COMMONWEALTH OF PENNSYLVANIA
DEPARTMENT OF HUMAN SERVICES

OFFICE OF DEVELOPMENTAL PROGRAMS
BUREAU OF SUPPORT FOR AUTISM AND SPECIAL POPULATIONS

AGREEMENT for the
ADULT COMMUNITY AUTISM PROGRAM
(ACAP)

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This Agreement is entered into between the Commonwealth of Pennsylvania Department of Human Services (hereinafter the Department), and Keystone Autism Services, a wholly owned subsidiary of Keystone Human Services, Inc. (hereinafter the Contractor), with a principal place of business located at 4391 Sturbridge Drive, Harrisburg, Pennsylvania 17110 and is effective July 1, 2023.

WHEREAS, the Pennsylvania Medical Assistance Program is authorized by Title XIX of the Social Security Act, 42 U.S.C.A. §§ 1396 - 1396v, and the Human Services Code, 62 P.S. §§ 101 - 1503, to provide payment for medical services to persons eligible for Medical Assistance; and

WHEREAS, federal regulations at 42 CFR Chapter 438 authorize delivery of Medical Assistance services through a Prepaid Inpatient Health Plan (PIHP); and

WHEREAS, the Department has determined to develop a PIHP for delivery of a comprehensive set of services to Medical Assistance recipients twenty-one (21) years of age or older with Autism Spectrum Disorder (ASD) focused on the unique needs of this population; and

WHEREAS, the Department has determined that the Contractor understands the needs of Medical Assistance recipients twenty-one (21) years of age or older with ASD and can provide or arrange for services and coordinate and manage the services provided to this population;

NOW, THEREFORE, in consideration of the mutual promises contained herein and intending to be legally bound, the Contractor and the Department hereby agree as follows:

ARTICLE I: DEFINITIONS

As used in this Agreement, each of the following terms shall have the specified meanings unless the context clearly indicates otherwise.

1.1 Abuse shall mean a practice that is inconsistent with sound fiscal, business, or medical practices, and results in an unnecessary cost to the Medical Assistance Program, or in reimbursement for services that are not Medically Necessary or that fail to meet professionally recognized standards for health care.

1.2 ACAP shall mean the Adult Community Autism Program.

1.3 Advance Directive shall mean a written instruction such as a living will or a health care power of attorney, which either allows another individual to make health care decisions for a Participant or expresses a Participant's wishes and instructions for health care and health care directions when the Participant is determined to be incompetent and has an end-stage medical condition or is permanently unconscious.

1.4 Applicant shall mean a person seeking enrollment in ACAP.

1.5 Authorized Services shall mean the Covered Services the Contractor has approved for payment.

1.6 Autism Spectrum Disorder (ASD) shall mean a condition determined by a licensed psychologist, licensed physician, licensed physician's assistant, or certified registered nurse practitioner (CRNP), based on the most recent criteria in the Diagnostic and Statistical Manual of Mental Disorders (DSM) applicable at the time of diagnosis.

1.7 Auxiliary Aids and Services shall mean qualified interpreters on-site or through video remote interpreting services, as defined in 28 CFR § 35.104 and § 36.303(b); note takers; real-time computer-aided transcription services; written materials; exchange of written notes; telephone handset amplifiers; assistive listening devices; assistive listening systems; telephones compatible with hearing aids; closed caption decoders; open and closed captioning, including real-time captioning; voice, text, and video-based telecommunication products and systems, text telephones (TTYs), videophones, and captioned telephones, or equally effective telecommunications devices; videotext displays; accessible electronic and information technology; or other effective methods of making aurally delivered information available to Participants who are deaf or hard of hearing; qualified readers; taped texts; audio recordings; Braille materials and displays; screen reader software; magnification software; optical readers; secondary auditory programs; large print materials; accessible electronic and information technology; or other effective methods of making visually delivered materials available to Participants who are blind or have low vision; and other similar services.

1.8 Aversive Conditioning shall mean the use of startling, painful or noxious stimuli with the intent to eliminate or reduce an undesired behavior.

1.9 BSASP shall mean the Bureau of Supports for Autism and Special Populations.

1.10 Capitation Services shall mean those services listed in Section 2.1 of this Agreement, including in lieu of services, for which the Contractor receives a Capitation Payment from the Department.

1.11 Capitation Payment shall mean the monthly payment issued to the Contractor by the Department on behalf of each Participant, based on the actuarially sound Capitation Rate for the provision of Capitation Services. In return for the payment, the Contractor accepts risk for providing Capitation Services and the responsibility for fulfilling the terms of this Agreement. The Department makes the payment regardless of whether the particular Participant receives services during the period covered by the payment.

1.12 Capitation Rate shall mean the rates, established by the Department, at which the Capitation Payment is made.

1.13 Chemical Restraint shall mean the use of a drug for the specific and exclusive purpose of controlling acute or episodic aggressive behavior. Chemical Restraint does not include a drug ordered by a health care practitioner or dentist for the following use or event: treatment of the symptoms of a specific mental, emotional or behavioral condition; pretreatment prior to a medical or dental examination or treatment; an ongoing program of medication; a specific, time-limited stressful event or situation to assist a Participant to control the Participant's behavior.

1.14 CMS shall mean the Centers for Medicare & Medicaid Services of the United States Department of Health and Human Services.

1.15 Complaint shall mean a dispute or objection regarding a Network Provider or the coverage, operations, or management of the Contractor, which has not been resolved by the Contractor and has been filed with the Contractor, including but not limited to:

A. a denial because the requested service or item is not a Covered Service;

B. the failure of the Contractor to meet the required time frames for providing a service or item;

C. the failure of the Contractor to decide a Complaint or Grievance within the specified time frames;

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

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

F. a denial of a Participant's request to dispute a financial liability, including cost sharing, copayments, premiums, deductibles, coinsurance, and other Participant financial liabilities; or

G. the decision to involuntarily disenroll the Participant from the Plan.

The term does not include a Grievance.

1.16 Contingency Plan shall mean a strategy developed by the Contractor to ensure that Authorized Services are delivered in the amount, frequency, and duration as specified in the Participant's Individual Support Plan (ISP).

1.17 Covered Services shall mean Capitation Services and those services that the Contractor has opted to provide as specified in Section 2.3.B.

1.18 Durable Medical Equipment (DME) shall mean a medical item or device that can withstand repeated use and is generally not useful to a person in the absence of illness or injury and is appropriate for home use.

1.19 Emergency Medical Condition shall mean an injury or illness that due to the severity, a reasonable person with no medical training would feel that there is an immediate risk to a person's life or long-term health.

1.20 Emergency Services shall mean services needed to treat or evaluate an Emergency Medical Condition.

1.21 Federally Qualified Health Clinic (FQHC) shall mean an entity which is receiving a grant as defined under the Social Security Act, 42 U.S.C. § 1396d(1), or is receiving funding from such a grant under a contract with the recipient of such a grant and meets the requirements to receive a grant under 42 U.S.C. § 1396d(1).

1.22 Fraud shall mean an intentional deception or misrepresentation made by a person with the knowledge that the deception could result in some unauthorized benefit to the person or some other person. It includes any act that constitutes fraud under applicable federal or state law.

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

A. deny, in whole or in part, payment for a service or item;

B. 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;

C. reduce, suspend, or terminate a previously Authorized Service or Item; and

D. deny the requested service or item but approve an alternative service or item.

The term does not include a Complaint.

1.24 Hospice Services shall mean home or inpatient care providing treatment for terminally ill Participants to manage pain and physical symptoms and provide supportive care to their families.

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

1.26 Individual Support Plan (ISP) shall mean a plan developed by the Participant's Team that specifies the services a Participant will receive, the reason(s) those services are needed, and the goals and objectives of the services.

1.27 Initial ISP shall mean the ISP developed for an eligible Applicant prior to the Applicant's enrollment in the Plan.

1.28 Institution for Mental Diseases (IMD) shall mean a hospital, nursing facility, or other institution of more than sixteen (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.

1.29 Life Sharing Home shall mean the private home of an individual or family in which residential care is provided that is licensed under 55 Pa. Code Chapter 6500 (Life Sharing Homes)

1.30 Long-term Services and Supports (LTSS) shall mean services and supports provided to a Participant who has a functional limitation and/or chronic illness that has the primary purpose of supporting the ability of the Participant to live or work in the setting of his or her choice, which may include the Participant's home, a worksite, a Provider-owned or controlled residential setting, a nursing facility, or other institutional setting.

1.31 Mechanical Restraint shall mean a device that restricts the movement or function of a Participant or portion of a Participant's body. Mechanical Restraint includes a geriatric chair, a bedrail that restricts the movement or function of the individual, handcuffs, anklets, wristlets, camisole, helmet with fasteners, muffs and mitts with fasteners, restraint vest, waist strap, head strap, restraint board, restraining sheet, chest restraint and other similar devices. Mechanical Restraint does not include the use of a seat belt during movement or transportation or a device prescribed by a health care practitioner for post-surgical or wound care use, to assist with balance or support; or for protection from injury during a seizure or other medical condition.

1.32 Medical Assistance shall mean the Medical Assistance Program administered by the Department as authorized by Title XIX of the Social Security Act, 42 U.S.C. §§ 1396 - 1396v, and the Human Services Code, 62 P.S. §§ 101 - 1503, and regulations promulgated thereunder.

1.33 Medical Loss Ratio (MLR) shall mean the percent of the Capitation Payment the Contractor spends on claims and expenses that improve health care quality.

1.34 Medically Necessary shall mean a service, item, procedure, or level of care that is compensable under the Medical Assistance Program and meets any one of the following standards:

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

B. 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.

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

D. The service, item, procedure, or level of care will provide the opportunity for a Participant receiving LTSS to have access to the benefits of community living, to achieve person-centered goals, and live and work in the setting of the Participant's choice.

1.35 Medication Therapeutic Management Plan shall mean a plan that is developed with input from a Doctor of Pharmacy that outlines how drug therapy will be optimized to improve the Participant's Outcomes.

1.36 Network shall mean the providers, facilities, and suppliers that have a written agreement with the Contractor to provide Covered Services to Participants.

1.37 Network Provider shall mean a Medical Assistance enrolled Provider that has a written Network Provider agreement and participates in the Contractor's Network to serve Participants.

1.38 Non-Capitation Services shall mean Covered Services that are not included in the Capitation Payment and which the Contractor is not required to provide.

1.39 Outcomes shall mean changes in the Participant's health, functional status, satisfaction or goal achievement that result from Covered Services or other services the Participant receives.

1.40 Out-of-Network Provider shall mean a Provider that does not have a signed Network Provider agreement with the Contractor and does not participate in the Contractor's Network but provides services to a Participant.

1.41 Participant shall mean a person who is enrolled in ACAP.

1.42 Physical Restraint shall mean a manual method that restricts, immobilizes or reduces a Participant's ability to move the Participant's arms, legs, head or other body parts freely. Physical Restraint does not include verbal redirection, physical prompts, escorting and guiding a Participant.

1.43 Plan shall mean the program through which the Contractor provides or arranges for the delivery of ACAP services as required by this Agreement.

1.44 Post-Stabilization Care Services shall mean Covered Services related to an Emergency Medical Condition or crisis intervention that are provided after a Participant is stabilized in order to maintain the stabilized condition, or to improve or resolve the Participant's condition.

1.45 Prevalent Non-English Language shall mean a non-English language spoken by five percent (5%) or more of the individuals living in the Service Area who may be eligible to enroll in ACAP.

1.46 Primary Care Provider (PCP) shall mean a physician, CRNP, or physician assistant who is responsible for coordinating a Participant's health care needs and initiating and monitoring referrals for specialized medical services when required.

1.47 Provider shall mean a person, firm, or corporation that may or may not be a member of the Network but has an agreement with the Contractor to deliver services to a Participant.

1.48 Readily Accessible shall mean electronic information and services which comply with modern accessibility standards such as Section 508 guidelines issued by the U.S. Access Board, Section 504 of the Rehabilitation Act, and W3C's Web Content Accessibility Guidelines (WCAG) 2.0 AA and successor versions.

1.49 Restrictive Procedure shall mean any practice that limits a Participant's movement, activity or function, interferes with a Participant's ability to acquire positive reinforcement, results in the loss of objects or activities that a Participant values, or requires a Participant to engage in a behavior that the Participant would not engage in given freedom of choice.

1.50 Rural shall mean territory, persons, and housing units in places which are designated as having less than 2,500 persons, as defined by the U.S. Census Bureau.

1.51 Seclusion shall mean the involuntary confinement of a Participant alone in a room or an area from which the Participant is physically prevented from having contact with others or leaving.

1.52 Service Area shall mean the geographic area as established by the Department within which a Participant must reside in order to participate in the Plan.

1.53 Specialist shall mean a physician or a CRNP who limits his or her practice to the study and treatment of one class of diseases or to treatment of specific parts of the body.

1.54 State-Funded Residential Habilitation Subsidy shall mean state-funded-only payment for costs related to room and board for Participants receiving Residential Habilitation Services.

1.55 Urban shall mean territory, persons, and housing units in places which are designated as having 2,500 persons or more, as defined by the U.S. Census Bureau. These places must be in close geographic proximity to one another.

ARTICLE II: SERVICE PROVISION

2.1 Functions and Duties of the Contractor

The Contractor shall:

A. Provide or arrange for the delivery of all Authorized Services to each Participant for the term of the Participant's enrollment.

B. Conduct assessments using the instruments and at the frequency specified by the Department, including the assessments identified in Appendix A.

C. Maintain a record for each Participant and require its Network Providers to maintain a record for each Participant.

1. The record maintained by each Network Provider must document all care provided and comply with the requirements specified in the Department's Medical Assistance regulations that are appropriate to the standard of care for that Provider.

2. The Contractor's record for each Participant must include, at a minimum, the following:

a. Identification of the Participant on each page

b. Identifying demographic information

c. A complete medical history

d. The Participant's complaints accompanied by the Contractor's findings

e. A preliminary working diagnosis as well as a final diagnosis based on the Participant's history and

examination

f. Documentation of all services provided, including documentation of the medical necessity of a rendered, ordered, or prescribed service

g. Multi-disciplinary assessments, reassessments, plans of care, treatment and progress notes

h. Drugs prescribed as part of the treatment, including the quantities and dosage, and if the prescription was telephoned to a pharmacist

i. Lab reports, including interpretations of diagnostic tests and reports of consultations

j. Hospital discharge records

k. Reports from the Contractor and Providers

l. Contacts with informal supports (Participant's family, friends, church, etc.)

m. The Participant's signed Enrollment Agreement, which includes a statement that the Participant or, if appropriate, the Participant's representative, received the Participant Handbook and the Participant Handbook was reviewed with the Participant or, if appropriate, the Participant’s representative

n. Physician orders

o. The Participant’s ISP, including if developed for the Participant, the Behavioral Support Plan, the Crisis Intervention Plan and the Restrictive Procedure Plan, and the Contingency Plan for each service in the ISP, and all updates and revisions to the ISP and Contingency Plan

p. The Participant’s Skill Building Plan, if developed for the Participant, and all updates and revisions to the Skill Building Plan

q. The Participant’s Medication Therapeutic Management Plan, if developed for the Participant, and all updates and revisions to the Medication Therapeutic Management Plan

r. The Participant’s Restrictive Procedure Plan, the

signatures of the members of the Human Rights Team that approved the Restrictive Procedure Plan, and a record of each use of a Restrictive Procedure that includes the following (when applicable for non-physical Restrictive Procedures, i.e., medication box, money safe):

i. Documentation of the specific behavior addressed through the use of the Restrictive Procedure;

ii. The method or procedure of Restrictive Procedure used;

iii. The date and time the Restrictive Procedure was used;

iv. The staff person who used the Restrictive Procedure;

v. The duration of the Restrictive Procedure; and

vi. The Participant's condition during and following the removal of the Restrictive Procedure.

s. The disposition of the case

3. The record shall be legible throughout and entries shall be signed and dated by the responsible Network Provider. Care rendered by ancillary personnel shall be countersigned by the responsible Network Provider. Alterations of the record shall be signed and dated.

D. Maintain an after-hours call-in system to provide prompt and easy access, twenty-four (24) hours per day, seven (7) days per week, three-hundred sixty-five (365) days per year, to Covered Services when Medically Necessary.

E. Ensure that a physician and Behavioral Specialist are on call to provide prompt, professional consultation to Participants twenty-four (24) hours per day, seven (7) days per week, three hundred sixty-five (365) days per year.

F. Provide prompt access to Supports Coordination services using Contractor's staff and to all other services using either Contractor's staff or Providers.

G. Demonstrate to the Department, and provide supporting documentation, that it has the capacity to serve the expected enrollment in the Service Area in accordance with the requirements in this Agreement by:

1. Maintaining an updated list of all Network Provider subcontracts that includes the Network Provider's name, address, phone number, services provided under the subcontract, subcontract expiration date, and whether or not the subcontract is automatically renewable.

2. Submitting a list of all subcontracts with Network Providers to the Department at the time the Contractor enters into this Agreement and annually thereafter.

3. Submitting an updated list of Network Provider subcontracts within two days of the Contractor's knowledge of a significant change that would affect capacity and services.

4. Submitting a list of all entities not enrolled in the Medical Assistance Program with which the Contractor has an agreement to provide services annually.

H. Require Network Providers to offer hours of operation that are no less than the hours of operation offered to commercial patients or comparable to the hours offered for individuals who receive Medical Assistance services in the Fee-for-Service delivery system, if the Network Provider serves only Medical Assistance patients.

