate with reviews by oversight agencies or their designees, including the Department, Pennsylvania Office of Attorney General Medicaid Fraud Control Unit, Office of Inspector General of the U.S. DHHS, and other state or federal agencies and auditors under contract to CMS or the Department 42 C.F.R. §438.3(h).

C. Failure to adhere to applicable state and federal laws and regulations.

D. Failure to adhere to the terms of the HealthChoices Agreement, and the relevant Exhibits which relate to Fraud, Waste and Abuse issues.

E. If a PH-MCO fails to provide the relevant operating agency, upon its written request, encounter data, claims data and information, payment methodology, policies and/or other data required to document the services and items delivered by or through the PH-MCO to Members 42 C.F.R. §438.604.

F. PH-MCO engaging in actions that indicate a pattern of wrongful denial of payment

for a health-care benefit, service or item that the organization is required to provide under its agreement.

G. If a PH-MCO or associate fails to furnish services or to provide members a health benefit, service or item that the organization is required to provide under its Agreement 42 C.F.R. § 438.700(b)(1).

H. PH-MCO engaging in actions that indicate a pattern of wrongful delay of at least for 45 days or a longer period specified in the Agreement (not to exceed 60 days) in making payment for a health-care benefit, service or item that the organization is required to provide under its Agreement.

I. Discriminating against Members or prospective Members on any basis including without limitation, age, gender, ethnic origin or health status 42 C.F.R. §438.3(d)(3-4)

J. The PH-MCO must conduct a preliminary investigation and may consult with other state agencies or law enforcement to determine credible allegations of fraud for which an investigation is pending under the Medicaid program against an individual, a provider, or other entity (42 C.F.R. §455.23(a)). Allegations are to be considered credible when there is indicia of reliability and the State Medicaid agency has reviewed all allegations, facts and evidence carefully and acts judiciously on a case by case basis (42 C.F.R. §455.2).

K. PH-MCO failure to pay overpayments to DHS as identified through network provider audits, reviews, investigations conducted by BPI or its designee and other state and federal agencies.

RANGE OF SANCTIONS

The Department may impose any of the sanctions indicated in Section VIII.H. of the Agreement including, but not limited to, the following:

A. Preclusion or exclusion of the PH-MCO, its officers, managing employees or other individuals with direct or indirect ownership or control interest in accordance with 42 U.S.C. §1320a-7, 42 C.F.R. Parts 1001 and 1002; 62 P.S. §1407 and 55 Pa. Code §§1101.75 and 1101.77.

These sanctions may, but need not be, progressive. The Department's intends to maintain an effective, reasonable and consistent sanctioning process as deemed necessary to protect the integrity of the HealthChoices Program.

EXHIBIT NN

SPECIAL NEEDS UNIT

A member with Special Needs is based upon a non-categorical or generic definition of Special Needs. This definition will include but not be limited to key attributes of ongoing physical, developmental, emotional or behavioral conditions or life circumstance which may serve as a barrier to the member's access to care or services. Examples of members with Special Needs will include but not be limited to: Children with Special Health Care Needs including those requiring skilled or unskilled home shift care, Children in Substitute Care, those with limited English Proficiency, or special communication needs due to sensory deficits those with Physical and/or Intellectual/ Developmental Disabilities, those with HIV/AIDS, those with significant behavioral challenges, or members requiring transportation assistance. Examples of factors in the determination of a member with Special Need(s) include but are not limited to the following:

- Require care and/or services of a type or amount that is beyond what is typically required;
- Require extensive rehabilitative, habilitative, or other therapeutic interventions to maintain or improve the level of functioning for the individual;
- May require that primary care be managed by a specialist, due to the nature of the condition;
- May incur higher morbidity without intervention and coordination in the care of the individual;
- Require care and/or services that necessitate coordination and communication among Network Providers and/or Out-of-Network Providers including, but not limited to, housing, food, and employment challenges;
- Require care and/or services that necessitate coordination and collaboration with public and private community services organizations outside the PH-MCO;
- Require coordination of care and/or services between the acute inpatient setting and other facilities and Community Providers;
- Result in the Member requiring assistance to schedule or make arrangements for appointments or services, including arranging for transportation to and from appointments;
- Result in the need for language, communication, or mobility accommodations; or
- Result in the need for a Member to be accompanied or assisted while seeking or receiving care by an individual who may act on the Member's behalf.

- Require assistance in discharge planning from an inpatient or long-term care or pediatric residential setting to ensure the member will receive services in the least restrictive environment possible.

- Any condition, event or life circumstance that as a result inhibits a member's access to any necessary service or support needed to address their medical condition or maintain their current level of functioning.

The PH-MCO will be required to develop, train, and maintain a unit within its organizational structure that will be responsible to provide support and case management services to members with Special Needs in a timely manner. This unit will be headed by a Special Needs Coordinator who must have access to and periodically consult with the Medical Director. The PH-MCO Special Needs Unit case manager must function as the single point of contact to coordinate all health care needs including social determinates of health needs for vulnerable populations. The case management staff must follow the Case Management Society of America standards of practice. Individual case management staff that are eligible should be certified case managers or be working toward certification. The staff members will work in close collaboration with the BMCO SNU and the Enrollment Assistance Program Contractor's Special Needs contact person. The Department expects the PH-MCO's Special Needs Unit to be staffed by individuals with either a medical and/or social services background, in sufficient number to initiate a response to a Member's inquiry within two (2) Business Days or sooner in urgent situations. The Department expects the core staff members of the Special Needs Unit to be responsible primarily for the functions and operations associated with the unit, including the primary case management and care coordination for members and families receiving special needs services. The Department also expects that at times the Special Needs Unit staff will have access to the resources of other departments within the PH-MCO to supplement the Special Needs Unit in assisting Members with Special Needs. The PH-MCO must show evidence of their access to and use of individuals with expertise in the treatment of Members with Special Needs to provide consultation to the Special Needs Unit staff, as needed.

The PH-MCO shall use knowledgeable and independent organizations such as consumer groups, disability advocacy groups, Special Needs consumers, and the Department of Health District Offices, when providing training to its Special Needs Unit staff, whenever possible.

The primary purpose of the Special Needs Unit is to ensure that each Member with Special Needs receives access to appropriate primary care, access to specialists trained and skilled in the needs of the Member including behavioral health and substance use disorder services, information about the access to a specialist as PCP if appropriate, information about and access to all covered services appropriate to the Member's condition or circumstance, including pharmaceuticals and DME, and access to needed community services to support housing, food and employment needs. The Special Needs Unit must have a direct link to the Utilization Management functions of the PH-MCO and have input into the case review process. The PH-MCO must have procedures in place that ensure the proactive identification of and outreach to Members with Special Needs who may not self-identify as having a Special Need.

Special Needs Unit Functions and Requirements

The staff of the PH-MCO Special Needs Unit will ensure the receipt of care and/or services by acting as the PH-MCO case manager for each Member with an identified Special Need. The PH-MCO Special Needs Unit case manager must function as the single point of contact to coordinate all health care needs including social determinates of health needs for vulnerable populations. In the event that a Member is not satisfied with PH-MCO performance in any area, the Special Needs Unit case manager will be responsible for facilitating dispute resolution and for informing the Member of the Complaint, Grievance, and DHS Fair Hearing mechanisms that are available and assisting in that process as needed or requested. Members with Special Needs determined to have ongoing needs for assistance will be assigned to a particular Special Needs Unit case manager and will have ready access to their Special Needs Unit case manager as long as they are enrolled in the PH-MCO. Members with Special Needs are permitted to change case managers as needed during their enrollment. The PH-MCO must be able to demonstrate that its staff will perform the following functions:

- Conduct necessary training for all PH-MCO staff to acquaint them with the purpose and function of the Special Needs Unit and the need to coordinate within departments to serve Members with Special Needs.

- Work towards education and training in the use of LifeCourse™ tools.

- Meet face-to-face at least twice a year with the child and family and/or caregivers for the most complex members receiving shift care services. At least one of the face-to-face visits must be at the time of initial or recertification of shift care services. The PH-MCO staff must be appropriate licensed Special Needs Unit case management staff.

- Ensure coordination between the PH-MCO and other health, education, and human services systems including County Children and Youth Services Offices, County Office of Intellectual Disability Services Offices and Juvenile Justice Offices. For a more inclusive list see Exhibit OO.

- Ensure adherence to state and federal laws, regulations, Departmental agreements and court requirements relating to individuals with Special Needs.

- A contact within the Special Needs Unit must be designated to act as a liaison with the BMCO SNU staff and the Enrollment Assistance Program contractor's Special Needs contact person. The PH-MCO must develop an appropriate automated process to operationalize the information on Special Needs individuals supplied by the Enrollment Assistance Program contractor.

- Sufficient telephone and alternative communication channels must be established to allow ready and timely interactions between the PH-MCO Special Needs Unit Coordinator, case managers, the Office of Medical Assistance Programs, the Enrollment Assistance Program contractor, Members with Special Needs, Providers

(Network and Out-of-Network) and other health, education, and human services systems servicing Members with Special Needs and involved agencies.

- The PH-MCO Special Needs Unit must have a resource account email box in place for receipt of transition of care documentation to ensure timely access to all medically necessary services. The Special Needs Unit Coordinator and multiple staff must have access to this resource account.

- Appropriate arrangements must be made to effectively assist Members with Special Needs who speak languages other than English in accordance with the RFP and Agreement requirements. In addition, efforts must be made to match Members with communication barriers due to disability or linguistic background with Providers with whom they can effectively communicate.

- Serve on interagency teams upon request by a Member or their family to facilitate and coordinate delivery of Physical Health Services contained in treatment plans for children and/or adults including, but not limited to, Individual Family Service Plans, Individual Educational Plans, Individual Habilitation Plans, and Individual Behavioral Health Treatment Plans.

- Special Needs Unit case managers must have a working knowledge of Children and Adolescent Support Services Program (CASSP) and the Community Support Program (CSP) principles and principles of drug and alcohol treatment.

- Ensure cooperation of the PH-MCO's Provider Network. Special Needs Unit case managers must facilitate communication and coordinate service delivery between primary care, specialty, ancillary, substance use disorder and behavioral health Providers to ensure Member's timely and uninterrupted access to care.

- Assist in the development of adequate Provider Networks, such as pediatric specialists, to serve Special Needs populations. Special Needs Unit case managers must assist and support Members with Special Needs in making an informed choice between Providers of equivalent services within the network. When adequate network capacity does not exist to allow for choice between network Providers of equivalent services, case managers must facilitate and coordinate services rendered by Out-of-Network Providers.

- Conduct necessary training for PCPs to assist them in providing services to diverse populations including the identification of the PH-MCO's Special Needs Unit contact persons.

- Provide ongoing coordination with PCPs to continually serve Special Needs population’s Members.

- Attend ad hoc meetings, workgroups, etc., hosted by the Department that require mandatory attendance by Special Needs Unit staff.

- Attend public/community sponsored meetings with the Department's representative(s) at the discretion of the PH-MCO.

- If the PH-MCO chooses to subcontract any of the Special Needs Unit functions, the PH-MCO must maintain accountability by assigning responsibility for oversight of the subcontract to a senior executive within the organization.

- Conduct necessary training for all PH-MCO providers to acquaint them with the purpose and function of the Special Needs Unit and identify a contact within the Special Needs Unit as a direct contact for any provider to refer a member with special needs for assistance.

- Provide assistance to any member needing help in filing a Complaint, Grievance, or Fair hearing, and serve in an advocacy role to assist the member in obtaining any information necessary from any PH-MCO provider in support of a Complaint, Grievance or DHS Fair Hearing.