I. Ensure that every Participant has an assigned PCP. Unless it would be to the Participant's benefit, the PCP must participate in the Contractor's Network. The assigned PCP may be a Specialist if the needs of a Participant warrant or if the Participant is an Indian, as defined by 42 CFR § 438.14(a), and the Participant wants to receive services from an IHCP PCP, the PCP may be an IHCP. The Contractor must offer each Participant a choice of at least two (2) PCPs. If a Participant fails to choose a PCP within fourteen (14) days of enrollment in the Plan, the Contractor must assign a PCP to the Participant. In assigning PCPs, the Contractor must consider current Provider-Participant relationships, special medical needs, area of residence, language and other needs, and access to transportation. The Contractor must have written procedures and policies for allowing the Participant to change his or her PCP. These procedures must receive advance written approval from BSASP.

J. Respond, report, and follow up on all incidents as specified in Appendix B.

K. Assign a Team to each Participant, which is responsible for assessment, service planning, care delivery and managing delivery of services, quality of services, and continuity of care.

1. The Team shall include at a minimum:

a. The Participant and the Participant's guardian, if the Participant has a guardian, and his or her family consistent with the Participant's or guardian's wishes

b. A Supports Coordinator

c. A Behavioral Health Practitioner

Other disciplines that must be available to the Team include individuals who are involved in the Participant's diagnosis or treatment, or who are responsible for the initiation, provision, coordination, or evaluation of care and services provided to the Participant. BSASP must also be allowed to participate in Team meetings if BSASP has notified the Contractor that it wants to participate in the Team meetings. Team members shall not change except as necessary to meet the needs of the Participant.

2. The Team is responsible for developing a draft of the Initial ISP within thirty (30) days of being notified that BSASP has approved the Contractor's recommendation to approve an Applicant's enrollment in the Plan. The time frame for developing the Initial ISP may be extended for circumstances beyond the Contractor's control with prior approval from BSASP. Prior to the date of the Applicant's enrollment in the Plan, the Initial ISP must be approved in the Department's Home and Community Services Information System (HCSis).

3. The ISP must be consistent with and support the assessed needs of the Participant and may include a Behavioral Support Plan and a Crisis Intervention Plan (as detailed in Appendix C).

4. The ISP must be reviewed at least every three (3) months to determine if it includes appropriate services based upon the Participant's needs and progress towards goals. The ISP must also be reviewed after an episode that triggers implementation of a Crisis Intervention Plan or the use of a Restrictive Procedure or Physical Restraint to determine if the ISP is accurate and includes appropriate services and to determine if changes in services are needed as a result of the implementation of the Crisis Intervention Plan or the use of a Restrictive Procedure or Physical Restraint. All changes to the ISP must be entered into HCSis.

5. The ISP must be updated based on the reassessed needs of the Participant at least annually or sooner if a Participant's needs change or if a Participant requests that the ISP be revised. Monitoring and annual reassessments must address the

Participant's progress toward more inclusive and less restrictive services than were provided the previous year. Annual updates to the ISP, including new service authorizations, must be completed in HCSis prior to the start of each new annual plan year, as determined by the anniversary of the Participant's enrollment in ACAP.

6. The assessments identified in Appendix A and other assessments specified by the Department must be conducted to inform the development of the ISP and any updates of the ISP. A Behavioral Specialist or a Behavioral Health Practitioner must complete the assessments prior to the Team meeting to develop or update the ISP and must complete the section of the ISP regarding the Participant's desired goals and health status during the ISP Team meeting. A summary of the findings from and the scores of each assessment used to develop and update the ISP must be entered into HCSis or the appropriate data system as identified by BSASP.

7. The Team must use a person-centered planning process to develop and update the ISP. The person-centered planning process must:

    a. Be led by the Participant where possible;

    b. Provide necessary information and support to ensure that the Participant directs the process to the maximum extent possible, and is enabled to make informed choices and decisions;

    c. Be timely and occur at times and locations of convenience to the Participant;

    d. Reflect cultural considerations of the Participant;

    e. Include strategies for solving conflict or disagreement within the process, including clear conflict-of-interest guidelines for the Participant's ISP Team;

    f. Understand the Participant's needs and desires in the present and future;

    g. Identify the services and other supports the Participant will need to meet his or her needs and desires and offer the Participant choices regarding the services and supports the Participant receives and who provides the services and supports the Participant receives; and

    h. Determine what steps need to be taken to meet the

Participant's needs and desires.

8. The ISP must include the Covered Services agreed to by the Team, and any other services and informal supports that complement the Covered Services that will be furnished to or coordinated for the Participant; which services the Contractor will pay for, the projected amount, frequency, and duration of services; the justification for each service; and appropriate, applicable goals, objectives, and expected Outcomes for each authorized service, including the linked goals, objectives, and expected Outcomes for any in lieu of service(s). In order to be authorized, Covered Services must be Medically Necessary; meet the Participant's needs in the most inclusive, cost-effective, and least-restrictive manner appropriate for the Participant's needs; and build on the Participant's strengths to improve social skills and self-management in ways that increase independence and participation in community life. Documentation must be included in the ISP that describes the decision-making process and how the services meet this requirement.

9. The Behavioral Support Plan and the Crisis Intervention Plan must be developed by either a Behavioral Health Practitioner or a Behavioral Specialist and be based on a functional behavioral assessment conducted in accordance with BSASP Functional Behavioral Assessment Training.

10. If a Participant is on medication and a member of the Team or BSASP recommends that a Medication Therapeutic Management Plan be developed, or a Participant is prescribed four (4) or more psychotropic medications, a Medication Therapeutic Management Plan must be developed with the input of a Doctor of Pharmacy.

11. The Skill Building Plan must be developed by the Skill Building Specialist and be based on the Participant’s goals.

12. A copy of the Initial ISP and all subsequent updates to the ISP must be provided to all Team members. A copy of the Participant’s ISP must be provided to all new team members assigned to provide services to the Participant prior to the delivery of those services. Copies of the updated ISP must be provided to all Team members at the same time the Contractor notifies the Participant or the Participant’s representative, as appropriate, of a decision to approve a change in services.

L. Develop and implement procedures to coordinate the Authorized Services provided to a Participant between settings of care, including appropriate discharge planning for short term and long-term

hospital and institutional stays, and with services he or she receives outside of the Plan and inform all Providers and the Department as necessary of the Participant's needs as identified by the Contractor and the Authorized Services delivered to the Participant to prevent duplication of activities. The procedures must ensure that each Provider furnishing services to Participants maintains and shares, as appropriate, the Participant's record in accordance with professional standards and each Participant's privacy is protected in accordance with the privacy requirements in 45 CFR parts 160 and 164 subparts A and E, to the extent that they are applicable.

M. Ensure that the Authorized Services are sufficient in amount, duration, and scope to reasonably achieve the purpose for which the services are furnished.

N. Ensure that Authorized Services are delivered promptly and consistent with the needs of the Participant and ensure that PCP and Specialist visits are scheduled in a timely manner and comply with additional standards for timeliness for delivery of services by Network Providers if CMS determines that the standards will promote the objectives of the Medicaid program for a provider type to be subject to a timeliness standard. Urgent medical or behavioral condition cases must be scheduled by the Contractor with the PCP or the Behavioral Specialist to take place within twenty-four (24) hours of the request for an appointment and with other Specialists, including OB/GYNs and Specialists who provide LTSS, to take place within twenty-four (24) hours of referral. Routine appointments must be scheduled by the Contractor with the PCP to take place within seven (7) days of the request for an appointment and with the Specialist, including OB/GYNs and Specialists who provide LTSS, to take place within seven (7) days of referral. Unless the Participant had a complete physical examination within three (3) months before enrolling in the Plan and the Team agrees that an examination is unnecessary, a general physical examination, including a vision test, must be conducted by the PCP within three (3) weeks of enrollment and annually thereafter. The annual physical examination must be completed within 380 calendar days of the date of the last physical examination (i.e. annual physical examinations must be completed no later than 11:59 pm on the 380th day from the previous examination date).

O. If the Contractor cannot directly or through Network Providers provide a Medically Necessary Covered Service to a Participant, the Contractor must provide or arrange for the provision of the service out of network for as long as the Contractor is unable to provide the service, without additional cost to the Participant. If the Participant is an Indian, as defined by 42 CFR § 438.14(a), the Out-of-Network Provider may be an IHCP. The Contractor must allow an Out-of-Network IHCP to refer a Participant who is an Indian to a Network Provider. The Contractor must enter into a written agreement with each Out-of-Network

Provider.

P. Develop and maintain policies and procedures regarding ongoing Participant education. The policies and procedures must be submitted to the Department within fifteen (15) days of the date the Contractor receives the Department's request to review the policies and procedures. Participant education must include the following topics:

1. Capitation Services and other Covered Services, including crisis intervention services, how to access services, and the need to obtain such services from Providers approved by the Contractor;

2. Services that require a referral and how to obtain a referral;

3. Complaint, Grievance, and Fair Hearing procedures;

4. Use of the after-hours call-in system;

5. Self-management of medical problems and behavioral problems;

6. Disease prevention;

7. Participant rights and responsibilities, as specified in Section 4.2.D; and

8. Written information on Advance Directives, as specified in Section 2.5.L.

Q. Provide the following Capitation Services in an amount, duration, and scope that is no less than the amount, duration, and scope of services provided to Medical Assistance recipients who receive their services through the Fee-for-Service system:

1. Physical and Behavioral Health Services:

   a) All physician services (including Emergency Services provided by a physician, psychiatric services, and direct access to a women's health Specialist to provide women's routine and preventative health care services, which is in addition to the Participant's PCP if the PCP is not a women's health Specialist)
   b) Audiologists' services
   c) CRNP services
   d) Chiropractors' services
   e) Dentists' services
   f) Health promotion and disease prevention services
   g) Hospice Services

h) Intermediate Care Facility (ICF) services
i) Medical supplies and DME
j) Mental health crisis intervention services
k) Non-emergency medical transportation to services covered under the Medical Assistance Program
l) Nursing facility services
m) Optometrists' services
n) Outpatient psychiatric clinic services
o) Podiatrists' services
p) Prosthetic eyes and other eye appliances
q) Respiratory services
r) Targeted Case Management

2. Long-Term Services and Supports:

a) Assistive Technology
b) Career Planning
   - Job Finding
   - Vocational Assessment
c) Community Transition Services
d) Day Habilitation
e) Family Support
f) Homemaker/Chore Services
g) Home Modifications
h) Non-medical Transportation
i) Nutritional Consultation
j) Personal Assistance Services
k) Residential Habilitation Services
l) Respite
m) Small Group Employment
n) Supported Employment Services
o) Supports Coordination
p) Specialized Skill Development
   - Behavioral Specialist Services
   - Systematic Skill Building
   - Community Support
q) Therapies: physical/mobility, occupational, speech/language, and counseling (group and individual)
r) Vehicle Modifications
s) Visiting Nurses Services

These services are defined in the Department's regulations or in Appendix D.

R. Provide alternative services to the services listed in Section 2.1.Q if they are cost effective alternative services and programs as in lieu of services. The Contractor may not require the Participant to receive in lieu of services.

In lieu of services must be approved by the Department. The Department will update the list of approved in lieu of services that will be taken into account in developing the Capitation Rate as needed.

The approved in lieu of services include the following categories of services:

1. Safety services (e.g. GPS Tracker)
2. Health and wellness services (e.g. gym/pool memberships, Weight Watchers memberships, personal trainers, air conditioner, air purifier)
3. Other therapy services (e.g. music therapy, equestrian therapy, art therapy)
4. Community participation/enrichment services (e.g. bowling fees, movie tickets, music/instrument/art lessons, swimming lessons)
5. Medical supply services (e.g. medical supplies that are not Assistive Technology or Medical Supplies and DME)

S. Provide LTSS in accordance with 42 CFR § 441.301(c)(4), which outlines allowable setting for home and community-based waiver services.

T. Provide or arrange for the provision of all Medically Necessary counseling or referral services, unless the Contractor objects to the service on moral or religious grounds.

If the Contractor objects to providing or arranging for the provision of counseling or referral services on moral or religious grounds, it must inform the Department of its objection prior to signing the Agreement and inform Applicants prior to enrollment that it does not provide or arrange for the provision of counseling or referral services to which it objects.

If the Contractor determines during the term of this Agreement that it objects to providing or arranging for the provision of counseling or referral services on moral or religious grounds, it must so inform the Department sixty (60) days and all Participants thirty (30) days prior to adopting the policy of not providing or arranging for the provision of counseling or referral services.

U. Provide the Participant with the opportunity to seek a second opinion from a qualified health care professional within the Network, if available, and if not available, arrange for the Participant to obtain a second opinion from a qualified health care professional outside of the Network, at no cost to the Participant.

V. Establish performance standards and incorporate them in the Contractor's policies and procedures. The performance standards

must be based on the Protocol described in Section 2.5.D and applicable licensing and certification criteria for the services provided by the Contractor and its Providers.

W. Ensure that the Contractor's staff and Network Providers:

1. Demonstrate competence to deliver the services they are to provide to a Participant;

2. Are appropriately trained and oriented to work with persons with ASD and co-occurring diagnoses prior to contact with Participants. Training and orientation include at a minimum: provider training developed by the Department (see Appendix E), CPR, and crisis prevention and intervention including training on Seclusion, Aversive Conditioning, Restrictive Intervention, and Restraint consistent with the requirements in Section 2.2.

X. Pay for Emergency Services that are Covered Services obtained within or outside the Network whether or not pre-approved by the Contractor, until the attending physician or other provider treating the Participant determines that the Participant is sufficiently stabilized for transfer or discharge.

The Contractor may not do the following:

1. Limit what constitutes an Emergency Medical Condition based exclusively on diagnosis or symptoms.

2. Hold a Participant who has an Emergency Medical Condition liable for payment for services needed to diagnosis the specific condition or stabilize the Participant.

3. Deny payment for Emergency Services that are Covered Services to a Participant who presented with what appeared to be an Emergency Medical Condition but was ultimately determined not to be, including cases in which the absence of immediate medical attention would not have placed the health of the Participant (or with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy, serious impairment of bodily functions, or serious dysfunction of any bodily organ or part.

4. Deny payment for Emergency Services that are Covered Services to a Participant whom a Contractor's representative instructed to seek Emergency Services.

5. Refuse to cover Emergency Services based on the emergency room provider, hospital, or fiscal agent not notifying the

Participant's PCP or Contractor of the Participant's screening and treatment within ten (10) days of presentation for Emergency Services.

The Contractor consistent with the provisions of 42 U.S.C. § 1396u2(b)(2)(D), will limit the amount to be paid to non-Network Providers of Emergency Services to no more than the amount that would have been paid for such services under the Department's Fee-for-Service Program.

Y. Pay for Post-Stabilization Care Services obtained within or outside the Network whether or not pre-approved by the Contractor, and charge a Participant no more for Post-Stabilization Care Services delivered by an Out-of-Network Provider than what the Contractor would charge the Participant if the Participant had obtained the services through the Contractor, if:

1. The Contractor does not respond to a request for pre-approval of Post-Stabilization Care Services within one hour of receiving the request; or

2. The Contractor cannot be contacted; or

3. The Contractor's representative and the treating physician cannot reach agreement concerning the Participant's care, and the Contractor's physician is not available for consultation, until the Contractor's physician is reached; or:

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

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

   c. The Contractor's representative and the treating physician reach agreement concerning the Participant's care; or

   d. The Participant is discharged.

Z. Establish practice guidelines to govern the authorization and delivery of services, which are based on valid and reliable clinical evidence or a consensus of professionals in the particular field, consider the needs of the Participants, are adopted in consultation with contracting health care professionals, and are reviewed and updated periodically as appropriate. Practice guidelines must be approved by the Department before being implemented. Guidelines must be shared with all affected Network Providers and, upon request, with

Participants and Applicants. Decisions regarding utilization management; Participant education; coverage of services; information provided to the Participant and, if appropriate, the Participant's representative concerning the Participant's diagnosis and treatment options; and other areas to which the guidelines apply must be consistent with the guidelines. The practice guidelines are to be reviewed and updated every two years or when requested by the Department.

AA. Ensure that the care and services required under this Agreement are provided and administered in accordance with accepted medical or behavioral health practices and professional standards.

BB. Establish, implement, and maintain documented emergency preparedness procedures to manage natural disasters in the Service Area. These procedures must include initial and ongoing training for Contractor staff, Network Providers, and Participants on what to do, where to go, and whom to contact in case of a natural disaster to ensure Participant safety and continuity of care.

CC. Provide advance notice to the Department, no later than ten (10) days prior to any action by the Contractor that will impact the Contractor's ability to provide services, including changes in the Network, services, benefits, Service Area, payment rates, or enrollment of a new population in the Plan. The notice must include a transition plan for all affected Participants.

DD. Maintain policies and procedures which address responsibility for scheduling and facilitating Team meetings; handling and resolving Team conflicts; and how Team members will be kept informed of the Participant's behavioral and health status. The policies and procedures must ensure effective communication, input, and interaction among members of the Team and Network Providers to continuously monitor and take appropriate corrective action concerning the Participant's health status, psycho-social condition, and effectiveness of the ISP, through observation, direct provision of services, and informal observation, including input from the Participant and persons who interact with the Participant on a regular basis.

EE. Not prohibit or otherwise restrict a health care professional acting within the lawful scope of practice from advising or advocating on behalf of a Participant who is his or her patient for the following:

1. The Participant's health status, medical care, behavioral health care, or treatment options, including any alternative treatment that may be self-administered.

2. Any information the Participant needs in order to decide

among available treatment and service options.

3. The risks, benefits, and consequences of treatment or services and non-treatment or non-receipt of services.

4. The Participant's right to participate in decisions regarding his or her health care, including the right to refuse treatment, and to express preferences about future treatment decisions.

FF. Participate in the Department's efforts to promote the delivery of services in a culturally competent manner that meets the unique needs of all Participants, including those with limited English proficiency, diverse cultural and ethnic backgrounds, disabilities, and regardless of gender, sexual orientation or gender identity.

GG. Notify BSASP and the appropriate County Assistance Office (CAO), in accordance with current Departmental procedures, when a Participant enters an IMD, ICF or nursing facility, and when the Participant returns to the community.

HH. Reserved.

II. If a Participant is admitted to an IMD, monitor the Participant's status and update BSASP at least weekly or more often as requested by BSASP and work with IMD staff and BSASP to develop a discharge plan if the Participant will continue to be enrolled in ACAP after discharge.

JJ. Notify the CAO upon a Participant's death or disenrollment.

KK. Notify BSASP upon a Participant's death, change in residence, or upon receipt of any information about changes in a Participant's circumstances that may affect the Participant's eligibility for ACAP.

LL. Not pay Network Providers for any provider-preventable condition that is identified in the State plan or identified below; has been found by the Department, 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; or includes at a minimum the 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.

Provider-preventable conditions include the following:

1. Foreign object retained after surgery
2. Air embolism

3. Blood incompatibility
4. Stage III and Stage IV pressure ulcers
5. Falls and trauma
    a. Fractures
    b. Dislocations
    c. Intracranial injuries
    d. Crushing injuries
    e. Burns
    f. Other injuries
6. Manifestations of poor glycemic control
    a. Diabetic ketoacidosis
    b. Nonketotic hyperosmolar coma
    c. Hypoglycemia coma
    d. Secondary diabetes with ketoacidosis
    e. Secondary diabetes with hyperosmolarity
7. Catheter-associated urinary tract infection
8. Vascular catheter-associated infection
9. Surgical site infection following:
    a. Coronary artery bypass graft – mediastinitis
    b. Bariatric surgery
        i. Laparoscopic gastric bypass
        ii. Gastroenterostomy
        iii. Laparoscopic gastric restrictive surgery
    c. Orthopedic procedures
        i. Spine
        ii. Neck
        iii. Shoulder
        iv. Elbow
    d. Cardiac implantable electronic device
    e. Iatrogenic Pneumothorax with Venous Catheterization
10. Deep Vein Thrombosis/Pulmonary Embolism
    a. Total knee replacement
    b. Hip replacement
11. Iatrogenic pneumothorax with venous catheterization.

MM. Develop and provide detailed information for a Contingency Plan for each Authorized Service a Provider renders that is included in the Participant's ISP and develop a written protocol to ensure successful implementation of each Contingency Plan. The written protocol must contain information that:

1. Assures and verifies that Authorized Services are being provided at the frequency and duration established by the Participant's ISP.

2. Verifies that Authorized Services are provided during changes in staffing patterns.

A Participant's Contingency Plan must be implemented when a

Participant is available for the Authorized Service to be delivered and an event occurs which requires the Provider to implement the Contingency Plan so the service continues to be rendered as specified in the approved ISP. Failure to implement the Contingency Plan when a Participant is available to receive services will result in an incident report of provider neglect as specified in ODP Bulletin #6000-04-01, *Incident Management.*

NN. Notify the Department if it has been accredited by a private independent accrediting entity and provide the Department a copy of its most recent accreditation review.

OO. Use the Goal Attainment Scaling (GAS) to develop, track, and report progress on goals and objectives as a result of Covered Services. The GAS must be developed by a Behavioral Health Practitioner, a Behavioral Specialist, or a Skill Building Specialist consistent with the training the Behavioral Health Practitioner, the Behavioral Specialist, or the Skill Building Specialist has received on the GAS. The Behavioral Health Practitioner, the Behavioral Specialist, or the Skill Building Specialist must develop GAS charts and reports on progress utilizing the GAS format for the following:

1. Day Habilitation
2. Residential Habilitation Services*
3. Small Group Employment
4. Specialized Skill Development: Behavioral Specialist Services (direct and consult)
5. Specialized Skill Development: Systematic Skill Building (direct and consult) – also responsible for the development of GAS charts for all goals linked to the selected service and Systematic Skill Building
6. Specialized Skill Development: Community Supports*
7. Supported Employment Services: Extended Employment Services*
8. Supported Employment Services: Intensive Job Coaching*

*For the selected services, corresponding GAS charts for all goals linked to the selected service and Systematic Skill Building are developed by the Systematic Skill Building service.

PP. Comply with the Department's requirements concerning the use of an Electronic Visit Verification (EVV) system for personal care services and home health care services, which includes developing and implementing procedures for verifying the type of service provided, the Participant receiving the service, the individual providing the service, the date of the service, the location of the service, and the time services begin and end.

QQ. Comply with the Department's requirements concerning the

implementation and maintenance of a secure, standards-based Patient Access application programming interface (API) that allows Participants to access their claims and encounter information through third-party applications of their choice.

RR. Comply with the Department's requirements to make provider directory information publicly available through a Fast Healthcare Interoperability Resources (FHIR) application programming interface.

SS. Establish, implement, and maintain written policies and procedures for oversight and expectations for monitoring conducted by Supports Coordinators.

2.2 Restrictive Procedures, Restraint, Seclusion, and Aversive Conditioning

A. The Contractor shall develop Restrictive Intervention, Restraint, Seclusion, and Aversive Conditioning policies and procedures as specified in this Section.

B. The Contractor shall ensure that its staff and Providers do not use Seclusion for any reason.

C. The Contractor shall ensure that its staff and Network Providers do not use Chemical Restraints for any reason.

D. The Contractor shall ensure that its staff and Network Providers do not use Mechanical Restraints for any reason.

E. The Contractor shall ensure that its staff and Network Providers do not use Aversive Conditioning for any reason.

F. The Contractor shall ensure that its staff and Network Providers use a Physical Restraint only in the case of an emergency to prevent a Participant from immediate physical harm to himself or herself or from harming others; immediately release a Participant from a Physical Restraint as soon as it is determined that the Participant is no longer a threat to himself or herself or to others; continuously observe the physical and emotional condition of the Participant during use of the Physical Restraint and document the observations at least every ten (10) minutes in the Participant's record; not use a Physical Restraint for more than thirty (30) minutes within a two (2) hour period; and file an incident report any time a Physical Restraint is used as specified in Appendix B.

G. The Contractor shall ensure that its staff and Network Providers do not use a prone Physical Restraint for any reason.

H. The Contractor shall ensure that its staff and Network Providers do

not use a Physical Restraint that inhibits digestion or respiration, inflicts pain, causes embarrassment or humiliation, causes hyperextension of joints, applies pressure on the chest or joints or allows for a free fall to the floor for any reason.

I. The Contractor shall establish a Human Rights Team and ensure that any Network Provider that uses Restrictive Procedures has a Human Rights Team.

1. The Human Rights Team must include an individual who meets the qualifications of a Behavioral Specialist specified in Section 2.5.I.1.l. The individual who meets the qualifications of a Behavioral Specialist may not have developed the Behavioral Support Plan component of the ISP of the Participant whose Restrictive Procedure Plan is being reviewed.

2. The majority of the members of the Human Rights Team may not directly provide services to the Participant whose Restrictive Procedure Plan is being reviewed.

3. The Human Rights Team must retain a record of each meeting of the Human Rights Team, which includes what was discussed during the meeting and the names of the members of the Human Rights Team.

J. For any Participant for whom Restrictive Procedures may be used, a Restrictive Procedure Plan must be written by a Behavioral Health Practitioner or a Behavioral Specialist prior to the use of a Restrictive Intervention. A Restrictive Procedure Plan must include the following:

1. The specific behavior to be addressed.

2. An assessment of the behavior, including the suspected reason for the behavior.

3. The single behavioral outcome desired by the use of a Restrictive Procedure in observable or measurable terms.

4. Methods for modifying or eliminating the behavior that is being addressed by the use of a Restrictive Intervention, such as changes in the Participant's physical and social environment, changes in the Participant's routine, improving communications, teaching skills and reinforcing alternative appropriate behavior.

5. The types of Restrictive Procedures that may be used and the circumstances under which the Restrictive Procedures may be

used.

6. The amount of time a Restrictive Procedure may be applied.

7. A target date for modifying or eliminating the behavior that is being addressed by the use of a Restrictive Intervention.

8. Any physical problems the Participant may have that require special attention during the use of Restrictive Procedures.

9. The name of the Behavioral Health Practitioner or the Behavioral Specialist responsible for monitoring and documenting any changes in the Participant's behavior as a result of the use of a Restrictive Intervention.

The Contractor's Human Rights Team must review the Restrictive Procedure Plan at least every six (6) months and provide the Behavioral Health Practitioner or the Behavioral Specialist with the results of its review or the Contractor must ensure that the Network Provider's Human Rights Team reviews the Restrictive Procedure Plan at least every six (6) months and provides the Behavioral Health Practitioner or the Behavioral Specialist with the results of its review. The Restrictive Procedure Plan must be revised every six (6) months by the Behavioral Health Practitioner or the Behavioral Specialist.

K. The Contractor shall ensure that its staff and Providers do the following:

1. Try all less intrusive alternatives to anticipate or de-escalate a Participant's behavior prior to using a Restrictive Intervention.

2. Use a Restrictive Procedure only as a last resort and only when less restrictive techniques and resources appropriate to a Participant's behavior have tried and failed.

3. Consider a Participant's medical and behavioral health history prior to using a Physical Restraint or a Restrictive Intervention.

4. When a Restrictive Procedure is used, inform the Participant as early as possible in the Restrictive Procedure process what is needed for the Restrictive Procedure to end.

5. Not use a Physical Restraint or Restrictive Procedure as a punishment, for retribution, as a therapeutic technique, as discipline, as retaliation, as coercion, or for convenience.

2.3 <u>Non-Covered Services</u>

A. The Contractor is not responsible for the following:

1. Non-Capitation Services unless they are Authorized Services.

2. Services or supplies provided outside the Commonwealth of Pennsylvania, except for Emergency Services that are Covered Services.

3. Services not prescribed or recommended by a health care provider acting within the scope of his or her practice.

4. Services not included in section 2.1.Q, including family planning services.

B. The Contractor may, at its option and sole expense, provide any services or items that are not Capitation Services. Any service or item that the Contractor opts to provide under this Section must be generally available to all Participants and be authorized if Medically Necessary. Participants may not be held liable for the cost of such services.

2.4 Service Authorization

A. The Contractor may not require prior authorization for Physician, Chiropractor, CRNP, and Respiratory Care services but may require that these services require a referral from the Participant's PCP. The Contractor shall prior authorize all other Capitation Services, in accordance with the practice guidelines for authorization decisions developed as specified in Section 2.1.Z and the procedures in this Section.

B. The Contractor must develop written policies and procedures for timely resolution of requests submitted on behalf of a Participant to initiate, terminate, reduce, or continue a service, including the role of the PCP and Team, consistent application of the practice guidelines for authorization decisions developed as specified in Section 2.1.Z, and consultation with the requesting Provider when appropriate.

C. Any decision to deny a request for a service or to authorize a service in an amount, duration, or scope that is less than requested must be made by a health care professional who has the appropriate clinical expertise in treating the Participant's condition or disease and who was not involved and does not supervise a person involved in the development of the Participant's ISP, including the Crisis Intervention Plan and Behavioral Support Plan if applicable.

D. The Contractor may not structure compensation to individuals who review requests for services in a manner that provides incentives for the individual to deny, limit, or discontinue Medically Necessary

services to a Participant.

E. Each Authorized Service must be the least-restrictive, most-inclusive, and cost-effective feasible option that meets the Participant's needs.

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

G. The amount, duration, or scope of a service may not be arbitrarily denied, reduced, or terminated solely because of the diagnosis, illness, or condition of a Participant.

H. Any request to authorize care in a nursing facility or ICF setting must be submitted to BSASP for review prior to authorization on the form provided by BSASP and include the ISP. The review by BSASP will be within the time frames for authorization specified in this Section.

I. If the Contractor determines that a Participant needs Residential Habilitation Services, the Contractor prior to authorizing the services must submit the ACAP Residential Habilitation Services Request Form to BSASP along with any information or documentation needed to support the request to authorize Residential Habilitation Services. The Contractor must also provide BSASP with any documents BSASP requests as part of its review of the need for Residential Habilitation Services. BSASP will review the request to authorize Residential Habilitation Services within the time frames for authorization specified in this Section.

J. The Supports Coordinator must submit the ISP in HCSis, along with supporting documentation, to the Behavioral Health Practitioner for authorization of the services as specified in the ISP. If the Team was unable to reach a consensus on which services to include in the ISP or the amount, duration, or scope of a service to include in the ISP, the Supports Coordinator must identify which services the Team did not reach consensus on and explain the position of each Team member.

K. Following submission of the ISP in HCSis, the Behavioral Health Practitioner must, in consultation with the Medical and Clinical Directors, as appropriate, resolve any areas in the ISP on which the Team did not reach consensus and decide whether to authorize services for the Participant in accordance with the timelines outlined in Section 2.4.O.

The Behavioral Health Practitioner may:

1. Authorize services as specified on the ISP,

2. Deny one or more services or authorize a different amount, duration, or scope of one or more services in the ISP, or

3. Request additional information from the Team to support the services included in the ISP or the amount, duration, or scope of a service included in the ISP.

L. The Contractor must enter the decision to approve and authorize services into HCSis and communicate the decision in writing to the Participant or the Participant's representative, as appropriate, and the prescribing Provider, if the prescribing Provider is not a member of the Team. The Contractor must include a copy of the updated ISP along with the written notice of the decision to the Participant or the Participant's representative, as appropriate.

M. If services are not approved as requested, the Contractor must notify the Participant or the Participant's representative, as appropriate, the Participant's Supports Coordinator, and the prescribing Provider, if the prescribing Provider is not a member of the Team, of the decision using the appropriate template supplied by the Department in Appendix N.

N. The Contractor is permitted to place appropriate limits on a service for the purpose of utilization control, provided that the services supporting Participants with ongoing or chronic conditions who require long-term services and supports are authorized in such a manner that reflects the Participant's ongoing need for such services and supports.

O. Time Frames for Service Authorization:

1. Standard Service Authorizations

a. The Contractor must notify the Participant or the Participant's representative, as appropriate, of the decision to approve or deny a request for services or to authorize a service in an amount, duration, or scope less than requested as expeditiously as the Participant's condition requires, at least orally, no later than five (5) days after receiving the request for service unless additional information is needed.

b. If no additional information is needed, the Contractor must mail or hand deliver written notice of the decision to the Participant or the Participant's representative, as appropriate; the Supports Coordinator; and the

prescribing Provider, if the prescribing Provider is not a member of the Team, within two (2) business days after the decision is made.

c. If additional information is needed to make a decision, the Contractor must request such information within three (3) days of receiving the request and allow seven (7) days for submission of the additional information. If the Contractor requests additional information, the Contractor must notify the Participant or the Participant's representative, as appropriate, on the date the additional information is requested, using the template found in Appendix F.

i. If the requested information is provided within seven (7) days, the Contractor must make the decision to approve or deny the service and notify the Participant or the Participant's representative, as appropriate, of the decision orally within two (2) business days of receipt of the additional information. The Contractor must mail or hand deliver written notice of the decision to the Participant or the Participant's representative, as appropriate; the Supports Coordinator; and the prescribing Provider, if the prescribing Provider is not a member of the Team, within two (2) business days after the decision is made.

ii. If the requested information is not received within seven (7) days, the Contractor must make the decision to approve or deny the service based upon the available information and notify the Participant or the Participant's representative, as appropriate, of the decision orally within two (2) business days after the additional information was to have been received. The Contractor must mail or hand deliver written notice of the decision to the Participant or the Participant's representative, as appropriate; the Supports Coordinator; and the prescribing Provider, if the prescribing Provider is not a member of the Team, within two (2) business days after the decision is made.

2. Expedited Service Authorizations

a. If a request to authorize the services specified in the ISP includes a certification from any member of the Team that the Participant's life, health, or ability to attain, maintain, or regain maximum function would be placed

in jeopardy by following the regular authorization process, the Contractor must notify the Participant or the Participant's representative, as appropriate, of the decision to approve or deny a request for services or to authorize a service in an amount, duration, or scope less than requested as expeditiously as the Participant's condition requires, at least orally, no later than seventy-two (72) hours after receiving the request for services unless additional information is needed.

b. If no additional information is needed, the Contractor must mail or hand deliver written notice of the decision to the Participant or the Participant's representative, as appropriate; the Supports Coordinator; and the prescribing Provider, if the prescribing Provider is not a member of the Team, within two (2) business days after the decision is made.

c. If additional information is needed to make a decision, the Contractor must request such information within one (1) business day of receiving the request and allow one (1) business day for submission of the additional information.

   i. If the requested information is provided within one (1) business day, the Contractor must make the decision to approve or deny the service and notify the Participant or the Participant's representative, as appropriate, of the decision orally within one (1) business day of receipt of the additional information. The Contractor must mail or hand deliver written notice of the decision to the Participant or the Participant's representative, as appropriate; the Supports Coordinator; and the prescribing Provider, if the prescribing Provider is not a member of the Team, within two (2) business days after the decision is made.

   ii. If the requested information is not received within one (1) business day, the Contractor must make the decision to approve or deny the service based upon the available information and notify the Participant or the Participant's representative, as appropriate, of the decision orally within one (1) business day after the additional information was to have been received. The Contractor must mail or hand deliver written notice of the decision to the Participant or the Participant's representative, as appropriate; the Supports Coordinator; and the

prescribing Provider, if the prescribing Provider is not a member of the Team, within two (2) business days after the decision is made.

3. In all cases, the Contractor must make the decision to approve or deny a request for services so that the Participant or the Participant's representative, as appropriate, receives written notification of the decision no later than twenty-one (21) days from the date the Contractor received the request, or the request is deemed approved. To satisfy the twenty-one (21) day time period, the Contractor must hand deliver the notice by the twenty-first (21st) day or mail written notice to the Participant or the Participant's representative, as appropriate, on or before the eighteenth (18th) day from the date the request is received. If the notice is not hand delivered by the twenty-first (21st) day or mailed by the eighteenth (18th) day after the request is received, then the request is deemed approved.