- Provide assistance to any member needing additional help to access the Department's Medical Assistance Transportation Program.

- Provide assistance to any member needing help transitioning from a pediatric to an adult provider. Proactively identify individuals between the ages of 18 and 21 that may be considered to be medically fragile members and provide enhanced assistance to them in transitioning to an adult provider. During this transitioning process ensure that they can receive care from a Pediatrician and adult Primary Care Provider at the same time to facilitate a seamless transition to adult care. These youth should be provided case management, at a minimum, until a successful transition is complete.

- Work in coordination with the Department's Resource Facilitation Team (RFT), other Department of Human Services Program Offices, and Service Coordinators to provide transition assistance to members receiving home shift care services under EPSDT into Home and Community Based Waivers and adult systems of support. This will include functioning as a liaison between the RFT and the member and family.

- For members in inpatient or residential facilities, provide assistance with discharge planning to ensure the member is transitioning not only to the most appropriate and community-based environment for the child as possible , but to ensure that the environment and supports are in place in the new setting prior to any discharge occurring. Provide all necessary oversight including home or site visits with family or other caregivers to ensure adequate supports are in place for a safe discharge. Members in residential facilities will be required to be in active case management by a PH-MCO case manager until the member is successfully discharged home or to another community or other care setting.

- Conduct face-to-face case management activities with members for whom telephonic case management has proven ineffective, and desired goals have not been attained.

Utilize and interface with community-based care management staff to maintain a person-centered approach and to ensure that member-specific needs are being met.

The PH-MCO will develop, implement, and maintain a targeted Quality Management component focused on Members with Special Needs that is integrated into the Quality Management/Utilization Management Program as outlined in Exhibit M(1), Quality Management and Utilization Management Program Requirements.

The Special Needs Unit will provide data as required for special needs related to existing and new Operations (OPS) Reports and ad hoc requests concerning members with special needs.

EXHIBIT OO

COORDINATION OF CARE ENTITIES

Examples of coordination of care entities are listed below. This list is not inclusive of all coordination of care entities.

- Community HealthChoices Managed Care Organizations (CHC-MCOs)
- HealthChoices Behavioral Health Managed Care Organizations (BH-MCOs)
- County Office of Drug and Alcohol Programs
- Department of Drug and Alcohol Programs (BDAP)
- Office of Children, Youth, and Families (OCYF)
- County Children and Youth Agencies
- Office of Developmental Programs (ODP)
- County Intellectual Disability (ID) Agencies and County ID Health Care Coordination Units
- Intermediate Care Facility Providers
- Office of Mental Health and Substance Abuse Services (OMHSAS)
- Office of Long Term Living (OLTL)
- County Mental Health Agencies
- PA. Department of Health's Community Health District Offices
- County and Municipal Health Departments
- Special Kids Network Helpline
- Childhood Lead Poisoning Prevention Projects (CLPPPs)
- School Districts and Intermediate Units
- School Based Health Centers
- Juvenile Detention Centers
- Juvenile Probation Offices
- Area Agency on Aging (AAA)
- Community Service Organizations
- Public Health Entities
- Consumer Advocacy Groups
- WIC Agencies, Head Start Agencies, and Family Centers
- Public Housing Authorities
- Opioid Use Disorder Centers of Excellence
- Career Link
- Office of Vocational Rehabilitation

EXHIBIT PP

PROVIDER MANUALS

The PH-MCO shall develop, distribute prior to implementation and maintain a Provider manual. In addition, the PH-MCO and/or PH-MCO Subcontractors will be expected to distribute copies of all manuals and subsequent policy clarifications and procedural changes to participating Providers following advance written approval of the documents by the Department. Provider manuals must be updated to reflect any program or policy change(s) made by the Department via MA Bulletin within six (6) months of the effective date of the change(s), or within six (6) months of the issuance of the MA Bulletin, whichever is later, when such change(s) affect(s) information that the PH-MCO is required to include in its provider manual, as set forth in this Exhibit. The Provider manual must include, at a minimum, the following information:

A. A description of the case management system and protocols;

B. A description of the role of a PCP as described in Section II, Definitions, and Section V.S.3, Primary Care Practitioner (PCP) Responsibilities, of the Agreement;

C. Information on how Members may access specialists, including standing referrals and specialists as PCPs;

D. A summary of the guidelines and requirements of Title VI of the Civil Rights Act of 1964 and its guidelines, and how Providers can obtain qualified interpreters familiar with medical terminology;

E. Contact information to access the PH-MCO, DHS, advocates, other related organizations, etc;

F. A copy of the PH-MCO's Formulary, Prior Authorization, and Program Exception process;

G. Contact follow-up responsibilities for missed appointments;

H. Description of role of Special Needs Unit and how to refer patients via the Special Needs Unit hotline and listing of the SNU hotline number;

I. Description of drug and alcohol treatment available and how to make referrals;

J. Complaint, Grievance and DHS Fair Hearing information;

K. Information on Provider Disputes;

L. PH-MCO policies, procedures, available services, sample forms, and fee schedule applicable to the Provider type;

M. A full description of covered services, listing all applicable services under the Medical Assistance Fee-for-Service Program;

N. Billing instructions;

O. Information regarding applicable portions of 55 PA Code, Chapter 1101, General Provisions;

P. Information on self-referred services and services which are not the responsibility of the PH-MCO but are available to Members on a Fee-for-Service basis;

Q. Provider performance expectations, including disclosure of Quality Management and Utilization Management criteria and processes;

R. Information on procedures for sterilizations, hysterectomies and abortions (if applicable);

S. Information about EPSDT screening requirements and EPSDT services, including information on the dental referral process);

T. A description of certain Providers' obligations, under law, to follow applicable procedures in dealing with Members on "Advance Directives" (durable health care power of attorney and living wills). This includes notification and record keeping requirements;

U. Information on ADA and Section 504 of the Rehabilitation Act of 1973, other applicable laws, and available resources related to the same;

V. A definition of “Medically Necessary” consistent with the language in the Agreement;

W. Information on Member confidentiality requirements;

X. Information regarding school-based/school-linked services in this HealthChoices zone; and

Y. The Department’s MA Provider Compliance Hotline (formerly the Fraud and Abuse Hotline) number and explanatory statement.

Z. Explanation of Contractor’s and DHS’s Recipient Restriction Program.

AA. Information regarding written translation and oral interpretation services for Members with LEP and alternate methods of communication for those requesting communication in alternate formats.

BB. List and scope of services for referral and Prior Authorization.

CC. Information about the Pennsylvania MA Provider Self Audit Protocol which allows Providers to voluntarily disclose overpayments or improper payments of MA funds.

The PH-MCO is required to provide documented training to its Providers and their staffs and to Subcontractors, regarding the contents and requirements of the Provider manuals.

EXHIBIT WW

HEALTHCHOICES AUDIT CLAUSE

AUDITS

Annual Agreement Audits

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

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

The PH-MCO shall ensure that audit working papers and audit reports are retained by the PH-MCO's auditor for a minimum of ten (10) years from the date of final payment under the Agreement, unless the PH-MCO's auditor is notified in writing by the Commonwealth to extend the retention period. Audit working papers shall be made available, upon request, to authorized representatives of the Commonwealth or Federal agencies. Copies of working papers deemed necessary shall be provided by the PH-MCO's auditor.

Annual Entity-Wide Financial Audits

The PH-MCO shall provide to the Commonwealth a copy of its annual entity-wide financial audit, performed by an independent, licensed Certified Public Accountant. Such audit shall be made in accordance with generally accepted auditing standards. Such audit shall be submitted to the OMAP, BFM, Division of Financial Analysis and Reporting via E-FRM within 30 days after the Auditors signature date.

Other Financial and Performance Audits

The Commonwealth reserves the right for federal and state agencies or their authorized representatives to perform additional financial or performance audits of the PH-MCO, its subcontractors or Providers. Any such additional audit work will rely on work already performed by the PH-MCO's auditor to the extent possible. The costs incurred by the federal or state agencies for such additional work will be borne by those agencies.

Audits of the PH-MCO, its subcontractors or Providers may be performed by the Commonwealth or its designated representatives and include, but are not limited to:

1. Financial and compliance audits of operations and activities for the purpose of determining the compliance with financial and programmatic record keeping and reporting requirements of this Agreement;

2. Audits of automated data processing operations to verify that systems are in place to ensure that financial and programmatic data being submitted to the Commonwealth is properly safeguarded, accurate, timely, complete, reliable, and in accordance with Agreement terms and conditions; and

3. Program audits and reviews to measure the economy, efficiency and effectiveness of program operations under this Agreement.

4. The Commonwealth must periodically, but no less frequently than once every three (3) years, conduct or contract for the conduct of, an independent audit of the accuracy, truthfulness, and completeness of the encounter and financial data submitted by, or on behalf of, the PH-MCO.

Audits performed by the Commonwealth shall be in addition to any federally-required audits or any monitoring or review efforts. Commonwealth audits of the PH-MCO or its subcontractor's operations will generally be performed on an annual basis. However, the Commonwealth reserves the right to audit more frequently, to vary the audit period, and to determine the type and duration of these audits. Audits of subcontractors or Providers will be performed at the Commonwealth's discretion.

The following provisions apply to the PH-MCO, its subcontractors and Providers:

1. Except in cases where advance notice is not possible or advance notice may render the audit less useful, the Commonwealth will give the entity at least three (3) weeks advance written notice of the start date, expected staffing, and estimated duration of the audit. In the event of a claims processing audit, the Commonwealth will strive to provide advance written notice of a minimum of thirty (30) calendar days. While the audit team is on-site, the entity shall provide the team with adequate workspace; access to a telephone, photocopier and facsimile machine; electrical outlets; and privacy for conferences. The PH-MCO shall also provide, at its own expense, necessary systems and staff support to timely extract and/or download information stored in electronic format, gather requested documents or information, complete forms or questionnaires, and respond to auditor inquiries. The entity shall cooperate fully with the audit team in furnishing, either in advance or during the course of the audit, any policies, procedures, job descriptions, Agreements or other documents or information requested by the audit team.

2. Upon issuance of the final report to the entity, the entity shall prepare and submit, within thirty (30) calendar days after issuance of the report, a Corrective Action Plan for each observation or finding contained therein. The Corrective Action Plan shall include a brief description of the finding, the specific steps to be taken to correct the situation or specific reasons why corrective action is not necessary, a timetable for performance of the corrective action steps, and a description of the monitoring to be performed to ensure that the steps are taken.

Record Availability, Retention and Access

The PH-MCO shall, at its own expense, make all records available for audit, review or evaluation by the Commonwealth, its designated representatives or federal agencies. Access shall be provided either on-site, during normal business hours, or through the mail. During the Agreement and record retention period, these records shall be available at the PH-MCO's chosen location, subject to approval of the Commonwealth. All records to be sent by mail shall be sent to the requesting entity within fifteen (15) calendar days of such request and at no expense to the requesting entity. Such requests made by the Commonwealth shall not be unreasonable.

The PH-MCO shall maintain books, records, documents, and other evidence pertaining to all revenues, expenditures and other financial activity pursuant to this Agreement as well as to all required programmatic activity and data pursuant to this Agreement. Records other than medical records may be kept in an original paper state or preserved on micro media or electronic format. Medical records shall be maintained in a format acceptable by the Department. These books, records, documents and other evidence shall be available for review, audit or evaluation by authorized Commonwealth personnel or their representatives during the Agreement period and ten years thereafter, except if an audit is in progress or audit findings are yet unresolved, in which case records shall be kept until all tasks are completed.