4. If a Participant is currently receiving a requested service and the request to continue the services is denied, or a decision is made to reduce or terminate the service during the authorization period, the written notice of decision must be mailed to the Participant at least ten (10) days prior to the effective date of the decision, unless the Contractor has verified probable Participant fraud or has factual information of a circumstance described in subsection b.

   a. If the Contractor has verified probable Participant fraud, notice must be mailed at least five (5) days before the effective date of the decision.

   b. Advance notice is not required when the Contractor has factual information of the following:

      i. Confirmation of the death of the Participant;

      ii. A signed written statement from the Participant requesting service termination or giving information requiring termination or reduction of services (and the Participant understands that this will be a result of supplying that information);

      iii. The Participant's health care practitioner prescribed a change in the level of care;

      iv. The Participant has been admitted to an institution where he or she is ineligible to receive services through the Plan;

v. The Participant's whereabouts are unknown, and the post office returns Contractor mail directed to the Participant with no forwarding address; or

vi. Confirmation that the Participant has been accepted for Medicaid services by another State.

P. If the Participant or the Participant's representative does not agree with the service authorization decision, he or she may file a Complaint or Grievance and, after exhausting the Complaint or Grievance process, request a Fair Hearing, as specified in Appendix G.

2.5 Administration

A. The Contractor shall establish a Governing Body as the Contractor's policymaking body.

a. The Governing Body is responsible for planning, organizing, administering, overseeing, and evaluating the operations and performance of the Plan.

b. The Governing Body is responsible for the fiduciary obligations of the Contractor and for ensuring that the Contractor satisfies its obligations to the Department and Participants.

c. The Governing Body shall be composed of individuals with knowledge and experience appropriate to the Governing Body's functions.

d. The Contractor shall provide the Department with the names and positions of the members of the Governing Body within five (5) days of receiving a request from the Department.

B. The Contractor shall establish a Member Advisory Committee.

a. The Member Advisory Committee shall be appointed by the Governing Body.

b. The Member Advisory Committee shall include the Medical Director, a Behavioral Health Practitioner, a Participant and a family member or other representative of a Participant for each county area, Network Providers representing the scope of services provided under the Plan, and representatives from the religious, law, and ethics communities. The membership of the Member Advisory Committee shall be reevaluated annually.

c. The Member Advisory Committee will report to and advise the Governing Body and establish Committees in accordance with the terms of this Agreement on matters related to the Complaint and Grievance Processes, Quality Management and Utilization Review Processes, and Ethics.

d. The Member Advisory Committee must meet at least once every six (6) months.

C. The Service Area for this Agreement includes the counties of Cumberland, Dauphin, Lancaster, and Chester.

D. Protocol

The protocol document completed by the Contractor (see Appendix H) shall be incorporated into and become part of this Agreement.

E. Information Systems

a. The Contractor must maintain a health information system that includes all compatible computer software and required licenses for the Contractor's and the Department's use that is necessary to allow for electronic communication and transfer of information between the Contractor and the Department in the format specified by the Department. The software the Contractor purchases must allow the Contractor to collect, analyze, integrate, and report data and be able to provide information on areas including, but not limited to, utilization, claims, Complaints and Grievances, and disenrollments for reasons other than loss of Medical Assistance eligibility.

b. The Contractor shall backup all electronically stored information daily. The backup file(s) must be in a separate location apart from the primary storage site.

c. The Contractor’s health information system must be approved by the Department and be able to collect data elements necessary to enable the mechanized claims processing and information retrieval systems in operation by the Department.

F. Assignment of Contract

The Contractor may not assign any right or delegate any duty or obligation imposed by this Agreement; however, except as specified in Section 2.1.G, the Contractor may meet its obligations under this Agreement by purchasing services from other qualified providers of such services.

G. Purchase of Service Subcontracts with Providers

a. The Contractor is accountable for the satisfactory performance of its Network Providers, including compliance with the terms of this Agreement and with governing federal and state statutes and regulations, and no subcontract shall operate to terminate or mitigate the Contractor's obligations under this Agreement.

b. All subcontracts for the purchase of services provided to Participants must be in writing, fulfill the requirements of this Agreement, be appropriate to the subcontracted service or activity, and contain provisions consistent with the terms of this Agreement. Each subcontract must include, at a minimum, the following:

  a. A provision that identifies the subcontracted activities or obligations and related reporting responsibilities;

  b. A provision that requires the Network Provider to perform the subcontracted activities or obligations and related reporting responsibilities in compliance with the Contractor's obligation under the Agreement;

  c. A provision that specifies the time frames within which services must be delivered;

  d. The payment arrangement(s) between the Contractor and the Network Provider and the procedure for resolving payment disputes;

  e. A provision that prohibits the Network Provider from seeking payment from the Department for any reason, including nonpayment by the Contractor;

  f. A provision that prohibits the Network Provider from holding any Participant liable for payment for an Authorized Service for any reason, including nonpayment by the Contractor or the Department;

  g. A provision that requires the Network Provider to notify the Contractor in writing when the Network Provider has received an overpayment, including the reason for the overpayment, and return the overpayment within sixty (60) days after the date on which the overpayment was identified.

  h. A provision that requires the Network Provider to comply with the requirements of Title XIX of the Social Security Act and accompanying regulations and the Department's

regulations that govern the Medical Assistance Program;

i. A provision that requires the Network Provider to obtain all required licenses, certifications, credentials, and permits from federal, state, and local authorities and comply with all applicable state and federal statutes and regulations that pertain to Participant rights, including Title VI of the Civil Rights Act of 1964; Title IX of the Education Amendments of 1972; the Age Discrimination Act of 1975; the Rehabilitation Act of 1973; the Americans with Disabilities Act as amended; the Health Information Protection and Accountability Act; and Section 1557 of the Patient Protection and Affordable Care Act; and regulations promulgated under each statute;

j. The sanctions, including termination, that can be imposed if the Network Provider has not performed satisfactorily;

k. A provision that requires the Network Provider to maintain professional malpractice and all other types of insurance in such amounts as required by applicable laws;

l. A provision that requires the Network Provider to comply with the Adult Protective Services Act, 35 P.S. §§ 10210.101 – 10210.704, the Older Adults Protective Services Act, 35 P.S. §§ 10225.101 -10225.5102, and the regulations promulgated thereunder;

m. A provision that requires the Network Provider to maintain all books, records, and other evidence pertaining to revenues, expenditures, and other financial activity and all source records for reports submitted to the Contractor;

n. A provision that requires the Network Provider to make available to the Contractor, the Department, and other federal and state officials, upon request, all records relating to the delivery of and payment for services delivered under the subcontract; all records relating to revenues, expenditures, and other financial activity; and source records for reports submitted to the Contractor;

o. A provision that requires the Network Provider to permit the Commonwealth, CMS, the Department of Health and Human Services Inspector General, the Comptroller General, and their designees to audit, evaluate, and

inspect any books, records, contracts, computers or other electronic systems of the Network Provider or the Network Provider's subcontractor that pertain to any aspect of services and activities performed or determination of amounts payable under this Agreement through ten (10) years from the final date of this Agreement or from the date of completion of any audit, evaluation, or inspection, whichever is later;

p. A provision that requires the Network Provider to make its premises, physical facilities, equipment, books, records, contracts, computer or other electronic system relating to its Participants available to the Commonwealth, CMS, the Department of Health and Human Services Inspector General, the Comptroller General, and their designees for purposes of an audit, evaluation, or inspection through ten (10) years from the final date of this Agreement or from the date of completion of any audit, whichever is later;

q. A provision that requires the Network Provider to allow the Commonwealth, CMS, the Department of Health and Human Services Inspector General, and their designees to inspect, evaluate, and audit the Network Provider at any time if the Commonwealth, CMS, or the Department of Health and Human Services Inspector General determines that there is a reasonable possibility of fraud or similar risk.

c. The Contractor may not enter into capitation arrangements with Providers.

d. Each Network Provider must be enrolled in the Medical Assistance Program. The Department must screen, enroll, and periodically revalidate all Network Providers. The Contractor may execute a subcontract with a Network Provider pending the outcome of the screening and revalidation process of up to 120 days. The Contractor must terminate the Network Provider immediately upon notification from the Department that the Network Provider cannot be enrolled or the expiration of one 120-day period without enrollment of the provider. The Contractor must notify affected Participants.

e. The Contractor must ensure that each Provider responds, reports, and follows up on critical incidents as specified in Appendix B.

f. The Contractor must ensure that all Provider facilities and offices are accessible to individuals with disabilities.

g. No later than when it enters in a subcontract with a Provider, the Contractor must inform the Provider of the following:

   a. The right of each Participant, or the Participant's representative acting on behalf of the Participant, which may include the Participant's Provider, with the Participant's written authorization to act on the Participant's behalf, to file a Complaint or Grievance; the requirements and time frames for filing a Complaint or Grievance as specified in Appendix G; the availability of assistance in the filing process; the toll-free numbers that the Participant can use to file a Complaint or Grievance; and the ability to continue to receive requested services if the Participant files a Complaint or Grievance within ten (10) days from the mail date on the written notice to terminate or reduce currently Authorized Services.

   b. The right of each the Participant, or the Participant's representative acting on behalf of the Participant, to request a Fair Hearing; the methods for obtaining a Fair Hearing; the time frame for requesting a Fair Hearing after a Complaint or Grievance has been decided; the rules that govern representation at Fair Hearings; and the ability to continue to receive requested services if the Participant files a request for a Fair Hearing within ten (10) days from the mail date on the written notice of a Complaint or Grievance decision to terminate or reduce currently Authorized Services.

h. When the Contractor or BSASP identifies deficiencies or areas for improvement in a Network Provider's performance, the Contractor and Network Provider must take corrective action to ensure that the Network Provider removes the deficiencies and improves its performance.

i. The Contractor must make a good faith effort to give written notice of the termination of a Network Provider within fifteen (15) days after receiving notice of the Network Provider's intent to terminate or issuing notice to the Network Provider of the Contractor's intent to terminate the Network Provider, to each Participant for whom the Network Provider served as a PCP or who otherwise received services from the Network Provider on a regular basis. The Contractor must ensure continuity of service when a Network Provider is terminated.

j. The Contractor shall establish and submit for Department approval a policy that requires Network Providers to report to the Contractor all provider-preventable conditions as defined

in 42 CFR § 447.26(b) and as required by 42 CFR § 438.3(g) and all provider-preventable conditions that are associated with claims for payment or treatment of Participants for which payment would otherwise be made. The Contractor shall submit reports on provider-preventable conditions to the Department upon request.

k. The Contractor must provide Participants with access to Federally Qualified Health Centers (FQHCs) within its Network. The Contractor must pay an FQHC a rate that is not less than Fee-for-Service Prospective Payment System rate(s), as determined by the Department. The Contractor must include in its Network every FQHC that is willing to accept Fee-for-Service Prospective Payment System rates as payment in full. When an IHCP is not enrolled in the Medical Assistance Program as an FQHC, it may receive its applicable encounter rate published annually in the Federal Register by the Indian Health Service, or in the absence of a published encounter rate, the amount it would receive if the services were provided under the Department's Medical Assistance Fee-for-Service program. When the amount the IHCP receives from the Contractor is less than the amount the IHCP would have received under the applicable encounter rate published annually in the Federal Register by the Indian Health Service or in the absence of a published encounter rate, the amount it would receive if the services were provided under the Department's Medical Assistance Fee-for-Service program, the Department will make a supplemental payment to the IHCP to make up the difference between the amount the Contractor pays and the amount the IHCP would have received under the applicable encounter rate.

H. Provider Selection

a. The Contractor may not preclude any potential provider who is acting within the scope of his or her license or certification under state law from participating in the Network or refuse to make payments to a Provider, solely on the basis of that license or certification.

b. The Contractor must submit written policies and procedures for the selection and retention of Network Providers within fifteen (15) days after signing this Agreement for approval by the Department. Those policies and procedures must include standards and procedures for credentialing and recredentialing Network Providers that are consistent with this Section and include the following criteria:

a. Network Providers must have applicable licenses or

certifications as required by Pennsylvania law.

b. Network Providers must have board certification or eligibility, as applicable.

c. Network Providers must not have been excluded from participating in Medicare or any State Medicaid or other health care program.

d. Network Providers must be enrolled in the Medical Assistance Program.

e. Network Providers must have malpractice/liability insurance.

f. Network Providers must disclose any past or pending lawsuits or litigation.

c. The Contractor may not discriminate against potential providers who serve high-risk populations or specialize in conditions that require costly treatment.

d. In establishing and maintaining a Network sufficient to provide prompt access to Capitation Services and other Covered Services, the Contractor must consider the following:

a. The anticipated number of Participants.

b. The expected utilization of services considering the needs of the population being served.

c. The numbers and types (in terms of training, experience, and specialization) of Network Providers required to furnish Capitation Services and other Covered Services in a timely manner.

d. The geographic location of Network Providers compared to Participants, considering distance, travel time, the means of transportation ordinarily used by Medical Assistance recipients, and whether the location provides physical access for Medical Assistance recipients with disabilities.

e. The number of Network Providers who are not accepting new Participants.

f. The ability of Network Providers to communicate with limited English proficient Participants in their preferred language.

g. The ability of Network Providers to ensure physical access, reasonable accommodations, culturally competent communications, and accessible equipment to Participants with physical or mental disabilities.

h. The availability of triage lines or screening systems, as well as the use of telemedicine, e-visits, or other evolving and innovative technological solutions.

e. The Network established and maintained by the Contractor must meet the following access standard for Capitation Services and other Covered Services:

a. The Contractor must maintain a Network sufficient to provide prompt access to Capitation Services and Covered Services that are not required to be delivered directly by the Contractor, including LTSS that are not provided in the Provider’s office. The Contractor must offer Participants a choice of at least two (2) Network Providers for each service or Provider type. The Contractor shall enter into written agreements with all Network Providers as specified in Section 2.5.

b. The access standard for ambulatory services to which the Participant travels, including PCPs, OB/GYNs, and LTSS, is at least two (2) Providers:

i. Within thirty (30) minutes travel time in Urban areas.

ii. Within sixty (60) minutes travel time in Rural areas.

The access standard for inpatient and residential services, including LTSS, is at least two (2) Providers one (1) of which must be located:

i. Within thirty (30) minutes travel time in Urban areas.

ii. Within sixty (60) minutes travel time in Rural areas.

The Contractor must obtain Department approval for network exception requests to cover situations in which the Contractor determines that a Participant is in need of a specialized service and a Network Provider is not available within the above listed travel timeframes. The

network exception request must provide for the appropriate delivery of services and the availability of local supports for the Participant. The Department will review and approve network exception requests based on the number of Network Providers in that specialty practicing in the Service Area.

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

f. The Contractor may use different payment amounts for different specialties or for different practitioners in the same specialty.

g. The Contractor shall notify providers in writing when they are denied participation in the Contractor's Network. Notification must include the reason for the denial.

I. Personnel Requirements

1. The Contractor shall hire, at a minimum, the following personnel:

a. <u>Executive Director</u>

The Executive Director must either work full-time for the Contractor as the Executive Director or work parttime for the Contractor in the position of Executive Director if the Contractor employs a Chief Operating Officer or Director of Operations. The Executive Director is responsible for the oversight, administration and day-to-day operations of the Plan and is accountable to the Governing Body. The Executive Director may be changed during the period of this Agreement only after written notice to the Department. The Executive Director shall be authorized to represent the Contractor with respect to all matters related to implementation of this Agreement.

b. <u>Medical Director</u>

The Medical Director must be a physician licensed to practice in the Commonwealth of Pennsylvania. The Medical Director is responsible for the management of the physical health services provided to Participants and for advising the Contractor and Member Advisory Committee on health-related issues.

c. Clinical Director

The Clinical Director must have at least a Master's Degree in Applied Behavior Analysis, Psychology, Special Education or a field related to Applied Behavior Analysis, Psychology, or Special Education, with a minimum of five (5) years of experience interpreting functional behavioral assessments applied to persons with ASD. The Clinical Director is responsible for clinical supervision of and clinical consultation with Behavioral Health Practitioners and other behavioral support staff.

d. Employment Services Director

The Employment Services Director must have:

i. At least a Bachelor's Degree in Rehabilitation, Business, Marketing or a field related to Rehabilitation, Business or Marketing; or

ii. At least a Bachelor's Degree in Education, Psychology or other social science field related to Education or Psychology and a minimum of two (2) years of experience related to job assessment, job finding or employment supports.

The Employment Services Director is responsible for oversight of job development services, which includes overseeing the work of Job Developers, and reporting to the Contractor and Member Advisory Committee on employment issues.

e. Behavioral Health Practitioner

A Behavioral Health Practitioner must have at least a Master's Degree in Social Work, Psychology, Education, or a related human services field and five (5) years of experience in administering or interpreting functional behavioral assessments applied to persons with severe behavioral problems including persons with ASD. The Behavioral Health Practitioner is responsible for overseeing the work of the Behavioral Specialist, authorizing services recommended in the ISP, and advising the Contractor and Member Advisory Committee on behavioral-health-related issues.

f. Chief Financial Officer

The Chief Financial Officer (CFO) is responsible for the Contractor's financial operations and effective utilization of all financial assets.

g. Chief Operating Officer or Director of Operations

The Contractor must employ a Chief Operating Officer or Director of Operations only if the Contractor employs a part-time Executive Director.

h. Director of Managed Care Operations

The Director of Managed Care Operations is responsible for developing, maintaining, and monitoring the plan's Network.

i. Nurse

The Nurse must have:

i. A valid Pennsylvania Registered Nurse license; and

ii. At least two years of experience working in a human services field, long-term care, or internal medicine setting.

The Nurse is responsible for collaborating with the Medical Director, Clinical Director, and Network Providers to monitor and coordinate the physical health services provided to Participants and for advising the Contractor and Member Advisory Committee on health-related issues.

j. Supports Coordination Manager

The Supports Coordination Manager must have:

i. At least a Bachelor's Degree in Education, Psychology, Social Work, or other related human services or social sciences field; and

ii. Either: 1) at least three years of experience providing case management for people with disabilities, or 2) at least three years of experience working with people with ASD.

The Supports Coordination Manager is responsible for oversight of Supports Coordination services, which

includes overseeing the work of Supports Coordinators and reporting to the Contractor and Member Advisory Committee on supports coordination issues.

k. Supports Coordinator

A Supports Coordinator must have at least a Bachelor's Degree in Education, Psychology, Social Work, or other related human services or social sciences field. The Supports Coordinator provides Support Coordination as defined in Appendix D.

l. Skill Building Specialist

A Skill Building Specialist must have at least a Bachelor's Degree in Social Work, Psychology or Education or in a human services field related to Social Work, Psychology or Education; or at least a Bachelor's Degree in another field and at least three (3) years of experience directly supporting individuals with ASD in the community. The Skill Building Specialist provides Systematic Skill Building services as defined in Appendix D.

m. Community Supports Professional

A Community Supports Professional must be at least eighteen (18) years of age and have a high school diploma or equivalent (Bachelor's Degree is not required). The Community Supports Professional provides Community Support services, which includes implementation of the Behavioral Support Plan (BSP), the Crisis Intervention Plan (CIP), and/or the Skill Building Plan (SBP), as defined in Appendix D.

n. Family Services Social Worker

The Family Services Social Worker must have at least a Master's Degree in Social Work or Counseling and at least three (3) years of experience in supporting families of adults with disabilities. The Family Services Social Worker provides support directly to families as needed and consultation about family issues to Community Supports Professionals, Behavioral Specialists, Supports Coordinators, and other staff as needed.

o. Behavioral Specialist

A Behavioral Specialist must have one of the following:

i. A Pennsylvania Behavioral Specialist License;

ii. At least a Master's Degree in Social Work, Psychology, Education, or Applied Behavior Analysis;

iii. At least a Master's Degree in a human services field related to Social Work, Psychology, or Education that includes 33% or more coursework in Applied Behavior Analysis; or

iv. At least a Master's Degree with 50% or more coursework in Applied Behavior Analysis.

A Behavioral Specialist can also be the program specialist in a community home licensed under 55 Pa. Code Chapter 6400 and operated by the Contractor. A Behavioral Specialist cannot be the program specialist for any other community home licensed under 55 Pa. Code Chapter 6400. A Behavioral Specialist provides Behavioral Specialist Services as defined in Appendix D.

p. Job Developer

A Job Developer must have one of the following:

i. A Bachelor's Degree in Rehabilitation, Business, or Marketing;

ii. A Bachelor's Degree in a field related to Rehabilitation, Business, or Marketing and one (1) year of experience related to job assessment, job finding, or employment supports;

iii. A Bachelor's Degree in Education, Psychology or other social science field related to Education or Psychology and one (1) year of experience related to job assessment, job finding, or employment supports;

iv. An Associate's Degree in Rehabilitation, Business, Marketing or a field related to Rehabilitation, Business or Marketing and two (2) years of experience related to job assessment, job finding, or employment supports; or

v. An Associate's Degree or higher in any field and five (5) years of experience related to job

assessment, job finding, or employment supports.

A Job Developer provides Career Planning and Supported Employment services. Supported Employment services include implementation of the BSP, the CIP, and/or the SBP, as defined in Appendix D.

q. Residential Habilitation Program Director

A Residential Habilitation Program Director must have at least a Bachelor's Degree, a minimum of two (2) years of experience in a human services field, including at least one (1) year working with individuals with ASD, and one year (1) of supervisory experience.

A Residential Habilitation Program Director supervises and oversees licensed community homes operated by the Contractor. A Residential Habilitation Program Director may supervise or oversee up to two (2) community homes operated by the Contractor. A Residential Habilitation Program Director may not supervise or oversee licensed community homes that are not operated by the Contractor.

2. All staff must complete all required training as outlined in Appendix E. If transporting Participants, staff must have a valid driver's license and automobile insurance.

3. The following staff will be designated as Executive Staff: Executive Director, Medical Director, Clinical Director, Director of Managed Care Operations, Supports Coordination Manager, Employment Services Director, Chief Operating Officer or Director of Operations (if employed by Contractor), Chief Financial Officer and Behavioral Health Practitioners.

   The following staff will be designated as Key Staff: Behavioral Specialists, Supports Coordinators, Nurse, Job Developers, Family Services Social Worker, Residential Habilitation Program Directors, Skill Building Specialists, and Community Supports Professionals.

4. Prior to altering the levels of effort of the Executive Staff among various activities under this Agreement or to diverting those individuals to other projects outside the scope of this Agreement, the Contractor shall notify the Department at least ten (10) days in advance and shall submit justification in sufficient detail to permit evaluation of the impact on the Plan. The Contractor may not alter or divert the level of effort of these personnel from the specified activities without the

Department's approval.

5. The Contractor shall notify the Department at least ten (10) days in advance of the departure of any individual employed by the Contractor as Executive Staff.

6. The Contractor shall supply to the Department, within ten (10) business days of request, the names of the personnel who are required to be employees of the Contractor.

7. The Contractor shall supply to the Department, within ten (10) business days of any changes in Executive Staff the names of the personnel who are required to be employees of the Contractor.

J. Third Party Liability (TPL)

The Contractor must comply with the Third Party Liability (TPL) procedures set forth at Section 1902(a)(25) of the Social Security Act, 42 U.S.C. § 1396a(a)(25), and implemented by the Department. Under this Agreement, the TPL responsibilities of the Department will be allocated between the Department and the Contractor.

1. Cost Avoidance Activities
    a. The Contractor shall be responsible for cost avoidance through the Coordination of Benefits (COB) for public and private resources, including but not limited to Medicare, private health insurance, Employee Retirement Income Security Act of 1974 (ERISA), 29 U.S.C. §§ 1001, et. seq., plans, and workers' compensation. The Contractor must attempt to avoid initial payment of Claims, whenever possible, where public or private resources are available. All cost-avoided funds must be reported to the Department on a form approved by the Department, showing that TPL has been pursued and the amount which has been cost-avoided. The Contractor 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 Contractor may not deny or delay approval of otherwise covered treatment or services based upon TPL considerations. The Contractor may neither unreasonably delay payment nor deny payment of claims unless it has established the probable existence of TPL at the time the claim is adjudicated.

2. Post-Payment Recoveries

    a. Post-payment recoveries are categorized by:

i. Health-related insurance resources, and

ii. Other Resources.

Health-related insurance resources are Medicare, ERISA health benefit plans, Blue Cross/Blue Shield subscriber contracts, private health insurance, workers' compensation, and health insurance contracts.

b. The Contractor 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 Contractor must indicate its intent to recover on health-related insurance by providing to the Department an electronic file of those cases that will be pursued. The electronic file must be provided to the Department by the Contractor within the nine (9) months from the date of service or six (6) months after the date of payment, whichever is later, 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 are not identified by the Contractor 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 Contractor, 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 Contractor has identified the cases to be pursued, the Contractor 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 Contractor 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 Contractor is responsible to notify the Department through the prescribed electronic file process of all results for those cases identified for pursuit.

b. As part of its authority under subparagraph 2.a.(i) above, the Contractor is responsible for pursuing, collecting, and retaining recoveries of health-related insurance resources where the liable party has

improperly denied payment based upon either a lack of Medically Necessary determination or lack of coverage.

c. 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 records, 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 Contractor.

d. The Department's Division of TPL retains the sole and exclusive right to investigate, pursue, collect, and retain all Other Resources, which include, but are not limited to, recoveries from personal injury claims, liability insurance, first-party automobile medical insurance, and accident indemnity insurance. Any correspondence or inquiry forwarded to the Contractor (by an attorney, provider of service, insurance carrier, or other entity) 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 a Participant and the services which were provided, must be immediately forwarded to the Department's Division of TPL. The Contractor may neither unreasonably delay payment nor deny payment of claims because they involved an injury stemming from an accident such as a motor vehicle accident, where the services are otherwise covered. Those funds recovered by the Department under the scope of these "Other Resources" shall be retained by the Commonwealth.

e. Should the Department fail to identify and establish a claim prior to settlement due to the Contractor's untimely submission of notice of legal involvement where the Contractor has received such notice, the amount of the Department's actual loss of recovery shall be assessed against the Contractor. 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.

3. Estate Recovery

Section 1412 of the Human Services Code, 62 P.S. § 1412, requires the Department to recover Medical Assistance costs paid on behalf of certain deceased individuals. Individuals age fifty-five (55) and older who were receiving Medical Assistance

benefits for any of the following services are affected:

a. Public or private nursing facility services;

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

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

The Department's Division of TPL is solely responsible for administering the Estate Recovery Program.

4. Requests for Additional Information

The Contractor must provide, at the Department's request, such information that may be necessary for the administration of TPL activity. The Contractor must use its best efforts to provide this information within fifteen (15) days of the Department's request. Such information may include, but is not limited to, Participant medical records for the express purpose of determining TPL for the services rendered. Confidentiality of the information must be maintained as required by federal and state statutes and regulations.

K. Physician Incentive Plans

The Contractor shall not enter into physician incentive plans as defined in 42 CFR § 422.208(a).

L. Advance Directives

The Contractor must:

1. Maintain written policies and procedures that meet the requirements for Advance Directives of 42 CFR § 422.128, state law, and applicable Department bulletins. The policies and procedures must be updated to reflect any changes in state law no later than ninety (90) days after the effective date of the change and must be made available to the Department upon request.
2. Provide written information to all Participants at enrollment concerning the Contractor's policies and procedures on Advance Directives, including a statement of any limitation regarding the implementation of an Advance Directive as a matter of conscience, and inform Participants of the right to request this information annually.

M. Risk Reserve

1. The Contractor shall maintain a risk reserve approved by the Department in the event the Contractor becomes insolvent. The risk reserve accounts must be separate from any operating accounts. The Contractor must demonstrate that it has arrangements in place in the amount of one (1) month's total capitation revenue and one (1) month's average payment to Network Providers to cover expenses in the event it becomes insolvent.

2. The requirement in this Section may be met by one or more of following arrangements:

   a. Insolvency insurance;

   b. An irrevocable, unconditional and automatically renewable letter of credit for the benefit of the Department, which is in place for the entire term of this Agreement;

   c. A guarantee from an entity, acceptable to the Department, with sufficient financial strength and credit worthiness to assume the payment obligations of the Contractor in the event of a default in payment resulting from bankruptcy or insolvency; or

   d. Other arrangements, satisfactory to the Department, that are sufficient to ensure payment to Network Providers in the event of a default in payment resulting from bankruptcy or insolvency.

N. Liability for Payment

The Contractor shall not hold Participants liable for the Contractor's debts in the event of insolvency.

O. Premiums and Cost Sharing

The Contractor is prohibited from imposing premiums, cost sharing, or similar charges on a Participant who is an Indian, as defined in 42 CFR § 438.14(a), and has received a service or item from an IHCP or through referral under contract health services.

ARTICLE III: PAYMENT PROVISIONS

3.1 Payment

A. The Department will pay a Capitation Payment to the Contractor for each Participant calculated on an actuarially sound basis. The

Capitation Payment rates and methodology for calculating the rates are described in Appendix I.

B. The Department will pay the Contractor a Capitation Payment for each Participant as of the effective date of the Participant's enrollment.

C. The Department will pay a State-Funded Residential Habilitation Subsidy to the Contractor for each Participant receiving Residential Habilitation Services in a Community Home.

D. Payment to the Contractor will be automatically generated on a monthly basis via the Provider Reimbursement and Operations Management Information System (PROMISe™).

1. The Contractor will receive payment from the Department at the current Capitation Rate. The Contractor is responsible to collect payment for room and board from any Participant who receives Residential Habilitation Services.

2. The Contractor will receive payment from the Department of the State-Funded Residential Habilitation Subsidy for any Participant receiving Residential Habilitation Services.

E. The amount a Participant pays for room and board if the Participant is receiving Residential Habilitation Services shall be the same as the amount charged as room and board to individuals in the Commonwealth of Pennsylvania who are enrolled in a waiver program under Section 1915(c) of the Social Security Act, 42 U.S.C. § 1396n(c), for individuals with an intellectual disability or autism.

F. The Contractor shall accept the Capitation Payment, any payment from the Participant for room and board, and the State-Funded Residential Habilitation Subsidy as payment for providing or arranging for all Medically Necessary Authorized Services to Participants as described in Article II.

G. The Contractor shall be liable for payment of all claims for Authorized Services provided to a Participant from the effective date of the Participant's enrollment in the Plan.

H. Except as specified in Section 3.1.G, the Capitation Payment and State-Funded Residential Habilitation Subsidy, if applicable, for a disenrolled individual shall be terminated effective on the date of disenrollment. The effective date of disenrollment is the last day of the month in which the Participant is disenrolling. Should the Contractor receive any Capitation Payment or State-Funded Residential Habilitation Subsidy for an individual after the effective date of disenrollment, the overpayment to the Contractor shall be

reconciled as a payment adjustment within sixty (60) days after the date on which the overpayment was identified as described in Section 3.2.A.

I. The Capitation Payment and State-Funded Residential Habilitation Subsidy, if applicable, for a Participant who is between twenty-one (21) and sixty-four (64) years of age and is admitted to an IMD shall be terminated the day after admission to the IMD. Should the Contractor receive any Capitation Payment or State-Funded Residential Habilitation Subsidy for the time after the Participant is admitted to an IMD, the overpayment to the Contractor shall be reconciled as a payment adjustment described within sixty (60) days after the date on which the overpayment was identified as is described in Section 3.2.A.

J. The Department will pay only the Contractor for Capitation Services, except when payment is specifically provided for in Title XIX of the Social Security Act, in 42 CFR Chapter IV, or when the Department has adjusted the Capitation Rate paid under the contract for graduate medical education.

K. The Department will pay the Contractor for start-up costs utilized for one-time activities related to the opening of a new location, the introduction of a new product or service, conducting business in a new geographic area, initiating a new process, or starting a new operation. Start-up costs cannot be incurred beyond the cap established by the Department annually for the waiver programs under Section 1915(c) of the Social Security Act, 42 U.S.C.A. § 1396n(c), for individuals with an intellectual disability or autism unless one of the following conditions are met:

1. The start-up costs are necessary to provide greater independence and access to the community for a Participant.

2. The start-up costs are necessary to meet life safety code-standards.

3. The cost of the start-up activity is more cost-effective than an alternative approach.

L. Capitation payments may only be made by the Department and retained by the Contractor for Participants who are eligible for Medical Assistance.

M. Should any part of the scope of work under this contract relate to a state program that is no longer authorized by law (e.g., which has been vacated by a court of law, or for which CMS has withdrawn federal authority, or which is the subject of a legislative repeal), the Contractor must do no work on that part after the effective date of

the loss of program authority. The Department will adjust Capitation Payments to remove costs that are specific to any program or activity that is no longer authorized by law. If the Contractor works on a program or activity no longer authorized by law after the date the legal authority for the work ends, the Contractor will not be paid for that work. If the Department paid the Contractor in advance to work on a no-longer-authorized program or activity and under the terms of this Agreement the work was to be performed after the date the legal authority ended, the payment for that work should be returned to the Department. However, if the Contractor worked on a program or activity prior to the date legal authority ended for that program or activity, and the Department included the cost of performing that work in its payments to the Contractor, the Contractor may keep the payment for that work even if the payment was made after the date the program or activity lost legal authority.

3.2 Reconciliation

A. Payment Adjustment Process

In the event that the Contractor receives an incorrect payment from the Department, the Contractor will immediately notify the Department. The Department will then initiate the appropriate payment adjustment via PROMISe™.

B. Capitation Rate Adjustment Process

1. The Capitation Rate shall be calculated annually to be effective on the first day of the Department's fiscal year. The Department will make its best effort to determine the rate prior to the start of the fiscal year. If the Department is unable to determine the rate before July 1, payment will continue to be made at the previous year's Capitation Rate until such time as the new rate has been established.

2. If payment has been made at the previous year's Capitation Rate during any portion of a new fiscal year, the Department will make a payment adjustment in the amount that results from the difference between the new Capitation Rate and the previous year's Capitation Rate.

3.3 Profit Sharing

The Department will share in profits realized by Contractor in each fiscal year as specified in Appendix L.

ARTICLE IV: OUTREACH AND ENROLLMENT

4.1 Outreach, Marketing, and Information for Participants

A. The Contractor shall:

1. In conjunction with the Department, promote ACAP to Medical Assistance recipients in the Service Area and, when appropriate, in the regional offices of the Department.

2. Obtain approval from BSASP of its plan for outreach, marketing, and enrollment on an annual basis or when changes occur. The plan shall include: how outreach to potential Applicants will be made; how ACAP will be promoted; a schedule for the sequence and timing of promotional and enrollment activities in the Service Area; development and procurement of resources needed for implementation; and how the Contractor will ensure that marketing, including plans and materials, is accurate and does not mislead, confuse, or defraud potential Applicants or the Department.

3. Obtain approval from BSASP prior to use of all outreach and marketing materials which are produced in any medium by or on behalf of the Contractor and can reasonably be interpreted as intended to influence a person to enroll in Contractor's Plan.

4. Inform potential Applicants of the basic features of the Plan, which populations are eligible and ineligible for ACAP, and the Plan's responsibilities for coordinating care.

5. Provide a summary, and make available more detailed information upon request, of the services provided; the Service Area; benefits that are available under the Medical Assistance Program, but are not Covered Services, including how and where the Participant may obtain those benefits; any cost sharing; how transportation is provided; which benefits are provided by the Contractor and which benefits are provided by the Department; the requirements for the Contractor to provide adequate access to services consistent with this Agreement; the Contractor's responsibility for coordination of Participant care; and the Contractor's quality and performance indicators, including Participant satisfaction.