Audits of Subcontractors

The PH-MCO shall include in all risk sharing PH-MCO subcontract agreements clauses, which reflect the above provisions relative to "Annual Agreement Audits", "Annual Entity-Wide Financial Audits", "Other Financial and Performance Audits" and "Record Availability, Retention, and Access."

The PH-MCO shall include in all contract agreements with other subcontractors or Providers, clauses which reflect the above provisions relative to "Other Financial and Performance Audits" and "Record Availability, Retention, and Access."

EXHIBIT XX

ENCOUNTER DATA SUBMISSION REQUIREMENTS AND PENALTY APPLICATIONS

The submission of timely and accurate Encounter Data is critical to the Commonwealth's ability to establish and maintain cost effective and quality managed care programs. Consequently, the requirements for submission and metrics for measuring the value of the data for achieving these goals are crucial.

- **CERTIFICATION REQUIREMENTS**

  All MCOs must be certified through the Department's MMIS prior to the submission of live Encounter Data. The certification process is detailed on the Pennsylvania HealthChoices Extranet.

- **SUBMISSION REQUIREMENTS**

  - Timeliness:

    With the exception of NCPDP Encounters, all MCO approved Encounters and those specified MCO-denied Encounters must be approved in the Department's MMIS by the last day of the third month following the month of initial MCO adjudication. Pharmacy Encounters must be submitted and approved in the Department's MMIS within thirty (30) days following the MCO adjudication.

    - Metric:

      During the six months following the month of the initial MMIS adjudication, Encounters will be analyzed for timely submission.

      - Failure to achieve the Department's MMIS approved/paid status for 98% of all MCO paid/approved and specified MCO denied Encounters by the last day of the third month following initial MCO adjudication may result in a penalty.

      - Any Encounter Data corrected or initially submitted after the last day of the third month following initial MCO adjudication may be subject to a penalty.

  Accuracy and Completeness:

    Accuracy and completeness are based on consistency between Encounter Data submitted to the Department's MMIS and information for the same service maintained by the MCO in their Claims/service history database.

    - Metric:

Accuracy and completeness will be determined through a series of analyses of MCO Claims history data and Encounters received and processed through the Department's MMIS. This analysis will be done at least yearly but no more than twice a year and will consist of making comparisons between encounter samples and what is found in the MCO's claims history. Samples may also be drawn from the MCO's service history and compared with Encounters processed through the Department's MMIS.

Samples will be drawn proportionally based on the MCO financial expenditures for each transaction type submitted during the review period. Each annual or semi-annual analysis will be based on a statistically valid sample of no less than 200 records.

- **PENALTY PROVISION**

Timeliness:

Failure to comply with timeliness requirements will result in a sanction of up to $10,000 for each program month.

Completeness and Accuracy:

Errors in accuracy or completeness that are identified by the Department in an annual or semi-annual analysis will result in sanctions as follows. An error in accuracy or completeness or both, in one sample record, counts as one error.

Percentage of the sample that includes an error	Sanction
Less than 1.0 percent	None
1.0 – 1.4 percent	$4,000
1.5 – 2.0 percent	$10,000
2.1 - 3.0 percent	$16,000
3.1 – 4.0 percent	$22,000
4.1 – 5.0 percent	$28000
5.1 – 6.0 percent	$34,000
6.1 – 7.0 percent	$40,000
7.1 – 8.0 percent	$46,000
8.1 – 9.0 percent	$52,000
9.1 – 10.0 percent	$58,000
10.1 percent and higher	$100,000

EXHIBIT AAA

PROVIDER NETWORK COMPOSITION/SERVICE ACCESS

1. Network Composition

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

- The anticipated MA enrollment,
- The expected utilization of services, taking into consideration the characteristics and health care needs of specific MA populations represented in the PH-MCO,
- The number and types, in terms of training, experience, and specialization, of Providers required to furnish the contracted MA services,
- The number of Network Providers who are not accepting new MA patients, and
- 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.

The PH-MCO must adhere to CMS network adequacy standards as outlined in 42 C.F.R. §438.68(b)(1)(viii) and 438.68(b)(3). The PH-MCO must ensure that its Provider Network is adequate to provide its Members in this HealthChoices Zone with access to quality Member care through participating professionals, in a timely manner, and without the need to travel excessive distances. Upon request from the Department, the PH-MCO must supply geographic access maps using Member level data detailing the number, location and specialties of their Provider Network to the Department in order to verify accessibility of Providers within their Network in relation to the location of its Members. The Department may require additional numbers of specialists and ancillary Providers should it be determined that geographic access is not adequate. The PH-MCO must also have a process in place which ensures that the PH-MCO knows the capacity of their Network PCP panels at all times and have the ability to report on this capacity.

The PH-MCO must make all reasonable efforts to honor a Member's choice of Providers who are credentialed in the Network. If the PH-MCO is unable to ensure a Member's access to provider or specialty provider services within the PH-MCO's network, within the travel times set forth in this Exhibit, the PH-MCO must make all reasonable efforts to ensure the Member's access to these services within the travel times herein through out-of-network providers. In locations where the PH-MCO can provide evidence that it has conducted all reasonable efforts to contract with providers and specialists and can provide verification that no providers or specialists exist to ensure a Member's access to these services within the travel times set forth in this

Exhibit, the PH-MCO must work with Members to offer reasonable provider alternatives. Additionally, the PH-MCO must ensure and demonstrate that the following Provider Network and access requirements are established and maintained for the entire HealthChoices Zone in which the PH-MCO operates if providers exist:

a. PCPs

Make available to every Member a choice of at least two (2) appropriate PCPs with open panels whose offices are located within a travel time no greater than thirty (30) minutes (Urban) and sixty (60) minutes (Rural). This travel time is measured via public transportation, where available. Members may, at their discretion, select PCPs located further from their homes.

b. Pediatricians as PCPs

Ensure an adequate number of pediatricians with open panels to permit all Members who want a pediatrician as a PCP to have a choice of two (2) for their child(ren) within the travel time limits (30 minutes Urban, 60 minutes Rural).

c. Specialists

i. For the following provider types, the PH-MCOs operating in Lehigh Capital, Southeast, and Southwest must ensure a choice of two (2) providers who are accepting new patients within the travel time limits (30 minutes Urban, 60 minutes Rural):

General Surgery	Cardiology
Obstetrics & Gynecology	Pharmacy
Oncology	Orthopedic Surgery
Physical Therapy	General Dentistry
Radiology	Pediatric Dentistry

PH-MCOs operating in Northeast and Northwest must ensure a choice of two (2) providers who are accepting new patients within the travel time limits (30 minutes Urban, 60 minutes Rural):

General Surgery	Cardiology
Obstetrics & Gynecology	Pharmacy
Orthopedic Surgery	Pediatric Dentistry
General Dentistry	

ii. For the following provider types, the PH-MCOs operating in Lehigh/Capital, Southeast, and Southwest must ensure a choice of one (1) provider who is accepting new patients within the travel time limits (30 minutes Urban, 60 minutes Rural) and a second choice, within the HealthChoices Zone:

Oral Surgery	Urology
Nursing Facility	Neurology
Dermatology	Otolaryngology

The PH-MCOs operating in Northeast and Northwest must ensure a choice of one (1) provider who is accepting new patients within the travel time limits (30 minutes Urban, 60 minutes Rural) and a second choice within the HealthChoices Zone:

Oral Surgery	Urology
Nursing Facility	Neurology
Dermatology	Otolaryngology
Oncology	Radiology
Physical Therapy	

iii. For all other specialists and subspecialists, the PH-MCO must have a choice of two (2) providers who are accepting new patients within the HealthChoices Zone.

d. Hospitals

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

e. Special Health Needs

Ensure the provision of services to persons who have special health needs or who face access barriers to health care. If the PH-MCO does not have at least two (2) specialists or sub-specialists qualified to meet the particular needs of the individuals, then the PH-MCO must allow Members to pick an Out-of-Network Provider if not satisfied with the Network Provider. The PH-MCO must develop a system to determine Prior Authorization for Out-of-Network Services, including provisions for informing the Recipient of how to request this authorization for Out-of-Plan Services. For children with special health needs, the PH-MCO must offer at least two (2) pediatric specialists or pediatric sub-specialists.

f. Anesthesia for Dental Care

For Members needing anesthesia for dental care, the PH-MCO must ensure a choice of at least two (2) dentists within the Provider Network with privileges or certificates to perform specialized dental procedures under general anesthesia or pay out of Network.

g. Rehabilitation Facilities

Ensure a choice of at least two (2) rehabilitation facilities within the Provider Network, at least one (1) of which must be located within this HealthChoices Zone.

h. CNMs / CRNPs, Other Health Care Providers

Ensure access to Certified Nurse Midwives (CNMs) and Certified Registered Nurse Practitioners (CRNPs) and other Health Care Providers. In accordance with RX for PA Principles, the PH-MCO must demonstrate its attempts to contract in good faith with a sufficient number of CNMs and CRNPs and other Health Care Providers and maintain payment policies that reimburse CNMs and CRNPs and other Health Care Providers for all services provided within the scope of their practice and allow them to practice to the fullest extent of their education, training and licensing.

i. Qualified Providers

The PH-MCO must limit its PCP Network to appropriately qualified Providers. The PH-MCO's PCP Network must meet the following:

- No less than seventy-five percent (75) of the Network consists of PCPs who have completed an approved primary care residency in family medicine, osteopathic general medicine, internal medicine or pediatrics; and

- No more than twenty-five percent (25%) of the Network consists of PCPs without appropriate residencies but who have, within the past seven (7) years, five (5) years of post-training clinical practice experience in family medicine, osteopathic general medicine, internal medicine or pediatrics. Post-training experience is defined as having practiced at least as a 0.5 full-time equivalent in the practice areas described.

j. Members Freedom of Choice

The PH-MCO must demonstrate its ability to offer its Members freedom of choice in selecting a PCP. At a minimum, the PH-MCO must have

or provide one (1) full-time equivalent (FTE) PCP who serves no more than one thousand (1,000) Recipients. For the purposes of this section, a full- time equivalent PCP must be a physician involved in clinical care. The minimum weekly work hours for 1.0 FTE is the number of hours that the practice considers to be a normal work week, which may be 37.5, 40, or 50 hours. A physician cannot be counted as more than 1.0 FTE regardless of the number of hours worked. If the PCP/PCP Site employs Certified Registered Nurse Practitioners (CRNPs)/Physician Assistants (PAs), then the Provider/Provider Site will be permitted to add an additional one thousand (1,000) Members to the panel. The number of Members assigned to a PCP may be decreased by the PH-MCO if necessary to maintain the appointment availability standards.

k. PCP Composition and Location

The PH-MCO and the Department will work together to avoid the PCP having a caseload or medical practice composed predominantly of HC Members. In addition, the PH-MCO must organize its PCP Sites so as to ensure continuity of care to Members and must identify a specific PCP or PCP group for each Member. The PH-MCO may apply to the Department for a waiver of these requirements. The Department may waive these requirements for good cause demonstrated by the PH-MCO. The PH- MCO will comply with the program standards regarding PCP assignment as set forth in Section V.Q. of the Agreement, Assignment of PCPs.

l. FQHCs / RHCs

The PH-MCO must include in its Provider Network every FQHC and RHC that are willing to accept PPS rates as payment in full and are located within the operational HealthChoices Zones in which the PH-MCO has an agreement. If the PH-MCO's primary care Network includes FQHCs and RHCs, these sites may be designated as PCP sites.

m. Medically Necessary Emergency Services

The PH-MCO must comply with the provisions of Act 112 of 1996 (H.B. 1415, P.N. 3853, signed July 11, 1996), the Balanced Budget Reconciliation Act of 1997 and Act 68 of 1998, the Quality Health Care Accountability and Protection Provisions, 40 P.S. 991.2101 et seq. pertaining to coverage and payment of Medically Necessary Emergency Services. The definition of such services is set forth herein at Section II of this Agreement, Definitions.

n. ADA Accessibility Guidelines

The PH-MCO must inspect the office of any PCP or dentist who seeks to participate in the PH-MCO's Provider Network (excluding offices located in hospitals) to determine whether the office is architecturally accessible to persons with mobility impairments. Architectural accessibility means compliance with ADA accessibility guidelines with reference to parking (if any), path of travel to an entrance, and the entrance to both the building and the office of the Provider, if different from the building entrance.