6. Inform potential Applicants of their ability to terminate enrollment voluntarily at any time.

7. Ensure that all staff and Network Providers who have contact with potential Applicants are fully informed of and understand the Contractor's policies for outreach, enrollment, and disenrollment.

8. Distribute its outreach and marketing materials in the entire Service Area.

9. Develop and publish outreach and marketing materials for potential Applicants in English and in the prevalent non-English languages spoken in the Service Area in a format that is easy to understand and in a font size no smaller than twelve (12) points.

10. Develop and publish written materials that are critical to obtaining services, including, at a minimum, Network Provider directories; Participant handbooks; Complaint, Grievance, and Fair Hearing notices; and denial and termination notices in English and in the prevalent non-English languages spoken in the Service Area and in a format that is easy to understand and in a font size no smaller than twelve (12) points.

11. Notify potential Applicants and Participants that outreach, marketing, and materials that are critical to obtaining services are available at no cost to the Applicant or the Participant in the prevalent non-English languages spoken in the Service Area and explain how to access those materials.

12. Develop and publish outreach and marketing materials for potential Applicants and all written materials for Participants upon request in alternative formats including print that is no smaller than eighteen (18) point font and through the provision of Auxiliary Aids and Services in an appropriate manner that takes into consideration the special needs of those who, for example, are visually limited, have limited reading proficiency, or limited English proficiency.

13. Notify potential Applicants and Participants that outreach, marketing, and all written materials are available at no cost to the Applicant or the Participant in alternative formats and explain how to access those materials

14. Make interpretation services available to potential Applicants and Participants free of charge and explain how to access these services. This includes oral interpretation in any language and written translation in the prevalent non-English languages.

15. Make Auxiliary Aids and Services that take into consideration the special needs of potential Applicants and Participants with disabilities including TTY/TDY and American Sign Language available upon request and explain how to access these services free of charge.

16. Include in significant publications and significant communications, including outreach and marketing materials for potential Applicants, and on the Contractor's website and at physical locations where the Contractor interacts with the public the notice of nondiscrimination included in Attachment IV.

17. Include in large sized significant publications and significant communications, including outreach and marketing materials for potential Applicants, and on the Contractor's website and at physical locations where the Contractor interacts with the public the taglines listed in Attachment V. The taglines must be in a font size that is conspicuously visible. This requirement does not apply to small sized publications and communication, such as postcards, tri-fold brochures, and pamphlets.

18. Include in small sized significant publications and significant communications, including outreach and marketing materials for potential Applicants, the taglines listed in Attachment VI. The taglines must be in a font size that is conspicuously visible.

19. Include in written materials that are critical to obtaining services the taglines listed in Attachment V.

20. Not provide information electronically to Participants unless all of the following conditions are met:

    a. The format is Readily Accessible;

    b. The information is placed in a location on the Contractor's Web site that is prominent and Readily Accessible;

    c. The information is provided in an electronic form which can be electronically retained and printed;

    d. The information is consistent with the content and language requirements set forth in this Agreement; and

    e. The Participant is informed that the information is available in paper form without charge upon request and the Contractor provides it upon request within five (5) business days.

21. If the Contractor uses any of the terms included in Appendix M in a written communication with a potential Participant or a Participant, the Contractor's use of the term must be consistent with the definition included in Appendix M.

B. The Contractor shall not:

1. Seek to influence enrollment in conjunction with the sale or offering of any private insurance.

2. Seek to influence an Applicant's decision to enroll by stating or implying, either orally or in writing, that the Applicant must enroll in the Plan in order to obtain benefits or in order not to lose benefits.

3. Directly or indirectly engage in door-to-door, telephone, email, texting or other cold-call marketing activities with a potential Applicant for the purpose of marketing, including any communication to a Medical Assistance recipient who is not enrolled in ACAP, that can reasonably be interpreted as intended to influence the potential Applicant to enroll in ACAP, or either to not enroll in or to disenroll from another Medical Assistance Program.

4. Seek to influence a potential Participant's decision to enroll by stating or implying, either orally or in writing, that the Contractor is endorsed by CMS, the federal government, the Department, or a similar entity.

5. Use any marketing incentive to influence a potential Participant.

4.2 Participant Handbook and Enrollment Agreement

A. The Contractor shall use the Participant Handbook specified by the Department and Enrollment Agreement template specified by the Department.

B. The Contractor must give the Participant a copy of the Participant Handbook prior to the Participant enrolling in the Plan and annually thereafter.

C. The Participant Handbook must include, at a minimum, the following:

1. A description of all Capitated Services provided through the Plan, in sufficient detail to enable the Participant or the Participant's representative, if appropriate, to understand the benefits available under the Plan.

2. The amount, duration, and scope of benefits available under the Plan in sufficient detail to enable the Participant or the Participant’s representative, if appropriate, to understand the

benefits to which the Participant is entitled.

3. An explanation of the circumstances under which the Contractor is responsible for Post-Stabilization Care Services.

4. An explanation of the procedure for obtaining Capitated Services, including any requirements for service authorizations and/or referrals for specialty care and for other benefits not furnished by the Participant's PCP.

5. Information on the Participant's right to choose his or her PCP and other Providers to the extent possible and appropriate, including information on any restrictions on the Participant's freedom of choice among Network Providers and the process for selecting and changing the Participant's PCP.

6. Locations, telephone numbers, and procedures for obtaining health services in the event of a crisis.

7. Participant rights and responsibilities, as defined in this Section.

8. The disenrollment procedures, as described in Section 4.6 of this Agreement.

9. Information concerning transportation arrangements offered by the Contractor.

10. The extent to which and how Participants may obtain benefits, including family planning services and supplies from Out-of-Network Providers. This must include that the Contractor cannot require a Participant to obtain a referral before choosing a family planning provider.

11. How and where to access any benefits, including family planning services, that are available under the Medical Assistance Program but are not covered under this Agreement, including any cost sharing and how transportation is provided.

12. The extent to which, and how, after-hours and emergency coverage are provided, including:

    a. What constitutes an Emergency Medical Condition and Emergency Services.

    b. That prior authorization is not required for Emergency Services.

    c. That if the Participant has an Emergency Medical

Condition, the Participant has a right to use any hospital or other setting for emergency care.

d. When emergency behavioral consultation and support is warranted.

13. Information on how to report suspected Fraud and Abuse.

14. Information about how to exercise an Advance Directive in accordance with 42 CFR § 438.3(j).

15. Information about how to access Auxiliary Aids and Services, including additional information in alternative formats or languages.

16. The toll-free number for member services, medical management, and any other unit providing services directly to Participants.

17. The counseling or referral services the Contractor does not cover because of moral or religious objections and how Participants can obtain information from the Department about how to access these services.

18. The right to file a Complaint or Grievance and request a Fair Hearing, the methods for filing a Complaint or Grievance or requesting a Fair Hearing, the time frame for requesting a Fair Hearing after a Complaint or Grievance has been decided, the availability of assistance with filing a Complaint or Grievance or requesting a Fair Hearing, the ability to continue to receive requested services if the Participant files a Complaint or Grievance within ten (10) days from the mail date on the written notice to terminate or reduce currently Authorized Services or requests a Fair Hearing within ten (10) days from the mail date on the written notice of a Complaint or Grievance decision concerning the termination or reduction of currently Authorized Services.

19. How to file a discrimination complaint with the Office of Civil Rights of the Department of Health and Human Services.

20. The transition of care policy, including how the Supports Coordinator will assist the Participant with coordinating services and supports.

21. The taglines listed in Attachment V must be in a font size that is conspicuously visible.

22. Any additional content required by the Department.

D. The Contractor must inform each Participant verbally and in the Participant Handbook of the following rights and responsibilities, at a minimum:

1. The Contractor's responsibility to respond to any questions or concerns the Participant has about the care rendered and to routinely check with the Participant about his or her satisfaction with the services being rendered.

2. The Contractor's responsibility to render services according to acceptable standards of care.

3. The Contractor's responsibility to provide care according to the ISP.

4. The Contractor's responsibility to notify the Participant in writing of any action taken which affects the status of the Participant's services.

5. The Contractor's responsibility to provide information on request regarding the structure and operation of the Plan.

6. The Participant's responsibility to treat employees of the Contractor and Providers with respect and to communicate problems immediately to the appropriate Contractor staff.

7. The Participant's responsibility to notify the appropriate Contractor's staff and Providers whenever the Participant is unable to keep an appointment.

8. The Participant's responsibility to pay for room and board if the Participant is receiving Residential Habilitation Services.

9. The Participant's responsibility to obtain a referral for services when required.

10. The Participant's right to be treated with respect and with due consideration for his or her dignity and privacy.

11. The Participant's right to receive all materials in a language, manner, and format that is easily understood.

12. The Participant's right to written information in the prevalent non-English languages of the Service Area and in an appropriate alternative format or manner that takes into consideration the special needs of Participants who, for example, are visually limited or have limited reading proficiency.

13. The Participant's right to free oral interpretation services in any language, written translation in prevalent non-English languages, Auxiliary Aids and Services upon request, and written materials in font that is no smaller than eighteen (18) point.

14. The Participant's right to file a Complaint or Grievance, the requirements and time frames for filing a Complaint or Grievance as specified in Appendix G, the availability of assistance in the filing process, the toll-free numbers that the Participant can use to file a Complaint or Grievance, and the ability to continue to receive requested services if the Participant files a Complaint or Grievance within ten (10) days of the notice to terminate or reduce currently Authorized Services.

15. The Participant's right to request a Fair Hearing, the methods for obtaining a Fair Hearing, the time frame for requesting a Fair Hearing after a Complaint or Grievance has been decided, the rules that govern representation at Fair Hearings, the ability to continue to receive requested services if the Participant files a request for a Fair Hearing within ten (10) days from the mail date on the written notice of a Complaint or Grievance decision to terminate or reduce currently Authorized Services.

16. The Participant's right to receive information on available treatment options and alternatives presented in a manner appropriate to the Participant's condition and ability to understand.

17. The Participant's right to participate in decisions regarding his or her health care, including the right to refuse treatment.

18. The Participant's right to be free from any form of Restraint used as a means of coercion, discipline, convenience or retaliation as specified in federal regulations on the use of Restraints and Seclusion.

19. The Participant's right to be free from Seclusion, Chemical Restraint, Mechanical Restraint, and Aversive Conditioning at any time and from Physical Restraint unless required by an emergency.

20. The Participant's right to request and receive copies of his or her medical records, and request that they be amended or corrected, as specified in 45 CFR §§ 164.524 and 164.526.

21. The Contractor's responsibility to provide information on request regarding the Adult Protective Services Act, 35 P.S. §§ 10210.101 – 10210.704, and the Older Adults Protective Services Act, 35 P.S. §§ 10225.101 – 10225.5102.

22. The Participant's right to be protected from Abuse, neglect, exploitation, and abandonment pursuant to the Adult Protective Services Act, 35 P.S. §§ 10210.101 – 10210.704, and the Older Adults Protective Services Act, 35 P.S. §§ 10225.101 – 10225.5102, as well as resources for Participants and how to report information required to be reported by the Acts.

23. The Participant's right to be free from discrimination on the basis of race, color, national origin, sex, age, or disability.

24. The Participant's right to free exercise of the Participant's rights and that the exercise of those rights may not adversely affect the way the Contractor or Network Provider treat the Participant.

25. Any additional rights and responsibilities identified in the Participant Handbook.

E. Prior to enrollment, the Contractor shall:

1. Review the Participant Handbook and the Enrollment Agreement with each Participant or the Participant's representative, as appropriate;

2. Provide each Participant or the Participant's representative, as appropriate, with a copy of the Participant Handbook;

3. Obtain the signature of the Participant or the Participant's representative, as appropriate, on the Enrollment Agreement, which includes a statement that the Participant or, if appropriate, the Participant's representative, received the Participant Handbook and the Participant Handbook was reviewed with the Participant or, if appropriate, the Participant's representative;

4. Provide each Participant or the Participant's representative, as appropriate, with a copy of the signed Enrollment Agreement;

5. Provide the Participant or the Participant's representative, as appropriate, with the contact information for the Participant's Supports Coordinator.

F. The Contractor must provide written notice to Participants of any

change in the Participant Handbook or Enrollment Agreement, policies, or any other significant change as determined by the Department to the delivery of Covered Services provided under the Plan, at least thirty (30) days before the intended effective date of change. The change must be approved by the Department prior to providing notification to the Participants.

G. The Contractor must inform Participants annually that they may obtain the information contained in the Participant Handbook upon request.

4.3 Network Provider Directory

A. The Contractor must make a directory available of Network Providers in paper form upon request and in electronic form.

B. The following information must be included in the directory of Network Providers for physicians, including Specialists; hospitals; and behavioral health providers:

1. The Provider's name as well as any group affiliation.

2. The Provider's street address(es).

3. The Provider's telephone number(s).

4. The Provider's web site URL, as appropriate.

5. The Provider's specialty, as appropriate.

6. Whether the Provider is accepting new Participants.

7. The Provider's cultural and linguistic capabilities, including languages (including American Sign Language) offered by the Provider or a skilled medical interpreter at the Provider's office, and whether the Provider has completed cultural competence training.

8. Whether the Provider's office/facility has accommodations for people with physical disabilities, including offices, exam room(s), and equipment.

C. Information included in a paper Provider directory must be updated at least monthly and electronic Provider directories must be updated no later than thirty (30) days after the Contractor receives updated information about a Network Provider.

D. Network Provider directories must be made available on the Contractor's website in a machine-readable file and format as

specified by CMS.

4.4 Enrollment

A. Number of Participants

1. Maximum monthly enrollment is limited to two hundred (200) Participants. The Department may restrict enrollment to fewer than two hundred (200) Participants. The Department will notify the Contractor each month of the maximum number of Applicants that can be enrolled for that month. Enrollment may proceed to the Contractor's maximum number unless restricted by the Department. Restrictions on the number of Participants will be defined in writing and the Contractor will be notified by the Department at least ten (10) days prior to the start of the period of restriction. Release of the restriction will be in writing and transmitted to the Contractor at least ten (10) days prior to the date of the release. Monthly enrollment restrictions do not apply to enrollments to replace loss of Participants due to disenrollment or death.

2. If the Contractor enrolls Medical Assistance Participants over the number specified by the Department, the Contractor must provide or arrange for the provision of services and pay for services to those Participants, but the Department will not remit Capitation Payments or State-Funded Residential Habilitation Subsidies for those Participants and the Contractor may not require those Participants to pay for the Authorized Services that are provided to them.

3. The Department may increase the maximum enrollment. The Department will notify the Contractor in writing of its intent to increase the maximum enrollment. The Contractor must notify the Department within five (5) days of receiving the Department's notification if the Contractor lacks capacity to serve the increased enrollment.

B. Eligibility

1. To participate in ACAP an individual must meet the following criteria:

   a. Be twenty-one (21) years of age or older;

   b. Be eligible for Medical Assistance;

   c. Have a diagnosis of ASD;

   d. Be certified as requiring services at the level of an

Intermediate Care Facility/Other Related Conditions (ICF/ORC);

e. Not be enrolled in a Medical Assistance home and community-based waiver program at the time of enrollment;

f. Not exhibit levels of extremely problematic behaviors that would impair the Contractor's ability to furnish services to the individual or others, including being a danger to self or others or posing a threat to property (such as suicidal or homicidal ideation, stalking, pedophilia, physical assaults, self-mutilations, bomb or fire threats);

g. Have three (3) or more substantial functional limitations in the following areas of major life activity: self-care, receptive and expressive language, learning, mobility, self-direction, or capacity for independent living;

h. Reside in the Service Area;

i. Not be enrolled in a Medical Assistance Managed Care Organization (MCO) at the time of enrollment in the Plan.

j. Not be enrolled in the Health Insurance Premium Payment (HIPP) Program at the time of enrollment in the Plan.

2. The Contractor shall enroll Applicants without regard to race, sex, religion, creed, color, national origin, ancestry, sexual orientation, gender identity, disability, health status or need for health care services. The Contractor shall enroll Applicants up to the number of slots specified by the Department in the order in which Applicants apply, except that five (5) slots are reserved for the following individuals who have a diagnosis of ASD and are eligible for ACAP: individuals who currently reside in a state center or a state hospital, individuals who are at risk of losing their home because of an unanticipated emergency, individuals who are at risk of losing their caregiver as a result of the caregiver's inability to care for the individual, and individuals for whom a protective services plan has been developed pursuant to the Adult Protective Services Act that specifies a need for long-term support.

C. Enrollment Procedures

1. Initial Referrals

a. The Contractor must refer all inquiries for enrollment to BSASP.