The PH-MCO must submit quarterly reports to the Department, in a format to be specified by the Department, on the results of the inspections.

If the office or facility is not accessible under the terms of this paragraph, the PCP or dentist may participate in the PH-MCO's Provider Network provided that the PCP or dentist: 1) requests and is determined by the PH-MCO to qualify for an exemption from this paragraph, consistent with the requirements of the ADA, or 2) agrees in writing to remove the barrier to make the office or facility accessible to persons with mobility impairments within six (6) months after the PH-MCO identified the barrier.

The PH-MCO must document its efforts to determine architectural accessibility. The PH-MCO must submit this documentation to the Department upon request.

o. Laboratory Testing Sites

The PH-MCO must ensure that all laboratory testing sites providing services have either a Clinical Laboratory Improvement Amendment (CLIA) certificate of waiver or a certificate of registration along with a CLIA identification number in accordance with CLIA 1988. Those laboratories with certificates of waiver will provide only the eight (8) types of tests permitted under the terms of their waiver. Laboratories with certificates of registration may perform a full range of laboratory tests. The PCP must provide all required demographics to the laboratory when submitting a specimen for analysis.

p. PH-MCO Discrimination

The PH-MCO must not discriminate with respect to participation, reimbursement, or indemnification as to any Provider who is acting within the scope of the Provider's license or certification under applicable State law, solely on the basis of such license or certification. This paragraph must not be construed to prohibit a PH-MCO from including Providers only to the extent necessary to meet the needs of the organization's Members or from establishing any measure designed to maintain quality and control costs consistent with the responsibilities of the PH-MCO.

q. Declined Providers

If the PH-MCO declines to include individual Providers or groups of Providers in its Network, it must give the affected Providers written notice of the reason for its decision.

r. Second Opinions

The PH-MCO must provide for a second opinion from a qualified Health Care Provider within the Network, at no cost to the Member. If a qualified Health Care Provider is not available within the Network, the PH-MCO must assist the Member in obtaining a second opinion from a qualified Health Care Provider outside the Network, at no cost to the Member, unless co-payments apply.

s. American Indians and Indian Healthcare Providers

Consistent with 42 C.F.R. §438.14(b)(1-3), The PH-MCO must:

- Demonstrate that there are sufficient I/T/U providers in the network to ensure timely access to services available under the Agreement for Indian enrollees who are eligible to receive services from such providers;

- Pay I/T/U providers, whether participating in the network or not, for covered Medicaid or CHIP managed care services provided to Indian enrollees who are eligible to receive services from such providers either at a rate negotiated between the PH-MCO and the I/T/U provider, or if there is no negotiated rate, at a rate no less than the level and amount of payment that would be made if the provider were not an I/T/U provider; and

- Permit any Indian who is enrolled in a non-Indian MCO and eligible to receive services from a participating I/T/U provider to choose to receive covered services from that I/T/U provider and if that I/T/U provider participates in the network as a primary care provider, to choose that I/T/U as his or her primary care provider, as long as that provider has capacity to provide the services.

Consistent with 42 C.F.R. §438.14(b)(5-6), the PH-MCO must permit American Indian members to access out of state IHCPs; or permit an out-of-network IHCP to refer an American Indian member to a network provider.

When an IHCP is enrolled in Medicaid as an FQHC, but not a participating

provider of the PH-MCO, the IHCP must be paid an amount equal to the amount the PH-MCO would have paid to a network FQHC. When the IHCP is not enrolled in Medicaid as an FQHC, the PH-MCO must reimburse the IHCP at the same rate as the IHCP's applicable encounter rate published annually in the Federal Register by the Indian Health Service. If there is no published encounter rate, the IHCP must receive the amount it would have been reimbursed if the services were provided under the Pennsylvania MA FFS FQHC payment methodology.

2. Appointment Standards

The PH-MCO will require the PCP, dentist, or specialist to conduct affirmative outreach whenever a Member misses an appointment and to document this in the medical record. Such an effort shall be deemed to be reasonable if it includes three (3) attempts to contact the Member. Such attempts may include, but are not limited to: written attempts, telephone calls and home visits. At least one (1) such attempt must be a follow-up telephone call.

a. General

PCP scheduling procedures must ensure that:

i. Emergency Medical Condition cases must be immediately seen or referred to an emergency facility.

ii. Urgent Medical Condition cases must be scheduled within twenty- four (24) hours.

iii. Routine appointments must be scheduled within ten (10) Business Days.

iv. Health assessment/general physical examinations and first examinations must be scheduled within three (3) weeks of Enrollment.

v. The PH-MCO must provide the Department with its protocol for ensuring that a Member's average office waiting time for an appointment for Routine Care is no more than thirty (30) minutes or at any time no more than up to one (1) hour when the physician encounters an unanticipated Urgent Medical Condition visit or is treating a Member with a difficult medical need. The Member must be informed of scheduling time frames through educational outreach efforts.

vi. The PH-MCO must monitor the adequacy of its appointment processes and reduce the unnecessary use of emergency room

visits.

b. Persons with HIV/AIDS

The PH-MCO must have adequate PCP scheduling procedures in place to ensure that an appointment with a PCP or specialist must be scheduled within seven (7) days from the effective date of Enrollment for any person known to the PH-MCO to be HIV positive or diagnosed with AIDS (e.g. self-identification), unless the Member is already in active care with a PCP or specialist.

c. Supplemental Security Income (SSI)

The PH-MCO must make a reasonable effort to schedule an appointment with a PCP or specialist within forty-five (45) days of Enrollment for any Member who is an SSI or SSI-related consumer unless the Member is already in active care with a PCP or specialist.

d. Specialty Referrals

For specialty referrals, the PH-MCO must be able to provide for:

i. Emergency Medical Condition appointments immediately upon referral.

ii. Urgent Medical Condition care appointments within twenty-four (24) hours of referral.

iii. Scheduling of appointments for routine care within fifteen (15) business days for the following specialty provider types:

Otolaryngology Orthopedic Surgery
Dermatology Pediatric Allergy &
Immunology Pediatric Endocrinology Pediatric
Gastroenterology Pediatric General Surgery Pediatric
Hematology
Pediatric Infectious Disease Pediatric Nephrology
Pediatric Neurology Pediatric Oncology
Pediatric Pulmonology Pediatric Rehab
Medicine Pediatric Rheumatology Pediatric Urology
Dentist Pediatric Dentistry

iv. Scheduling of appointments for routine care within ten (10) business days of referral for all other specialty provider types not listed above.

e. Pregnant Women

Should the EAP contractor or Member notify the PH-MCO that a new Member is pregnant or there is a pregnancy indication on the files transmitted to the PH-MCO by the Department, the PH-MCO must contact the Member within five (5) days of the effective date of Enrollment to assist the woman in obtaining an appointment with an OB/GYN or Certified Nurse Midwife. For maternity care, the PH-MCO must arrange initial prenatal care appointments for enrolled pregnant Members as follows:

i. First trimester — within ten (10) Business Days of the Member being identified as being pregnant.

ii. Second trimester — within five (5) Business Days of the Member being identified as being pregnant.

iii. Third trimester — within four (4) Business Days of the Member being identified as being pregnant.

iv. High-risk pregnancies — within twenty-four (24) hours of identification of high risk to the PH-MCO or maternity care Provider, or immediately if an emergency exists.

f. EPSDT

EPSDT screens for any new Member under the age of twenty-one (21) must be scheduled within forty-five (45) days from the effective date of Enrollment unless the child is already under the care of a PCP and the child is current with screens and immunizations.

The PH-MCO must distribute quarterly lists to each PCP in its Provider Networks which identify Members who have not had an Encounter during the previous twelve (12) months or within the time frames set forth in this Exhibit, or Members who have not complied with EPSDT periodicity and immunization schedules for children. The PH-MCO must contact such Members, documenting the reasons for noncompliance and documenting its efforts for bringing the Members' care into compliance.

3. Policies and Procedures for Appointment Standards

The PH-MCO will comply with the program standards regarding service accessibility standards that are set forth in this Exhibit and in Section V.S. of the Agreement, Provider Agreements.

The PH-MCO must have written policies and procedures for disseminating

its appointment standards to all Members through its Member handbook and through other means. In addition, the PH-MCO must have written policies and procedures to educate its Provider Network about appointment standard requirements. The PH-MCO must monitor compliance with appointment standards and must have a corrective action plan when appointment standards are not met.

4. Compliance with Access Standards

a. Mandatory Compliance

Per 42 C.F.R. §438.68(b)(1)(viii), the PH-MCO must adhere to any time and distance access standards established by CMS. The PH-MCO must comply with the access standards in accordance with this Exhibit and Section V.S of the Agreement, Provider Agreements. If the PH-MCO fails to meet any of the access standards by the dates specified by the Department, the Department may terminate this Agreement.

b. Reasonable Efforts and Assurances

The PH-MCO must make reasonable efforts to honor a Member's choice of Providers among Network Providers as long as:

i. The PH-MCO's agreement with the Network Provider covers the services required by the Member; and

ii. The PH-MCO has not determined that the Member's choice is clinically inappropriate.

The PH-MCO must provide the Department adequate assurances that the PH-MCO, with respect to each zone of operation, has the capacity to serve the expected Enrollment in each zone of operation. The PH-MCO must provide assurances that it will offer the full scope of covered services as set forth in this Agreement and access to preventive and primary care services. The PH-MCO must also maintain a sufficient number, mix and geographic distribution of Providers and services in accordance with the standards set forth in this Exhibit and Section V.S. of the Agreement, Provider Agreements.

c. PH-MCO's Corrective Action

The PH-MCO must take all necessary steps to resolve, in a timely manner, any demonstrated failure to comply with the access standards. Prior to a termination action or other sanction by the Department, the PH-MCO will be given the opportunity to institute a corrective action plan. The PH-MCO must submit a corrective action plan to the Department for

approval within thirty (30) days of notification of such failure to comply, unless circumstances warrant and the Department demands a shorter response time. The Department's approval of the PH-MCO's corrective action plan will not be unreasonably withheld. The Department will make its best effort to respond to the PH-MCO within thirty (30) days from the submission date of the corrective action plan. If the Department rejects the corrective action plan, the PH-MCO shall be notified of the deficiencies of the corrective action plan. In such event, the PH-MCO must submit a revised corrective action plan within fifteen (15) days of notification. If the Department does not receive an acceptable corrective action plan, the Department may impose sanctions against the PH-MCO, in accordance with Section VIII.H. of the Agreement, Sanctions. Failure to implement the corrective action plan may result in the imposition of a sanction as provided in this Agreement.

EXHIBIT BBB

OUTPATIENT DRUG SERVICES

1. General Requirements

a. All requirements in this Exhibit apply to all Covered Outpatient Drugs regardless of the setting in which the drug is dispensed or administered and regardless of the billing provider type.

b. The amount, duration, and scope of Covered Outpatient Drugs must be consistent with coverage under the Fee-for-Service (FFS) program. The PH-MCO must cover all Covered Outpatient Drugs listed on the Center for Medicare and Medicaid Services (CMS) Quarterly Drug Information File when determined to be Medically Necessary, unless otherwise excluded from coverage. (See 2. Coverage Exclusions below for exclusions.) This includes brand name and generic drugs, and over-the-counter drugs (OTCs), prescribed by licensed providers enrolled in the MA program, and sold or distributed by drug manufacturers that participate in the Medicaid Drug Rebate Program.

c. The PH-MCO must provide coverage for all medically accepted indications, as described in Section 1927(k)(6) of the Social Security Act, 42 U.S.C.A. 1396r-8(k)(6). This includes any use which is approved under the Federal Food, Drug, and Cosmetic Act, 21 U.S.C.A. 301 et seq. or whose use is supported by the nationally recognized pharmacy compendia, or peer-reviewed medical literature.

d. Unless financial responsibility is otherwise assigned, all Covered Outpatient Drugs are the payment responsibility of the Member's PH-MCO. The only exception is that the behavioral health managed care organization (BH-MCO) is responsible for the payment of methadone when used in the treatment of substance abuse disorders and when prescribed and dispensed by BH-MCO service Providers.

e. All Covered Outpatient Drugs must be dispensed through PH-MCO Network Providers. This includes Covered Outpatient Drugs prescribed by both the PH-MCO and the BH-MCO Providers.

f. Under no circumstances will the PH-MCO permit the therapeutic substitution of an outpatient drug by a pharmacist without explicit authorization from the licensed prescriber.

g. All proposed pharmacy policies, programs and drug utilization management programs, such as prior authorization, step therapy, partial fills, specialty pharmacy, pill-splitting, mail order, 90day supply programs, etc. must be submitted to the Department for review and written approval prior to implementation, prior to implementation of any changes, and annually thereafter.

h. The PH-MCO must include in its written policies and procedures an assurance that all requirements and conditions governing coverage and payment for Covered Outpatient Drugs, such as, but not limited to, prior authorization (including step therapy), medical necessity guidelines, age edits, drug rebate encounter submission, reporting, notices of decision, etc. will,

   i. Apply, regardless of whether the Covered Outpatient Drug is provided as an outpatient drug benefit or as a "medical benefit" incident to a medical service and billed by the prescribing Provider using codes such as the Healthcare Common Procedure Coding System (HCPCS).

   ii. Ensure access for all medically accepted indications as documented by package labeling, nationally recognized pharmacy compendia, peer-reviewed medical literature, Statewide Preferred Drug List (PDL) prior authorization guidelines, if applicable, and FFS guidelines to determine medical necessity of drugs that require prior authorization in the MA FFS Program, when designated by the Department.

i. The PH-MCO must submit for review and approval a policy for each section of Exhibit BBB that includes the requirements in the respective section and the PH-MCO's procedures to demonstrate compliance.

j. The PH-MCO must agree to adopt the same requirements for prior authorization and some or all of the same guidelines to determine medical necessity of selected drugs or classes of drugs as those adopted by the MA FFS Program when designated by the Department.

k. The PH-MCO must comply with Section 2117 of Article XXI of the Insurance Company Law of 1921, as amended, 40 P.S. 991.2117 regarding continuity of care requirements and 28 PA Code Ch. 9. The PH-MCO must also comply with the procedures outlined in MA Bulletin 99-03-13 and MA Bulletin # 99-96-01. The PH-MCO policy and procedures for continuity of care for outpatient drugs, and all subsequent changes to the Department-approved policy and procedures, must be submitted to the Department for review and approval prior to implementation. The policy and procedures must address how the PH-MCO will ensure no interruption in drug therapy and the course of treatment, and continued access to outpatient drugs that the Member was prescribed before enrolling in the PH-MCO.

l. The PH-MCO must allow access to all new drugs approved by the Food and Drug Administration (FDA) and meet the definition of a Covered Outpatient Drug either by addition to the Statewide PDL or MCO Formulary for drugs and products not included in the Statewide PDL, or through prior authorization, within ten (10) days from their availability in the marketplace.

2. Coverage Exclusions

a. In accordance with Section 1927 of the Social Security Act, 42 U.S.C.A. 1396r-8, the PH-MCO must exclude coverage for any drug marketed by a drug company (or labeler) who does not participate in the Medicaid Drug Rebate Program. The PH-MCO is not permitted to provide coverage for any drug product, brand name or generic, legend or non-legend, sold or distributed by a company that did not sign an agreement with the federal government to provide rebates to the Medicaid agency. This requirement does not apply to vaccines, compounding materials, certain vitamins and minerals or diabetic supplies.

b. The PH-MCO must not provide coverage for Drug Efficacy Study Implementation (DESI) drugs under any circumstances.

c. The PH-MCO must exclude coverage of noncompensable drugs in accordance with 55 PA Code §1121.54.

3. Formularies and Preferred Drug Lists (PDLs)

a. The PH-MCO must utilize the Statewide PDL developed by the Department's Pharmacy and Therapeutics (P&T) Committee.
If the PH-MCO fails to meet Statewide PDL quarterly compliance of 95% (excluding TPL) a financial sanction consistent with the difference in net cost using PH-MCO actual compliance rate and the net cost if compliance rate was 95%. The minimum penalty of $25,000 per quarter will be imposed.

b. The PH-MCO must implement use of the Statewide PDL, any changes to the Statewide PDL, the Statewide PDL prior authorization guidelines, and any changes to the Statewide PDL prior authorization guidelines on the effective date provided by the Department.

c. The PH-MCO must apply Statewide PDL prior authorization guidelines to all drugs and products included on the Statewide PDL. The PH-MCO may not impose additional prior authorization requirements for drugs and products included on the Statewide PDL. Quantity limits can be no more restrictive than the Department's quantity limits.

The PH-MCO must submit the policies, procedures, and guidelines to determine medical necessity of drugs included on the Statewide PDL to the Department. Submissions must occur prior to the effective date of the changes as determined by the Department and at least annually.

d. The PH-MCO may use a Formulary or PDL to manage MA covered drugs and products that are outside the scope of the Statewide PDL as long as the Department has prior approved it and the Formulary or PDL meets the clinical needs of the MA population.

The Formulary or PDL must be developed and reviewed at least annually by the PH-MCO's P&T Committee, as defined in Section 6 of this Exhibit.

e. The PH-MCO must allow access to all non-formulary or non-preferred drugs that are included in the CMS Quarterly Drug Information File, other than those excluded from coverage by the Department, when determined to be Medically Necessary through a process such as Prior Authorization (including Step Therapy), in accordance with Prior Authorization of Services Section V. B.1. and Exhibit H, Prior Authorization Guidelines for Participating Managed Care Organizations in the HealthChoices Program, and this Exhibit.

f. The PH-MCO must receive written approval from the Department of the Formulary or PDL, the list of specialty drugs, quantity limits, age edits, and the policies, procedures and guidelines to determine medical necessity of drugs and products not included on the Statewide PDL that require prior authorization, including drugs that require step therapy and drugs that are designated as non-formulary or non-preferred, prior to implementation of the Formulary or PDL, the designation of specialty, and the requirements. PH-MCOs may add drugs to the specialty drug list that are in therapeutic classes already included on the specialty drug list prior to receiving approval from the Department. However, these additions must be included in the specialty drug designations submitted to the Department for written approval. Submissions for annual reviews must occur at least thirty (30) days before effective date of the updated information.

g. The PH-MCO must submit all Formulary or PDL deletions for drugs and products outside the scope of the Statewide PDL to the Department for review and written approval prior to implementation.

h. The PH-MCO must submit written notification of any Formulary or PDL additions for drugs outside the scope of the statewide PDL to the Department within fifteen (15) days of implementation.

i. The PH-MCO must make available on the website in a machine readable file and format, information about its drug formulary or PDL, listing which medications are covered, including both brand and generic names.

4. Prior Authorization of Outpatient Drugs

a. For Covered Outpatient Drugs that require Prior Authorization (including step therapy) as a condition of coverage or payment:

i. The PH-MCO must provide a response to the request for prior authorization by telephone or other telecommunication device indicating approval or denial of the prescription within twenty-four (24) hours of the request, and

ii. If a Member's prescription for a medication is not filled when a prescription is presented to the pharmacist due to a Prior Authorization requirement, the PH-MCO must instruct the pharmacist to dispense either a:

- Fifteen (15) day supply if the prescription qualifies as an Ongoing Medication, unless the PH-MCO or its designated subcontractor issued a proper written notice of benefit reduction or termination at least ten (10) days prior to the end of the period for which the medication was previously authorized and a Grievance or DHS Fair Hearing request has not been filed, or

- A seventy-two (72) hour supply of a new medication.

b. For drugs not able to be divided and dispensed into individual doses, the PH-MCO must instruct the pharmacist to dispense the smallest amount that will provide at least a seventy-two (72) hour or fifteen (15) day supply, whichever is applicable.

c. The requirement that the Member be given at least a seventy-two (72) hour supply for a new medication or a fifteen (15) day supply for an Ongoing Medication does not apply when a pharmacist determines that the taking of the prescribed medication, either alone or along with other medication that the Member may be taking, would jeopardize the health or safety of the Member.

d. In such an event, the PH-MCO and/or its subcontractor must require that its participating dispensing Provider make good faith efforts to contact the prescriber.

e. If the PH-MCO denies the request for prior authorization, the PH-MCO must issue a written denial notice, using the appropriate Outpatient Drug Denial Notice template within twenty-four (24) hours of receiving the request for prior authorization.

f. If the Member files a Grievance or DHS Fair Hearing request from a denial of an Ongoing Medication, the PH-MCO must authorize the medication until the Grievance or DHS Fair Hearing request is resolved.

g. Requests for prior authorization will not be denied for lack of medical necessity unless a physician reviews the request for a medical necessity determination. Such a request for prior authorization must be approved when, in the professional judgment of the physician reviewer, the services are medically necessary to meet the medical needs of the Member.

h. In addition, for children under the age of twenty-one (21), requests for service will not be denied for lack of medical necessity unless a physician or other health care professional with appropriate clinical expertise in treating the

Member's condition or disease determines:

i. That the prescriber did not make a good faith effort to submit a complete request, or

ii. That the service or item is not medically necessary, after making a reasonable effort to consult with the prescriber. The reasonable effort to consult must be documented in writing.

i. When medication is authorized due to the PH-MCO's obligation to continue services while a Member's Grievance or Fair Hearing is pending, and the final binding decision is in favor of the PH-MCO, a request for subsequent refill of the prescribed medication does not constitute an Ongoing Medication.

j. The PH-MCO guidelines to determine medical necessity of Covered Outpatient Drugs outside the scope of the Statewide PDL cannot be more stringent than the FFS guidelines. The PH-MCO must follow the Statewide PDL Prior Authorization guidelines for drugs and products included on the Statewide PDL.

k. The PH-MCO must comply with the requirements for Prior Authorization of Services, Section V. B. 1. and Exhibit H, Prior Authorization Guidelines for Participating Managed Care Organizations in the HealthChoices Program, and receive written approval from the Department prior to implementation and annually thereafter.