2. BSASP Eligibility Determination

a. BSASP will determine whether the Applicant meets the following eligibility requirements:

i. Is twenty-one (21) years of age or older;

ii. Has a diagnosis of ASD;

iii. Has been certified by the Applicant's physician as requiring services at the level of an ICF/ORC;

iv. If the Applicant has been certified by the Applicant's physician as requiring services at the level of an Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/ID) a Qualified Developmental Disability Professional (QDDP) has certified that the Applicant meets ICF/ORC level of care;

v. Will not be enrolled in a Medical Assistance home and community-based waiver program at the time of enrollment;

vi. Does not exhibit levels of extremely problematic behaviors that would impair the Contractor's ability to furnish services to the Applicant or others, including being a danger to self or others or posing a threat to property (such as suicidal or homicidal ideation, stalking, pedophilia, physical assaults, self-mutilations, bomb or fire threats);

vii. Has three (3) or more substantial functional limitations in the following areas of major life activity: self-care, receptive and expressive language, learning, mobility, self-direction, or capacity for independent living;

viii. Resides in the Service Area;

ix. Is willing to disenroll from a Medical Assistance MCO, if enrolled; and

x. Is willing to disenroll from the HIPP Program, if enrolled.

b. BSASP will use the following, as needed, to determine if the Applicant meets the above eligibility requirements:

i. Applicant's responses to questions asked during phone intake;

ii. Applicant's application for ACAP;

iii. Medical Evaluation (MA-51);

iv. Evaluation by a QDDP who has one of the following qualifications:

1. A Master's Degree or above from an accredited college or university and one (1) year of work experience working directly with persons with intellectual disabilities;

2. A Bachelor's Degree from an accredited college or university and two (2) years of work experience working directly with persons with intellectual disabilities; or,

3. An Associate's Degree or sixty (60) credit hours from an accredited college or university and four (4) years of work experience working directly with persons with intellectual disabilities.

v. Information obtained during an in-home visit with the Applicant, the Applicant's representative, as appropriate, and any family members or others the Applicant may request.

c. If BSASP determines that the Applicant is ineligible for ACAP, BSASP will provide written notice to the Applicant that enrollment is denied.

3. Financial Eligibility Determination

a. The CAO will determine whether the Applicant is financially eligible for Medical Assistance.

b. If the CAO determines that the Applicant is not financially eligible for Medical Assistance, the CAO will provide written notice to the Applicant that the Applicant is not eligible for Medical Assistance.

4. Eligible Applicants

a. If BSASP determines that the Applicant appears to be functionally eligible for ACAP, and the CAO determines that the Applicant is financially eligible for Medical Assistance, BSASP will refer the information it has on the Applicant to the Contractor and notify the Contractor if it wants to participate in the comprehensive in-home assessment.

b. Upon receipt of the Applicant's referral from BSASP, the Contractor must contact the Applicant by the next business day to schedule an appointment with the Applicant and the Applicant's representative, as appropriate, and any family member or others as the Applicant may request, and BSASP, if BSASP has notified the Contractor that it will be participating, to conduct a comprehensive in-home assessment, meet and observe the Applicant and his or her family in the home environment, and complete the assessments prescribed by BSASP.

c. After completing the comprehensive in-home assessment, the Contractor must confirm that the Applicant:

i. Resides in the Service Area;

ii. Is willing to disenroll from a Medical Assistance MCO, if enrolled;

iii. Is willing to disenroll from the HIPP Program, if enrolled;

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

v. Has a diagnosis of ASD.

5. Contractor’s Recommendation to Approve or Deny Enrollment

The Contractor must notify BSASP of its recommendation to approve or deny enrollment no later than fifteen (15) days after the comprehensive in-home assessment to confirm program eligibility. This time requirement may be extended for circumstances beyond the Contractor's control with prior approval from BSASP. The Contractor must submit a written report describing the basis for the recommendation; the information, documentation, screenings and evaluations or assessments used to make the decision; and names and disciplines of those involved in the decision to BSASP at the

time it recommends enrollment or within seven (7) days of making the recommendation to deny enrollment. The Contractor must maintain all supporting documentation related to the denial according to Article VII.

a. If the Contractor recommends enrollment, BSASP will notify the Contractor of its decision to approve or disapprove the recommendation within three (3) business days of receipt of the recommendation.

i. If BSASP approves the recommendation for enrollment, the Contractor must notify the Applicant that the Applicant is eligible to enroll in ACAP and follow the Enrollment process as outlined in Section 4.4.C.6.

ii. If BSASP disapproves of the recommendation for enrollment, BSASP will provide written notice to the Applicant that enrollment is denied.

b. If the Contractor recommends that enrollment be denied, BSASP will notify the Contractor of its decision to approve or disapprove the recommendation within seven (7) days of receipt of the Contractor's written report.

i. If BSASP approves the recommendation that enrollment be denied, BSASP will provide written notice to the Applicant that enrollment is denied.

ii. If BSASP disapproves the recommendation that enrollment be denied, the Contractor must notify the Applicant they are eligible to enroll in ACAP and follow the Enrollment process as outlined in Section 4.4.C.6.

6. Enrollment into ACAP

a. After receiving BSASP's approval for enrollment, the Contractor will schedule a Team meeting to develop the Initial ISP as specified in Section 2.1.K. The Contractor shall provide a copy of the Initial ISP to the Applicant and inform the Applicant that he or she must decide whether to enroll in the Plan within seven (7) days of receiving the authorized Initial ISP. The Contractor shall also inform the Applicant that if the Applicant disagrees with the authorized Initial ISP, the Applicant may choose not to enroll in the Plan or may enroll in the Plan and file a Grievance to dispute the services that were authorized.

b. The Contractor must complete all necessary enrollment forms, as specified by BSASP, and forward all completed enrollment forms to BSASP prior to the date of the Applicant's enrollment in the Plan.

c. If the Applicant chooses to enroll in the Plan, he or she will sign the Enrollment Agreement. The effective date of enrollment, as specified on the Enrollment Agreement, must be the first day of a month that follows the date the Applicant confirms the Applicant's decision to enroll in the Plan, but no later than sixty (60) days after the date the Enrollment Agreement is signed.

d. If the Applicant or the Applicant's representative, as appropriate, informs the Contractor that the Applicant no longer wants to enroll in the Plan, the Contractor must notify BSASP within three (3) business days of being so informed by the Applicant.

7. In order to expedite the enrollment process, to ensure timelier enrollment in the Plan, or for any reason the Department deems necessary, the Department may modify the enrollment process. The Department will confirm any such changes to the enrollment process in writing and send notice in accordance with Section 12.6.

D. Annual Recertification

1. Level of care recertification

A new MA-51 form must be completed annually by a physician licensed in Pennsylvania to verify that the Participant continues to have an ASD diagnosis. The new MA-51 must include the Participant's level of care. An updated MA-51 form must be completed within one year of the date of the physician's signature on the current MA-51 form in order to avoid a lapse in recertification (i.e. MA-51 expires at 11:59 pm on the 365th day from the date signed by physician).

a. The Contractor must assist the Participant with obtaining a new MA-51 form from the Participant's physician. The Contractor will work with the Participant's physician's office as needed to schedule an appointment for the completion of the MA-51.

b. The Contractor will send the completed MA-51 form certifying that the Participant continues to require services at the level of an ICF/ORC to BSASP.

c. In the event the Participant's physician does not certify that the Participant continues to require services at the level of an ICF/ORC, the Contractor must immediately notify BSASP. If the Participant's physician has indicated on the MA-51 form that the Participant requires services at the level of an ICF/ID, BSASP will facilitate consultation with a QDDP to confirm that the Participant meets ICF/ID level of care.

d. BSASP will notify the Participant and the Contractor if the Participant is no longer eligible for ACAP based on the following:

i. The annual recertification by the Participant's physician of the Participant does not indicate a continued need for services at an ICF/ORC level of care; or

ii. The recertification of a QDDP indicates that the Participant does not meet the ICF/ID level of care.

2. Financial eligibility recertification

Participants must be eligible for Medical Assistance to be enrolled in ACAP. In order to maintain Medical Assistance eligibility, Participants are responsible for renewing their benefits through the CAO.

a. The Contractor will be available to assist the Participant in completing the necessary forms as required by the CAO to confirm that the Participant continues to remain eligible for Medical Assistance. The Contractor will be available to assist the Participant with providing the completed forms to the appropriate CAO.

b. If the CAO determines that the Participant is no longer eligible for Medical Assistance, the CAO will provide written notice to the Participant that the Participant is not eligible for Medical Assistance.

E. Identification Card

The Contractor must provide each Participant with a Department-approved identification card to identify the Participant as a Participant in the Plan. The identification card must identify the Participant's name, the Contractor's phone number, and the name or title of the contact person for the Contractor, and also specify that Emergency Services may be rendered to the Participant

by Out-of-Network Providers without prior authorization.

4.5 Continuity of Care

The Contractor must comply with the procedures for continuity of care included in Attachments A, C, and D of Medical Assistance Bulletin 99-03-13, Continuity of Care for Recipients Transferring Between and Among Fee-for-Service and Managed Care Organizations. The Contractor must implement a transition of care policy that is consistent with Attachments A, C, and D of Medical Assistance Bulletin 99-03-13 and compliant with 42 CFR § 438.62(b)(1).

4.6 Disenrollment

A. The Contractor must use the disenrollment letters in Appendix J.

B. The Contractor shall assist individuals who disenroll by making appropriate referrals for continuity of care and providing medical records to new providers.

C. The Contractor shall notify all Providers that were delivering services to an individual who disenrolls that the Provider will not be paid for services rendered after the effective date of disenrollment or, for Participants between twenty-one (21) and sixty-four (64) years of age who are admitted to an IMD, that the Provider will not be paid for services rendered after the date of admission to the IMD.

D. The Contractor shall not terminate enrollment for any reason except as provided in this Section.

E. Voluntary Disenrollment

1. A Participant may disenroll voluntarily from ACAP at any time without cause. To disenroll, the Participant or, if appropriate, the Participant's representative must notify a member of the Contractor's staff. The Contractor must use the Voluntary Disenrollment Letter in Appendix J to notify the Participant and, if appropriate, the Participant's representative of the last day the Participant can receive Authorized Services.

2. The Contractor shall submit a copy of the Voluntary Disenrollment Letter to BSASP within three (3) business days of sending the letter.

3. The Contractor shall inform Participants annually of their right to terminate their enrollment voluntarily at any time and the process for exercising the right to voluntarily terminate enrollment, as well as the alternatives available to the

Participants based on the Participant's specific circumstances.

F. Involuntary Disenrollment

1. The Contractor shall involuntarily disenroll a Participant if the Participant:

   a. Moves out of the Contractor's Service Area;

   b. Fails to pay or make satisfactory arrangements to pay the Contractor an amount owed after a thirty (30) day grace period from the due date;

   c. Falsified or omitted information at application that was used to determine eligibility for enrollment;

   d. Becomes ineligible for Medical Assistance, except as specified in Section 4.6.F.1.i.;

   e. Is out of the Contractor's Service Area for more than 30 consecutive days (unless special arrangements are made with the Team);

   f. Enrolls in a home and community-based waiver or Medical Assistance MCO or HIPP Program;

   g. Engages in uncooperative or disruptive behavior that seriously impairs the Contractor's ability to furnish services to either that Participant or other Participants;

   h. Misuses (or attempts to misuse) his or her Medical Assistance identification card by attempting to obtain the services provided under this Agreement for any other person, or engages in fraudulent activity involving Medical Assistance benefits; or

   i. Is between twenty-one (21) and sixty-four (64) years of age and is admitted to and remains in an IMD for more than ten (10) days or such longer period of time as BSASP specifies.

2. The Contractor shall not involuntarily disenroll any Participant solely because of:

   a. A change in health or living situation that affects the Participant's ability to remain in the community;

   b. The Participant's request for a service a Provider does not cover because of moral or religious objections;

c. An adverse change in the Participant's health status;

d. The Participant's utilization of medical services;

e. The Participant's diminished mental capacity; or

f. Uncooperative or disruptive behavior resulting from a Participant's special needs (except when his or her continued enrollment would seriously impair the Contractor's ability to furnish services to either that Participant or other Participants).

3. The Contractor must notify BSASP within one (1) day of awareness of a situation that may lead to a Participant's involuntary disenrollment.

4. Involuntary Disenrollment Procedures

a. The Contractor must submit documentation to BSASP supporting the involuntary disenrollment, report that the situation has been resolved, or request an extension within ten (10) days of notifying BSASP of a situation that may lead to an involuntary disenrollment.

b. BSASP will notify the Contractor in writing whether it approves or disapproves the involuntary disenrollment within fourteen (14) days of receipt of the Contractor's documentation. If BSASP requests additional information, the time frame for approval or disapproval begins upon receipt of the additional information. If BSASP determines the Contractor has not adequately documented acceptable grounds for disenrollment, the Contractor shall not disenroll the Participant.

c. The Contractor must use the Involuntary Disenrollment Form in Appendix J to notify the Participant and, if appropriate, the Participant's representative of the decision to involuntarily disenroll the Participant. The Contractor must give the Participant or, if appropriate, the Participant's representative at least thirty (30) days advance notice of the disenrollment. The notice must include an explanation of the reason for disenrollment, the effective date of the disenrollment, that the Participant will continue to receive services through ACAP until the effective date of the disenrollment, information about how to access services outside of ACAP, the right of the Participant to file a Complaint and request a Fair Hearing after exhausting the Complaint

process, and the right of the Participant to continue enrollment after the proposed effective date if the Participant files a Complaint within ten (10) days from the mail date on the written notice and requests a Fair Hearing within ten (10) days from the mail date on the written notice of the Complaint decision.

d. The Contractor must provide a copy of the Involuntary Disenrollment Form to BSASP and the Participant's CAO.

G. In order to expedite the disenrollment process, to ensure more timely disenrollment from ACAP, or for any reason the Department deems necessary, the Department may modify the disenrollment process. The Department will confirm any such changes to the disenrollment process in writing, and send notice to the Contractor in accordance with Section 12.6.

H. Effective Date of Disenrollment

1. The effective date for disenrollment must be on the last day of a month.

2. The effective date of the disenrollment is suspended if the Participant files a Complaint within ten (10) days from the mail date on the written notice of disenrollment.

3. The effective date of an approved disenrollment must be no later than the first day of the second month following the month in which the Participant requests disenrollment or the Contractor refers the request to the Department.

I. Disenrollment Documentation

A discharge summary must be completed for each individual who voluntarily or involuntarily disenrolls from the Plan and be forwarded to the Quality Management and Utilization Review Committee for review within ten (10) days of the discharge. The summary must include detailed reasons for the disenrollment, and activities or incidents that led to the disenrollment.

ARTICLE V: COMPLAINTS, GRIEVANCES, AND FAIR HEARINGS

5.1 Complaint, Grievance, Fair Hearing Components

A. The Contractor's Member Advisory Committee shall establish, maintain, and provide support to a Complaint and Grievance Committee that is accountable to the Governing Body on issues addressed by the Complaint and Grievance Committee. The

Complaint and Grievance Committee membership must include Participants, caregivers, and others to be identified by BSASP. The Complaint and Grievance Committee will review the Contractor's performance in carrying out the Complaint and Grievance procedures and make recommendations for improvements to the procedures.

B. The Contractor shall develop Complaint, Grievance, and Fair Hearing procedures that comply with Appendix G. The Contractor's procedures must be approved by the Department before implementation.

C. The Contractor cannot unilaterally determine that a Participant’s dispute or objection regarding a Network Provider or dispute or objection to the coverage, operations, management, or decision of the Contractor, is not a Complaint or a Grievance. All disputes or objections regarding a Network Provider or disputes or objections to the coverage, operations, management, or decisions of the Contractor must be treated as either a Complaint or a Grievance.

D. The Complaint and Grievance Committee must meet at least once every six (6) months.

ARTICLE VI: QUALITY MANAGEMENT AND UTILIZATION REVIEW

6.1 Quality Management

A. Administrative

The Contractor shall:

1. Perform quarterly audits of medical and service records to ensure record entries are appropriate, complete, and legible, and contain all required information such as assessments, progress notes, responsible Provider signatures and recording of services delivered.

2. Establish ongoing mechanisms to monitor Network Provider compliance with the Department's standard for timely access to care and services as specified in this Agreement and take corrective action if there is a failure to comply.

3. Monitor the performance of its Network Providers on an ongoing basis, conducting formal reviews and, if any deficiencies or areas of improvement are identified, take corrective action or require the Network Provider to take corrective action. The Contractor is required to monitor all Network Providers at least once every three (3) years.

4. Establish and provide support, including staff and alternative forms of communication, to a committee composed primarily of Participants that will report directly to the Member Advisory Committee on, at a minimum, issues of Participant satisfaction, quality of care, and service delivery.

5. Develop and, after Department approval, implement a plan of Quality Assurance and Improvement that includes the reports specified in Appendix K, which shall be designed to objectively and systematically monitor and evaluate quality and appropriateness of Participant care and identify and resolve problems relating to Participant care. The plan of Quality Assurance and Improvement must include a mechanism to detect both under-utilization and over- utilization of services and to assess the quality and appropriateness of care furnished to all Participants including those with special health care needs and those that need LTSS. It must also include a system of ongoing assessment, implementation, evaluation, and revision of activities related to overall program administration and service delivery. The plan of Quality Assurance and Improvement shall provide for the periodic submission of reports and records to the Contractor's Governing Body and Member Advisory Committee.

6. Meet with the Department on a semi-annual basis (or as the Department otherwise requests) to review the Contractor's performance of all obligations under this Agreement, the development of specific quality goals, the establishment of performance measurement criteria, and discuss other areas the Department deems necessary. The Contractor must submit the reports required by Appendix K to the Department two (2) weeks before it meets with the Department.

B. Quality Management and Utilization Review Committee

1. The Member Advisory Committee shall establish, maintain, and provide support to a Quality Management and Utilization Review Committee, and be accountable to the Governing Body on issues addressed by the Quality Management and Utilization Review Committee.

2. The Quality Management and Utilization Review Committee shall provide guidance and assistance to support the Contractor in carrying out the following quality management responsibilities:

a. Developing mechanisms for collecting and evaluating information, identifying problems, formulating

recommendations, disseminating information, implementing corrective actions, and evaluating the effectiveness of actions taken;

b. Reviewing annually and making recommendations concerning the formulation, revision or implementation of the policies governing the scope of services offered, practice guidelines, medical supervision, ISPs, crisis intervention care, clinical records, personnel qualifications and program evaluation;

c. Providing technical advice regarding professional questions and individual service problems;

d. Participating in program evaluation including annual evaluation of the Contractor's performance;

e. Assisting in maintaining liaison with professional groups and health providers in the community;

f. Participating in the development and ongoing review of written policies, procedures, and standards of patient care and quality management;

g. Reviewing the adequacy and effectiveness of quality management and utilization activities on a quarterly basis; and

h. Developing mechanisms for evaluating responsiveness of the Complaint and Grievance processes and for collecting and analyzing information about voluntary disenrollments.