5. Provider and Member Notification

The PH-MCO must have policies and procedures for notification to Providers and Members of changes to the Statewide PDL or MCO Formulary used by the PH-MCO for drugs and products outside the scope of the Statewide PDL, Prior Authorization requirements and other requirements for Covered Outpatient Drugs such as, but not limited to, specialty program requirements.

a. Written notification for changes to requirements must be provided to all affected Providers and Members at least thirty (30) days prior to the effective date of the change.

b. The PH-MCO must provide all other Providers and Members written notification of changes to the requirements upon request.

c. The PH-MCO also must generally notify Providers and Members of changes through Member and Provider newsletters, its web site, or other regularly published media of general distribution.

d. Member notices must be submitted to the Department for review and approval

prior to mailing.

6. PH-MCO Pharmacy & Therapeutics (P&T) Committee

a. The P&T Committee membership must include physicians, including a minimum of two (2) behavioral health physicians, pharmacists, MA program consumers and other appropriate clinicians. MA program consumer representative membership must include the following:

   i. One (1) physical health consumer representative. The physical health consumer representative must be a consumer enrolled in the PH-MCO, or a physician, a pharmacist, or a physical health consumer advocate designated by consumers enrolled in the PH-MCO to represent them.

   ii. One (1) behavioral health consumer representative. The behavioral health consumer representative must be a consumer enrolled in the PH-MCO, or a physician, a pharmacist, a behavioral health consumer advocate, or a family member designated by consumers enrolled in the PH-MCO to represent them.

b. The PH-MCO must submit a P&T Committee membership list for Department review and approval upon request.

c. When the P&T Committee addresses specific drugs or entire drug classes requiring medical expertise beyond the P&T Committee membership, specialists with knowledge appropriate to the drug(s) or class of drugs being addressed must be added as non-voting, ad hoc members.

d. The minutes from each PH-MCO P&T Committee meeting must be posted for public view on the PH-MCO's website within thirty (30) days of the date of the meeting at which the minutes are approved. Minutes will include vote totals.

7. Pharmacy Provider Network

a. The PH-MCO or Subcontractor must contract on an equal basis with any pharmacy qualified to participate in the MA Program that is willing to comply with the PH-MCO's payment rates and terms and to adhere to quality standards established by the PH-MCO as required by 62 P.S. 449.

   i. The provisions for any willing pharmacy apply if the PH-MCO or Subcontractor enters into agreements with specific pharmacies to provide defined drugs or services such as but not limited to, specialty, mail order, and 90-day supplies. PH-MCOs are required to contract on an equal basis with any pharmacy qualified to participate in the MA program that is willing to accept the same payment rate(s) and comply with the same terms and conditions for quality standards and reporting.

ii. Subcontracts and agreements with specific pharmacies contracted to provide defined drugs or services must be submitted to the Department for advance written approval. Any changes to subcontracts or agreements must also be submitted to the Department for advance written approval.

iii. The PH-MCO must submit annually the list of specific pharmacies contracted to provide defined drugs or services, and a list of the drugs or services each pharmacy is contracted to provide, to the Department for review and written approval. Submissions for annual reviews must occur at least thirty (30) days before the effective date of the updated information.

iv. The PH-MCO must notify the Department on an ongoing basis of the following: (1) specific pharmacies that are no longer contracted to provide defined drugs or services and the reason why, (2) pharmacies that request contracting to provide defined drugs or services but are not admitted into the specific pharmacy network and the reason why, (3) any pharmacies that are only contracted to provide a limited scope of defined drugs or services and the reason why.

b. The PH-MCO must develop, implement, and maintain a process that ensures the amount paid to all network pharmacies reflects the pharmacy's acquisition cost, professional services and cost to dispense the prescription to a Medicaid beneficiary. The PH-MCO must submit to the Department the policies and procedures for development of network pharmacy payment methodology including the process to ensure that brand and generic payment rates reflect the pharmacy's acquisition cost (from a readily available distributor doing business in Pennsylvania) and the professional dispensing fee accurately reflects the pharmacist's professional services and cost to dispense the prescription to a Medicaid beneficiary.

c. The PH-MCO or subcontractor must submit to the Department for review and approval all changes to the payment methodology prior to implementation.

d. The PH-MCO or subcontractor must report all changes to the payment methodology and rates, including but not limited to the maximum allowable cost rates, to network pharmacy providers.

e. If a network pharmacy's claim is approved through the adjudication process, the PH-MCO and any subcontractor will not retroactively deny or modify the reimbursement unless the claim was fraudulent, the network pharmacy was reimbursed for the claim previously, or the services reimbursed were not rendered by the network pharmacy.

f. The PH-MCO and any subcontractor will not charge a fee related to a network pharmacy's claim unless the amount of the fee is disclosed and applied at the time of claim adjudication.

8. Drug Rebate Program

Under the provisions of Section 1927 of the Social Security Act 42 U.S.C.A. 1396r-8, drug companies that wish to have their products covered through the

MA Program (both FFS and managed care) must sign an agreement with the federal government to provide rebates to the State. The Affordable Care Act (ACA) provides for federal drug rebates for drugs paid for by the PH-MCOs.

a. In order to ensure full compliance with the provisions of the ACA, PH-MCOs must report the necessary Outpatient Drug Encounter Data in order for the Department to invoice drug manufacturers for rebates for all Covered Outpatient Drugs. This includes physician-administered drugs, drugs dispensed by 340B covered entities or contract Pharmacies, and drugs dispensed to PH-MCO Members with private or public pharmacy coverage and the PH-MCO provided secondary coverage.

b. The PH-MCO must report all outpatient drug information, including National Drug Codes (NDCs) and accurate NDC units for all drug claim types, NCPDP, 837 Professional, 837 Institutional, etc. as designated by the Department.

If the PH-MCO fails to submit Outpatient Drug Encounter Data when invoiced to manufacturers for rebate, at least 90% are collectable within 90 calendar days of invoicing by the Commonwealth a sanction of $25,000 per quarter shall be imposed until the PH-MCO reaches the 90% threshold.

The PH-MCO or subcontractor may not negotiate rebates and discounts for Covered Outpatient Drugs. The PH-MCO or subcontractor may not negotiate its own rebates and discounts for non-drug products included on the Statewide PDL. If the PH-MCO negotiates and collects its own rebates and discounts for non-drug products that are not included on the Statewide PDL, the PH-MCO must report to the Department the full value of the rebates and discounts in a format designated by the Department. If the PH-MCO assigns responsibility for negotiating and/or collecting the rebates and discounts for non-drug products not included on the Statewide PDL to a subcontractor, the subcontractor–must pass the full value of all rebates and discounts on drugs dispensed to the PH-MCO's Members back to the PH-MCO. The subcontractor may not retain any portion of the rebates or discounts. The PH-MCO must report the full value of all the rebates and discounts to the Department in a format designated by the Department.

The PH-MCO or subcontractor may negotiate outcomes-based contracts for Covered Outpatient Drugs. The PH-MCO must submit the contract to DHS for review and approval prior to implementation and report to the Department the full value of the financial impact of the outcomes-based contract in a format designated by the Department.

9. Outpatient Drug Encounters

a. The PH-MCO shall submit all Outpatient Drug Encounters to the Department within 30 days (for NCPDP) and 90 days (for 837P and 837I) of the adjudication date of the claim to the MCO for payment.

b. The PH-MCO shall provide all Outpatient Drug Encounter data and supporting information as specified by the Department to collect rebates through the

Medicaid Drug Rebate Program and the Statewide PDL. For all Outpatient Drug Encounter data including pharmacy point-of-sale (NCPDP), physician-administered drugs (837P), outpatient hospital drugs (837I), and drugs dispensed by 340B covered entities and contract pharmacies, the following data elements are required:

i. Valid NDC for the drug dispensed.

- The PH-MCO shall also include the HCPCS code associated with the NDC for all 837P and 837I encounters where payment was made by the MCO based on the HCPCS code and HCPCS code units.

- The PH-MCO shall also include the diagnosis codes associated with the NDC for all 837P and 837I encounters where payment was made by the PH-MCO based on the HCPCS code and HCPCS code units.

ii. Valid NDC units for the drug dispensed

- The PH-MCO shall also include the HCPCS units associated with the NDC for all 837P and 837I encounters where payment was made by the PH-MCO based on the HCPCS code and HCPCS code units.

iii. Actual paid amount by the PH-MCO, or the PH-MCO's PBM, to the provider for the drug dispensed.

iv. Actual TPL amount paid by the Member's primary pharmacy coverage to the provider for the drug dispensed.

v. Actual copayment paid by the Member to the provider for the drug dispensed.

vi. Actual dispensing fee paid by the PH-MCO, or the PH-MCO's PBM, to the provider for the drug dispensed.

vii. The billing provider's:

- NPI and/or Medical Assistance Identification Number

- Full address and phone number associated with the NPI

viii. The prescribing provider's:

- NPI and/or Medical Assistance Identification Number

- Full address and phone number associated with the NPI

ix. The date of service for the dispensing of the drug by the billing provider.

x. The date of payment by the PH-MCO, or the PH-MCO's PBM, to the provider for the drug.

xi. Any other data elements identified by the Department to invoice for drug rebates.

c. The PH-MCO shall edit and validate claim transaction submissions and Outpatient Drug Encounter data for completeness and accuracy in accordance with claim standards such as NCPDP. The actual paid amount by the PH-MCO, or the PH-MCO's PBM, to the dispensing provider must be accurately submitted on each Outpatient Drug Encounter to the Department.

d. The PH-MCO shall ensure that the NDC on all Outpatient Drug Encounters is appropriate for the HCPCS code based on the NDC and units billed. The NDC must represent a drug that was available to the prescriber in an outpatient setting for administration.

e. The Department will review the Outpatient Drug Encounters and remove applicable 340B covered entity encounters from the drug rebate invoicing process.

f. The PH-MCO shall meet Outpatient Drug Encounter Data accuracy requirements by submitting PH-MCO paid Outpatient Drug Encounters with no more than a 3% error rate, calculated for a month's worth of Encounter submissions. The Department will monitor the PH-MCO's corrections to denied Encounters by random sampling performed quarterly and over the term of this Agreement. The PH-MCO shall have corrected and resubmitted 75% of the denied Encounters for services covered under this Agreement included in the random sample within 30 calendar days of denial.

g. If the PH-MCO fails to submit Outpatient Drug Encounter data within timeframes specified, the Department shall assess civil monetary penalties upon the PH-MCO. These penalties shall be $2,000 for each calendar day that the Outpatient Drug Encounter data is not submitted. The Department may waive these sanctions if it is determined that the PH-MCO was not at fault for the late submission of the data.

10. Prospective Drug Utilization Review (Pro-DUR)

a. The PH-MCO must provide for a review of drug therapy before each prescription is filled or delivered to a Member at the point-of-sale or point-of-distribution. The review shall include screening for potential drug therapy problems due to therapeutic duplication, drug-disease contraindications, drug-drug interactions, incorrect drug dosage or duration of drug treatment, drug-allergy interactions and clinical abuse/misuse.

b. The PH-MCO must provide for counseling of Members receiving benefits from pharmacists in accordance with State Board of Pharmacy requirements.

11. Retrospective Drug Utilization Review (Retro-DUR)

a. The PH-MCO must, through its drug claims processing and information retrieval system, examine claims data and other records to identify patterns of fraud, abuse, gross overuse, or inappropriate or medically unnecessary care among physicians, pharmacists and Members.

b. The PH-MCO shall, on an ongoing basis, assess data on drug use against explicit predetermined standards (using nationally recognized compendia and peer reviewed medical literature) including but not limited to monitoring for therapeutic appropriateness, overutilization and underutilization, appropriate use of generic products, therapeutic duplication, drug-disease contraindications, drug-drug interactions, incorrect drug dosage or duration of drug treatment, and clinical abuse/misuse and, as necessary, introduce remedial strategies, in order to improve the quality of care.

c. The PH-MCO shall provide for active and ongoing educational outreach programs to educate practitioners on common drug therapy problems aimed at improving prescribing or dispensing practices.

12. Annual Drug Utilization Review (DUR) Report

The PH-MCO must submit an annual report on the operation of its Pennsylvania Medicaid Drug Utilization Review (DUR) program in a format designated by the Department. The format of the report will include a description of the nature and scope of the prospective and retrospective drug use review programs, a summary of the interventions used, an assessment of the impact of these educational interventions on quality of care, and an estimate of the cost savings generated as a result of the DUR program.

13. Drug Utilization Review Board (DUR Board)

The Department maintains a DUR Board that reflects the structure of the health care delivery model that includes both a managed care and a fee-for-service delivery system. Each PH-MCO and BH-MCO is required to include a representative to serve as a member of the DUR Board. The DUR Board is a standing advisory committee that recommends the application of predetermined standards related to Pro-DUR, Retro-DUR, and related administrative and educational interventions designed to protect the health and safety of the MA program recipients. The Board reviews and evaluates pharmacy claims data and prescribing practices for efficacy, safety, and quality against predetermined standards using nationally recognized drug compendia and peer reviewed medical literature as a source. The Board recommends appropriate utilization controls and protocols including prior authorization, automated prior authorization, system edits, guidelines to determine medical necessity, generic substitution, and quantity limits

for individual medications or for therapeutic categories.

14. Pharmacy Benefit Manager (PBM)

The PH-MCO may use a PBM to process prescription Claims only if the PBM Subcontract complies with the provisions in Section XII: Subcontractural Relationships, and has received advance written approval by the Department. The standards for Network composition and adequacy for outpatient drug services includes the requirements for any willing pharmacy as described above. The PH-MCO must indicate the intent to use a PBM, and identify the proposed PBM Subcontract, the PH-MCO's payment methodology or methodologies (ingredient cost and dispensing fee) for payment to the PBM Subcontractor, the PBM's payment methodology or methodologies (ingredient cost and dispensing fee) for actual payment to the providers of covered outpatient drugs, and the ownership of the proposed PBM subcontractor. If the PBM is owned wholly, in part, or by the same parent company as a PH-MCO, retail pharmacy Provider, chain drug store or pharmaceutical manufacturer, the PH-MCO must submit a written description of the assurances and procedures that will be put in place under the proposed PBM Subcontract, such as an independent audit, to assure confidentiality of proprietary information. These assurances and procedures must be submitted and receive advance written approval by the Department prior to initiating the PBM Subcontract. The Department will allow the continued operation of existing PBM Subcontracts while the Department is reviewing new contracts.

The PH-MCO must:

a. Report the PBM's payment methodology, or methodologies for actual payment to all network pharmacy providers of covered outpatient drugs, including community pharmacies, long-term care pharmacies, network pharmacies contracted to provide specialty drugs, and dispensing prescribers for existing PBM Subcontractors and new PBM Subcontractors.

b. Include on each outpatient drug encounter the PBM received amount (amount paid to the PBM by the PH-MCO [ingredient cost and dispensing fee]) and the provider received amount (the actual amount paid by the PBM [ingredient cost and dispensing fee] to the dispensing pharmacy or prescribing provider).

c. Report differences between the amount paid by the PH-MCO to the PBM and the amount paid by the PBM to the providers of covered outpatient drugs as administrative fees.

d. Report all PBM administrative fees, including the differences in amounts paid as described in d. above, in a format designated by the Department.

e. Submit a written description of the procedures that the PH-MCO will put in place to monitor the PBM for compliance with the term and conditions of the Agreement related to covered outpatient drugs and actual payments to the providers of covered outpatient drugs.

f. Upon request by the Department, conduct an independent audit of the PBM's transparent pricing arrangement in compliance with the provision in Exhibit WW HealthChoices Audit Clause.

g. Ensure that the PBM is fully compliant with the requirements in Section V. K. Provider Dispute Resolution System.

h. Develop, implement, and maintain a Second Level PBM Provider Pricing Dispute Resolution Process that provides for settlement of a PBM network Provider's pricing dispute with the PBM, on the condition that the PBM's network Provider exhausted all of its remedies against the PBM.

i. Submit to the Department, prior to implementation, the PH-MCO's policies and procedures relating to the resolution of PBM Provider pricing disputes.

    i. The PH-MCO must submit any changes to the policies and procedures to the Department for approval prior to implementation of the changes.

    ii. The PH-MCO's submission of new or revised policies and procedures for review and approval by the Department shall not act to void any existing policies and procedures that have been prior approved by the Department for operation in a HC Zone. Unless otherwise required by law, the PH-MCO may continue to operate under such existing policies and procedures until the Department approves the new or revised version.

j. At a minimum, include in the PH-MCO's Second Level PBM Provider Pricing Dispute Resolution policies and procedures the following:

    i. The process for submission and settlement of Second Level PBM Provider Pricing Disputes;

    ii. A requirement that the PBM Provider must exhaust all of its remedies against the PBM before requesting a PH-MCO Second Level PBM Provider Pricing Dispute Resolution;

    iii. Acceptance and usage of the Department's definition/delineation of Provider Disputes;

    iv. Timeframes for submission and resolution of Second Level PBM Provider Pricing Disputes;

    v. Processes to ensure equal treatment of all PBM providers in the resolution of pricing disputes.

    vi. Process to ensure the paid amount reflects the pharmacy's drug acquisition cost, professional services, and cost to dispense the prescription to an MA beneficiary.

vii. A requirement for both the PBM Provider and the PBM to provide documentation supporting each entity's position(s) related to the pricing dispute;

viii. Designation of PH-MCO staff responsible for resolution of the PBM Provider Pricing Dispute who have:

- The knowledge and expertise to address and resolve PBM Provider Pricing Disputes;
- Access to data and documentation of the informal resolution of the PBM Provider Dispute and the formal PBM Provider Appeal and decisions necessary to assist in making decisions; and

ix. Mechanisms and time-frames for reporting PH-MCO PBM Provider Pricing Dispute decisions to the PBM Provider, the PBM and the Department. If the dispute is denied by the PH-MCO, the Provider Pricing Dispute decisions must include the specific rationale for the denial;

k. Require the PBM and the PBM provider to abide by the final decision of the PH-MCO. If the Provider Pricing Dispute is overturned by the PH-MCO, adjustment must be made to the appealed claim and to future claims for the appealed drug. The PBM/PH-MCO must update their payment methodology for the appealed drug; and

l. Require the PBM to inform all PBM providers of the process and conditions to request a Second Level PBM Provider Pricing Dispute.

15. Requirements For PH-MCO and BH-MCO Interaction and Coordination of Outpatient Drug Services

a. BH-MCO prescribing Providers must comply with the PH-MCO requirements for utilization management of outpatient behavioral health drugs.

b. The BH-MCO will be required to issue an initial list of BH-MCO Providers to the PH-MCO, and quarterly updates that include additions and terminations. Should the PH-MCO receive a request to dispense medication prescribed by a BH Provider not listed on the BH-MCO's Provider file, the PH-MCO must work through the appropriate BH-MCO to identify the Provider. The PH-MCO is prohibited from denying prescribed medications solely on the basis that the BH-MCO Provider is not clearly identified on the BH-MCO Provider file.

c. Payment for inpatient pharmaceuticals during a BH admission is the responsibility of the BH-MCO and is included in the hospital charge.

d. The PH-MCO may deny payment of a claim for a Covered Outpatient Drug prescribed by a BH-MCO Provider only if one of the following occurs:

   i. The drug is not being prescribed for the treatment of substance abuse/dependency/ addiction or mental illness and any side effects of psychopharmacological agents. Those drugs are to be prescribed by the PH-MCO's PCP or specialists in the Member's PH-MCO Network.

   ii. The prescription has been identified as a case of Fraud, Abuse, or gross overuse, or the dispensing pharmacist determined that taking the medication either alone or along with other medications that the Member may be taking, would jeopardize the health and safety of the Member.

e. The PH-MCO must receive written approval from the Department of the policies and procedures for the PH-MCO and BH-MCO to:

   i. When deemed advisable, require consultation between practitioners before prescribing medication, and sharing complete, up-to-date medication records.

   ii. Timely resolve disputes which arise from the payment for or use of drugs, including a mechanism for timely, impartial mediation when resolution between the PH-MCO and BH-MCO does not occur.

   iii. Share independently developed Quality Management/Utilization Management information related to outpatient drug services, as applicable.

   iv. Collaborate in adhering to a drug utilization review program approved by the Department. Collaborate in identifying and reducing the frequency of patterns of Fraud, Abuse, gross overuse, inappropriate or medically unnecessary care among physicians, pharmacists and Members associated with specific drugs.

f. The PH-MCO must send data files, via the Department's file transfer protocol (FTP), containing records of detailed outpatient drug services as provided to individual enrollees of the BH-MCOs contracted with the Department. The PH-MCO must adhere to the file delivery schedule established at the implementation of the data exchange process or notify the Department in advance of schedule changes. Files must be sent directly to the Department for distribution by the Department.

EXHIBIT CCC

PHYSICAL HEALTH MCO (PH-MCO) PROVIDER AGREEMENTS

The PH-MCO is required to have written Provider Agreements with a sufficient number of Providers to ensure Member access to all Medically Necessary services covered by the HealthChoices Program. The PH-MCO is also required to ensure that its participating providers are enrolled in Medical Assistance, and to require that their information is kept up to date in the DHS PROMISe™ system.

The PH-MCO's Provider Agreements must include the following provisions:

a. A requirement that the PH-MCO must not exclude or terminate a Provider from participation in the PH-MCO's Provider Network due to the fact that the Provider has a practice that includes a substantial number of patients with expensive medical conditions.

b. A requirement that the PH-MCO must not exclude a Provider from the PH-MCO's Provider Network because the Provider advocated on behalf of a Member for Medically Necessary and appropriate health care consistent with the degree of learning and skill ordinarily possessed by a reputable Health Care Provider practicing according to the applicable legal standard of care.

c. A provision that prohibits the Provider from denying services to a Member during the MA FFS eligibility window prior to the effective date of the PH-MCO Enrollment.

d. Notification of the prohibition and sanctions for submission of false Claims and statements.

e. The definition of Medically Necessary as defined in Section II of this Agreement, Definitions.

f. A requirement that the PH-MCO cannot prohibit or restrict a Health Care Provider acting within the lawful scope of practice from discussing Medically Necessary care and advising or advocating appropriate medical care with or on behalf of a Member including; information regarding the nature of treatment options; risks of treatment; alternative treatments; or the availability of alternative therapies, consultation or tests that may be self-administered.

g. A requirement that the PH-MCO cannot prohibit or restrict a Health Care Provider acting within the lawful scope of practice from providing information the Member needs in order to decide among all relevant treatment options and the risks, benefits, and consequences of treatment or nontreatment.

h. A requirement that the PH-MCO cannot terminate a contract or employment with a Health Care Provider for filing a Grievance on a Member's behalf.

i. A clause which specifies that the agreement will not be construed as requiring the PH-MCO to provide, reimburse for, or provide coverage of, a counseling or referral service if the Provider objects to the provision of such services on moral or religious grounds.

j. A requirement securing cooperation with the QM/UM Program standards outlined in Exhibit M(1) of this Agreement, Quality Management and Utilization Management Program Requirements.

k. A requirement for cooperation for the submission of Encounter Data for all services provided within the time frames required in Section VIII of this Agreement, Reporting Requirements, no matter whether reimbursement for these services is made by the PH-MCO either directly or indirectly through capitation.

l. A continuation of benefits provision which states that the Provider agrees that in the event of the PH-MCO's insolvency or other cessation of operations, the Provider must continue to provide benefits to the PH-MCO's Members, including Members in an inpatient setting, through the period for which the Capitation has been paid.

m. A requirement that the PCPs who serve Members under the age of twenty-one (21) are responsible for conducting all EPSDT screens for individuals on their panel under the age of twenty-one (21). Should the PCP be unable to conduct the necessary EPSDT screens, the PCP is responsible for arranging to have the necessary EPSDT screens conducted by another Network Provider and ensure that all relevant medical information, including the results of the EPSDT screens, are incorporated into the Member's PCP medical record. For details on access requirements, see Exhibit AAA of this Agreement, Provider Network Composition/Service Access, as applicable.

n. A requirement that PCPs who serve Members under the age of twenty-one (21) report Encounter Data associated with EPSDT screens, using a format approved by the Department, to the PH-MCO within ninety (90) days from the date of service.

o. A requirement that PCPs contact new Members identified in the quarterly Encounter lists who have not had an Encounter during the first six (6) months of Enrollment, or who have not complied with the scheduling requirements outlined in the RFP and this Agreement. The PH-MCO must require the PCP to contact Members identified in the quarterly Encounter lists as not complying with EPSDT periodicity and immunization schedules for children. The PCP must be required to identify to the PH-MCO any such Members who have not come into compliance with the EPSDT periodicity and immunization schedules within one (1) month of such notification to the site by the PH-MCO. The PCP must also be

required to document the reasons for noncompliance, where possible, and to document its efforts to bring the Member's care into compliance with the standards. PCPs shall be required to contact all Members who have not had an Encounter during the previous twelve (12) months or within the time frames set forth in Exhibit AAA of this Agreement, Appointment Standards, as applicable, to arrange appointments.

p. A requirement that the PH-MCO include in all capitated Provider Agreements a clause which requires that should the Provider terminate its agreement with the PH-MCO, for any reason, that the Provider provide services to the Members assigned to the Provider under the contract up to the end of the month in which the effective date of termination falls.

q. A requirement that ensures each physician providing services to Members eligible for Medical Assistance under the State Plan to have a unique identifier in accordance with the system established under section 1173(b) of the Social Security Act.

r. Language which requires the Provider to disclose annually any Physician Incentive Plan or risk arrangements it may have with physicians either within its group practice or other physicians not associated with the group practice even if there is no Substantial Financial Risk between the PH-MCO and the physician or physician group.

s. A requirement for cooperation with the PH-MCO's and DHS's Recipient Restriction Program.

t. A requirement that health care facilities and ambulatory surgical facilities develop and implement, in accordance with P.L.154, No. 13 known as the Medical Care Availability and Reduction of Error (Mcare) Act, an internal infection control plan that is established for the purpose of improving the health and safety of patients and health care workers and includes effective measures for the detection, control and prevention of Health Care-Associated Infections.

u. A provision that the PH-MCO's Utilization Management (UM) Departments are mandated by the Department to monitor the progress of a member's inpatient hospital stay. This must be accomplished by the PH-MCO's UM department receiving appropriate clinical information from the hospital that details the member's admission information, progress to date, and any pertinent data within two (2) business days from the time of admission. The PH-MCOs providers must agree to the PH-MCO's UM Department's monitoring of the appropriateness of a continued inpatient stay beyond approved days according to established criteria, under the direction of the PH-MCO's Medical Director. As part of the concurrent review process and in order for the UM Department to coordinate the discharge plan and assist in arranging additional services, special diagnostics, home care and durable medical equipment, the PH-MCO must receive all clinical information

on the inpatient stay in a timely manner which allows for decision and appropriate management of care.

v. Requirements regarding coordination with Behavioral Health Providers (if applicable):

- Comply with all applicable laws and regulations pertaining to the confidentiality of Member medical records, including obtaining any required written member consents to disclose confidential medical records.

- Make referrals for social, vocational, education or human services when a need for such service is identified through assessment.

- Provide health records if requested by the Behavioral Health Provider.

- Notify BH Provider of all prescriptions, and when deemed advisable, check with BH Provider before prescribing medication. Make certain BH clinicians have complete, up-to-date record of medications.

- Be available to the BH Provider on a timely basis for consultations.

w. The PH-MCO must require that participating ER staff and physicians know the procedures for reporting suspected abuse and neglect in addition to performing exams for the county.

x. The PH-MCO must require that each provider furnishing services to members maintains and shares, as appropriate, a member health record in accordance with professional standards.

The PH-MCO may not enter into a Provider Agreement that prohibits the Provider from contracting with another PH-MCO or that prohibits or penalizes the PH-MCO for contracting with other Providers.

The PH-MCO must make all necessary revisions to its Provider Agreements to be in compliance with the requirements set forth in this section. Revisions may be completed as Provider Agreements become due for renewal provided that all Provider Agreements are amended within one (1) year of the effective date of this Agreement with the exception of the Encounter Data requirements which must be amended immediately, if necessary, to ensure that all Providers are submitting Encounter Data to the PH-MCO within the time frames specified in Section VIII.B.1 of this Agreement, Encounter Data Reporting.

Exhibit DDD

PATIENT CENTERED MEDICAL HOME (PCMH) PROGRAM

The PCMH model of care includes key components such as: whole person focus on behavioral health and physical health, comprehensive focus on wellness as well as acute and chronic conditions, increased access to care, improved quality of care, team-based approach to care management/coordination, and use of electronic health records (EHR) and health information technology to track and improve care.

The PH-MCO will contract with high volume providers in their network who meet the requirements of a PCMH, make payments to their contracted PCMHs, collect quality related data from the PCMHs, reward PCMHs with quality-based enhanced payments, develop a learning network that includes PCMHs and other PH-MCOs, and report annually on the clinical and financial outcomes of their PCMH program.

A. The PH-MCO will educate members what the PCMH model is and inform members of the resources available through the PCMH.

B. The PH-MCO will ensure the PCMH provider meets the following requirements:

   1. Will be a high-volume Medicaid practice already participating in the PH-MCO provider pay for performance program or a defined set of practices willing to share care management resources,

   2. Will accept all new patients or be open for face-to-face visits at least 45 hours per week,

   3. Will have already received a payment in the Medicaid or Medicare electronic health record meaningful use program,

   4. Will join a Pennsylvania Patient and Provider Network (P3N) certified health information organization (HIO) by 12/31/2020 in order to share health related data,

   5. Will deploy a community-based care management team as described below,

      The PCMH must deploy a community-based care management (CBCM) team that consists of licensed professionals such as nurses, pharmacists or social workers and unlicensed professionals such as peer recovery specialists, peer specialists, community health workers or medical assistants. The CBCM team's activities can replicate but not duplicate already existing and CBCM reimbursed care management services. The care management team will work within their local community to accept individuals with complex care needs from local emergency departments, physical and behavioral health hospitals, specialty providers, and PH-MCO. Through actively engaging patients and taking into

account their preferences and personal health goals, the CBCM team will develop care plans that help individuals with complex chronic conditions to stay engaged in comprehensive treatment regimens that include, but are not limited to physical health, substance use disorder and mental health treatments. The CBCM team will also connect individuals as needed to community resources and social support services through “warm hand off” referrals for assistance with problems such as food insecurity and housing instability.

6. Will collect and report annual quality data and outcomes pertinent to their patient population as defined by the current PH-MCO provider pay for performance program, the Integrated Care Plan pay for performance program, and additional population specific measures defined by the Department,

7. Will conduct internal clinical quality data reviews on a quarterly basis, report results and discuss improvement strategies with the PH-MCO,

8. Will measure patient satisfaction using a validated low literacy appropriate tool to assess individual and family/caregiver experience,

9. Will include as part of the health care team patient advocates or family members to support the patients’ health goals and advise practices,

10. Will see 75% of patients within seven days of discharge from the hospital with an ambulatory sensitive condition,

11. Will participate in a PCMH learning network,

12. Will complete a Social Determinants of Health assessment, at least annually and more frequent for patients who screen positive, using a Nationally recognized tool focusing on the following domains: education, literacy and language; employment; housing security; economic hardships (resources and materials); social health; psychosocial and stress; experiences with crime, violence and judicial system; safety and domestic violence; and family and social support issues and submit ICD-10 diagnostic codes for all patients with identified needs. For patients with identified needs, the PCMH must assist the member with obtaining the needed services and monitor the outcome of the referral The PCMH must track referrals and outcomes and be able to submit to the PH-MCO and Department a report as requested, and

13. Will educate and disclose to patients through low-literacy appropriate material the practice is a PCMH that has a community-based care management team available to help patients manage complex care needs.

C. The PH-MCO will make monthly payments to each PCMH based on factors such as: clinical complexity, age, medical costs, and composition of the care management team.

D. The PH-MCO's PCMH network will include high volume adult and pediatric providers that serve the percentage of total membership and percentage of members that fall within the top 5th percentile of medical costs.

- Calendar year 2020 – PCMHs' must serve at least 20% of their total membership and at least 33% of members that fall within the top 5th percentile of medical costs.

E. The PH-MCO will collect key quality metrics from the PCMHs and report those results annually to the Department.

F. The PH-MCO will reward PCMHs with quality-based enhanced payments focusing on key performance measures defined by the Department. Current provider pay for performance dollars may be used for these quality-based payments.

G. The PH-MCO will develop a quarterly regional learning network that includes all PCMHs, patient advocates or family team members, and PH-MCOs in a HealthChoices region. At least one of the PCMH Learning Collaboratives needs to be face-to-face.

H. The PH-MCO will report annually on the clinical and financial outcomes of their PCMH program. The report will address key quality, utilization, and financial outcomes as well as a return on investment calculation. The report will also describe the number of PCMHs that have gain share arrangements, risk arrangements, payments made for quality, and payments made for gain share or risk arrangements. The report will also list the total medical costs of the patients attributed to the PCMHs.

I. Data Sharing

The PH-MCO must provide timely and actionable data to its PCMHs. This data should include, but is not limited to, the following:

1. Identification of high risk patients;

2. Comprehensive care gaps inclusive of gaps related to quality metrics used in the value-based payment arrangement; and

3. Service utilization and claims data across clinical areas such as inpatient admissions, outpatient facility (SPU/ASC), emergency department, radiology services, lab services, durable medical equipment and supplies, specialty physician services, home health services, and prescriptions.

J. The PH-MCO must work towards developing a value-based arrangement with Person-Centered Ambulatory Intensive Care Centers (PC-AICCs) in each zone they operate, unless the PH-MCO demonstrates to OMAP's satisfaction that the PH-MCO is not able to reach an agreement with the PC-AICC. A PC-AICC is a practice that provide comprehensive physical and behavioral health care to those individuals who are high cost and in high need of medical and social services. These practices serve individuals who demonstrate non-episodic impactable medical costs over $30,000 and are typically the costliest 2 - 3% of individuals who account for up to 40% of the PH-MCOs medical spend.