3. The Quality Management and Utilization Review Committee must meet at least once every three months.

C. Ethics Committee

1. The Contractor's Member Advisory Committee shall establish, maintain, and provide support to an Ethics Committee and be accountable to the Governing Body on issues addressed by the Ethics Committee. The Ethics Committee shall be composed of administration and program staff and the community at large in the fields of primary health care, behavioral health, religion, law, and ethics to represent diversity of Participants.

2. Responsibilities of the Ethics Committee shall include the following:

a. Reviewing the ethical dimensions of medical, behavioral health, and non-clinical decisions on behalf of Participants and making non-binding recommendations;

b. Providing guidance to the Contractor's Governing Body and Member Advisory Committee on recurring behavioral health and medical-ethical issues;

c. Assisting in the development of procedures in documenting Advance Directives, living wills, and general Participant health wishes as required by state and federal law; and

d. Providing needed staff training around ethical issues and concerns.

3. The Ethics Committee shall meet when directed to meet by the Contractor or the Department.

6.2 Quality Management Report

The Contractor shall submit a written report of quality management activities including standard measures required by the Department to the Governing Body, Member Advisory Committee and the Department on an annual basis, which describes topics reviewed, method of review, recommendations for improvement, and evaluation of corrective actions implemented.

6.3 Departmental Monitoring

A. The Contractor shall cooperate with the Department and the Department's authorized representatives in the Department's monitoring of the Contractor's and Network Providers' compliance with the requirements specified in this Agreement, the Contractor's and Network Providers' performance as it relates to Participant Outcomes and consistency of quality indicators (see Appendix K), and the Department's monitoring of the performance of the Contractor in at least the following areas:

1. Administration and management.

2. Complaint and Grievance systems.

3. Claims management.

4. Participant materials and customer services.

5. Finance, including Medical Loss Ratio reporting.

6. Information systems, including encounter data reporting.

7. Marketing.

8. Medical management, including utilization management and case management.

9. Program integrity.

10. Provider Network management, including Provider directory standards.

11. Availability and accessibility of services, including Network adequacy standards.

12. Quality improvement.

13. All other provisions of the Agreement, as appropriate.

The Department's monitoring may include routine on-site compliance and quality of care reviews; participation in the Contractor's assessments of Participants and in ISP Team meetings as determined necessary by BSASP; review of at least ten percent (10%) of ISPs on an ongoing basis; and on-site visits of Participants' environments. BSASP will perform the on-site complaint and quality of care reviews at least annually either unannounced or schedule at a time mutually agreed upon.

B. The Contractor shall provide BSASP access to electronic health records (EHR) within two (2) business days of BSASP's request to view the information entered into the EHR.

C. The Department will report any problems identified during the monitoring reviews to the Contractor for corrective action. The Department will not request corrective action if the reason the Contractor has failed to comply with a provision in the Agreement is because the provision was not included in prior Agreements and the Contractor has not had a reasonable opportunity to comply with the provision.

D. The Contractor shall submit a written corrective action plan, which must include the schedule for implementation, to the Department within thirty (30) days of receipt of the Department's report for review and written Department approval, unless the corrective action plan is the result of problems identified during the Department's monitoring of ISPs. If the corrective action plan is required because of problems identified during the Department's monitoring of ISPs, the Contractor shall submit it to the Department within seven (7) business days of receipt of the Department's report for review and

written Department approval. The Contractor shall implement the Department-approved corrective action plan and the Department will monitor implementation.

E. The Contractor shall comply with requests from the Department for submission of data required to complete an annual external independent review of the quality Outcomes and timeliness of, and access to, Authorized Services.

ARTICLE VII: RECORD RETENTION, AUDIT, AND INSPECTION

7.1 Records

A. The Contractor must maintain all books, records, and other evidence pertaining to revenues, expenditures, and other financial activity pursuant to this Agreement and in such detail as shall properly substantiate claims for payment under this Agreement.

B. The Contractor must maintain all source records for reports submitted to the Department.

C. The Contractor shall maintain all documents relating to litigation, adjudicatory proceedings, claims negotiations, audits, or other actions, including appeals, commenced during the term of this Agreement.

7.2 Record Retention and Access to Records

A. The Contractor shall make available for audit, review, or evaluation to the Department, federal agencies or their designees all records relating to the Plan, including but not limited to the records referenced in Section 7.1. The Contractor shall afford access to these items at its offices at all reasonable times. In the event that the Department, federal agencies or their designees request access to the records after the expiration or termination of this Agreement but before the expiration of the period for which the Contractor is required to retain such records, the Contractor, at its own expense, must send copies of the requested records to the requesting entity within thirty (30) days of such request.

B. The Contractor shall preserve all records relating to the Plan, including but not limited to the records referenced in Section 7.1 for a period of ten (10) years from the termination date of this Agreement.

7.3 Recovery of Funds

During the term of this Agreement and after this Agreement is terminated, the Department retains the right to disallow or recover an appropriate

amount of funds after fully considering the findings resulting from any audit covering the term of this Agreement. Such audits may be conducted after the termination date.

7.4 False Claims

The Contractor understands that any false claims, statements, or documents may be prosecuted under applicable laws.

7.5 Audits

A. The Contractor shall permit the Commonwealth, CMS, the Department of Health and Human Services Inspector General, the Comptroller General, and their designees at any time to audit, evaluate, and inspect any books, records, contracts, computers or other electronic systems that pertain to any aspect of services and activities performed or determination of amounts payable under the Agreement with the Commonwealth through 10 years from the final date of this Agreement or from the date of completion of any audit, evaluation, or inspection, whichever is later.

B. The Contractor shall permit the Commonwealth, CMS, the Department of Health and Human Services Inspector General, the Comptroller General, and their designees at any time to inspect its premises, physical facilities, or equipment where Medical Assistance related activities or work is conducted through 10 years from the final date of the Agreement or from the date of completion of any inspection, whichever is later.

ARTICLE VIII: CONFIDENTIALITY

8.1 Holder of Data

A. The Contractor shall protect all information, records, and data collected in connection with this Agreement from unauthorized disclosure as provided in 42 CFR Chapter 431, Subpart F and 45 CFR Chapters 160 and 164, Subparts A and E, and applicable state statutes and regulations. Except as otherwise required by law or as authorized by the Participant, access to such information shall be limited to the Participant, the Contractor, Network Providers, and the Department or the Department's designee in performance of duties related to this Agreement. The Contractor shall comply with all applicable statutory and regulatory provisions governing such data and the requirements in the Commonwealth of Pennsylvania, Department of Human Services Health Insurance Portability and Accountability Act (HIPAA) Business Associate Agreement and Data Certification (Attachment I).

B. The Contractor shall return to the Department any and all personal and confidential data furnished pursuant to this Agreement promptly at the request of the Department in whatever form it is maintained by the Contractor. Upon the termination or completion of this Agreement, the Contractor shall not use any such data or any material derived from the data for any purpose and, where so instructed by the Department, shall destroy such data or material.

8.2 Data Security

The Contractor shall take reasonable steps to ensure the physical security of such data under its control, including but not limited to: fire protection; protection against smoke and water damage; alarm systems; locked files, guards, or other devices reasonably expected to prevent loss or unauthorized removal of manually held data; passwords, access logs, badges, or other methods reasonably expected to prevent loss or unauthorized access to electronically or mechanically held data; limited terminal access; limited access to input documents and output documents; and design provisions to limit use of Participant or Applicant names.

ARTICLE IX: TERMS AND CONDITIONS

9.1 Laws and Regulations

The Contractor shall obtain and require its Network Providers to obtain all required licenses, certifications, credentials, and permits from federal, state and local authorities needed to implement activities under this Agreement and to comply with all federal, state, and municipal laws, ordinances, and regulations relating to activities under this Agreement, including any applicable federal and state laws that pertain to Participant rights, including but not limited to Title VI of the Civil Rights Act of 1964; Title IX of the Education Amendments of 1972; the Age Discrimination Act of 1975; the Rehabilitation Act of 1973; the Americans with Disabilities Act, as amended; the Health Insurance Portability and Accountability Act; Section 1557 of the Patient Protection and Affordable Care Act; and regulations promulgated under each statute.

9.2 Representation and Warranties of the Contractor

A. The Contractor represents and warrants to the Department that, to the best of its knowledge, it and its Network Providers have complied with and are complying with all applicable statutes, orders, rules and regulations promulgated by any federal, state, municipal, or other governmental authority relating to their property and the conduct of their operations, and no violations of any statute, order, rule, or regulation are existing or threatened.

B. If, at any time during the term of this Agreement, the Contractor, or any of its Network Providers, incurs loss of clinical licensure(s), accreditation(s), or state approval(s), the Contractor shall report such loss to the Department no later than the next business day following the discovery of such loss. Such loss may be grounds for termination of this Agreement under the provisions of Section 11.2.

9.3 Independent Contractors

The Contractor, its employees, Network Providers, or any other of its agents are independent contractors and not officers, employees, or agents of BSASP, the Department, or the Commonwealth of Pennsylvania.

9.4 Other Contracts

A. Nothing in this Agreement shall be construed to prevent the Contractor from operating other comprehensive health care plans or providing health care services to persons other than those covered under this Agreement. If the Contractor does so, the Contractor shall submit to the Department a complete list of such plans and services, including rates, upon request.

B. Nothing in this Agreement shall be construed to prevent the Department from contracting with other health care plans in the same Service Area.

9.5 Entire Agreement

This Agreement, including all Attachments and Appendices, constitutes the entire agreement of the parties with respect to the subject matter hereof and supersedes all prior agreements, representations, negotiations, and undertakings not set forth or incorporated herein. The terms of this Agreement shall prevail notwithstanding any variances with terms and conditions of any written or verbal communication subsequently occurring, except as provided in Section 12.4.

9.6 Section Heads

The headings of the sections of this Agreement are for convenience only and will not affect the construction this Agreement.

9.7 Administrative Procedures Not Covered

Administrative procedures not provided for in this Agreement will be set forth when necessary, in separate memoranda in accordance with Section 12.4.

9.8 Effect of Invalidity of Clauses

If any clause or provision of this Agreement is in conflict with any state or federal statute or regulation, that clause or provision shall be null and void, and any such invalidity shall not affect the validity of the remainder of this Agreement.

9.9 Program Integrity

A. The Contractor shall implement and maintain arrangements and procedures that are designed to detect and prevent Fraud, waste, and Abuse. The arrangements or procedures must include the following:

1. A compliance program that includes, at a minimum, all of the following elements and complies with CMS publication "Guidelines for Constructing a Compliance Program for Medicaid Managed Care Organizations and Prepaid Health Plans" found at https://www.cms.gov/Medicare-Medicaid-Coordination/Fraud-Prevention/FraudAbuseforProfs/Downloads/mccomplan.pdf :

   a. Written policies, procedures, and standards of conduct that articulate the Contractor's commitment to comply with all applicable requirements and standards in the Agreement and all applicable federal and state requirements.

   b. The designation of a compliance officer who is responsible for developing and implementing policies, procedures, and practices designed to ensure compliance with the Agreement's requirements. The compliance officer must report directly to the Executive Director and the board of directors.

   c. The establishment of a regulatory compliance committee on the board of directors and at the senior management level charged with overseeing the Contractor's compliance program and its compliance with the Agreement.

   d. A system for training and education for the compliance officer and all of the Contractor's employees, including senior management, for the federal and state standards and requirements in the Agreement.

   e. Effective lines of communication between the compliance officer and the Contractor's employees.

f. Enforcement of standards through well publicized disciplinary guidelines.

g. 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 reoccurrence, and ongoing compliance with the Agreement's requirements.

2. Provision for a method to verify, by sampling or other methods, whether services that have been represented to have been delivered by Network Providers were received by Participants and the application of such verification processes on a regular basis.

3. Provision for the Contractor's suspension of payments to a Network Provider for which there has been a determination that there is a credible allegation of Fraud in accordance with 42 CFR § 455.23.

B. The Contractor shall establish a Program Integrity unit within the organization comprised of experienced Program Integrity reviewers. This unit shall have the primary purpose of preventing, detecting, investigating and reporting suspected Fraud and Abuse that may be committed by Network Providers, Participants, employees, or other third parties with whom the Contractor contracts.

C. The Contractor shall create and maintain, and submit for Department approval, and comply with written policies and procedures for the prevention, detection, investigation and reporting of suspected Fraud and Abuse, including written policies required under the Deficit Reduction Act, 42 U.S.C. § 1396a(a)(68). The Contractor's submission of new or revised policies and procedures for review and approval by the Department shall not act to void or supersede any existing policies and procedures which were previously approved by the Department. Unless otherwise required by law, the Contractor may continue to operate under such existing policies and procedures until such time as the Department approves the new or revised policies and procedures.

1. The policies and procedures must provide and certify the Contractor's Program Integrity unit has access to records of

Network Providers.

2. The policies and procedures must also contain the following:

   a. A description of the methodology and standard operating procedures used to identify and investigate Fraud and Abuse, and to recover overpayments or otherwise sanction Network Providers.

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

   c. The Contractor must develop a certification process that demonstrates the policies and procedures were reviewed and approved by the Contractor's senior management.

D. The Contractor shall establish a policy on referral of suspected Fraud and Abuse to the Department.

E. The Contractor shall create and disseminate written materials for the purpose of educating employees, managers, Network Providers, subcontractors and subcontractors' employees about Medical Assistance laws, the Contractor's policies and procedures for preventing and detecting Fraud and Abuse, and the rights of employees to act as whistleblowers.

F. The Contractor shall promptly refer any potential Fraud, waste, or Abuse that it identifies to centralized oversight agencies responsible for Fraud and Abuse detection and prosecution activities and cooperate fully with these agencies. Such agencies include, but are not limited to, the Department's Bureau of Program Integrity, Governor's Office of the Budget, Office of Attorney General's Medicaid Fraud Control Section, the Pennsylvania State Inspector General, the CMS Office of Inspector General, and the United States Justice Department. Such cooperation must include providing access to all necessary case information, computer files, and appropriate staff. In addition, such cooperation may include participating in periodic Fraud and Abuse training sessions, meetings, and joint reviews of subcontracted Providers or Participants.

G. The Contractor shall ensure that the Department's toll-free Medical Assistance Provider Compliance Hotline number and accompanying explanatory statement is distributed to its Participants and Network Providers through its Participant and Provider handbooks. Notwithstanding this requirement, the Contractor is not required to reprint handbooks for the sole purpose of revising them to include

Medical Assistance Provider Compliance Hotline information. The Contractor shall, however, include such information in any new version of these documents to be distributed to Participants and Network Providers.

H. The Contractor may not knowingly have a Relationship with the following:

1. An individual or entity who is debarred, suspended, or otherwise excluded from participating in procurement activities under the Federal Acquisition Regulation or from participating in non-procurement activities under regulations issued under Executive Order No. 12549 or under guidelines implementing Executive Order No. 12549.

2. An individual or entity who is an Affiliate, as defined in the Federal Acquisition Regulation at 48 CFR § 2.101, of a person described in paragraph (l).

3. An individual or entity that is excluded from participation in any federal health care program under Section 1128 or 1128A of the Social Security Act.

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

a. A director, officer, or partner of the Contractor.

b. A subcontractor of the Contractor.

c. A person with beneficial ownership of five percent (5%) or more of the Contractor's equity.

d. A Network Provider or person with an employment, consulting or other arrangement for the provision of items and services that are significant and material to the Contractor's obligations under this Agreement with the Department.

The Contractor must disclose in writing any Relationship and require all Network Providers or subcontractors with whom the Contractor has entered into an agreement to disclose in writing any Relationship.

I. The Contractor will report to the Department, within ten (10) business days of the Contractor's notice of same, circumstances that may have material adverse effect upon financial or operational conditions of the Contractor, including, but not limited to the following:

1. Suspension, debarment, or exclusion from federally funded healthcare programs of the Contractor or any affiliate or related party, by any state or federal government.

2. Having a person who is debarred, suspended, or excluded act as a director, officer, or partner of the Contractor with beneficial ownership of more than five percent (5%) of the Contractor's equity who has been debarred from participating in procurement activities under federal regulations.

3. Notice of suspension, debarment, or exclusion from participation in healthcare programs or notice of an intent to suspend, debar, or exclude issued by any state or federal government to the Contractor or any affiliate or related party; or

4. Any lawsuits or investigations by any federal or state agency involving the Contractor or any affiliate or related party.

J. The Contractor shall immediately notify the Department, in writing, when the Contractor receives information about a change in a Network Provider's circumstances that may affect the Network Provider's eligibility to participate in the Plan or if a Provider or subcontractor with whom the Contractor has entered into an agreement is subsequently suspended, terminated or voluntarily withdraws from participation in the program as a result of suspected or confirmed Fraud or Abuse. The Contractor must also immediately notify the Department, in writing, if it terminates or suspends an employee as a result of suspected or confirmed Fraud or Abuse. The Contractor must inform the Department, in writing, of the specific underlying conduct that lead to the suspension, termination, or voluntary withdrawal. Subcontracts with Providers must carry notification of the prohibition and sanctions for submission of false claims and statements. Contractors who fail to report such information are subject to sanctions, penalties, or other actions.

K. The Contractor must promptly notify the Department in writing if it identifies or recovers overpayments or improper payments, including overpayments related to Fraud, Abuse, or waste of Medical Assistance funds, from non-administrative overpayments or improper payments made to Network Providers, or otherwise takes an adverse action against a Network Provider, e.g. restricting the Participants or services of a PCP. The Contractor must specify the overpayments due to potential Fraud, Abuse, or waste of Medical Assistance funds. The Contractor may retain all recovered overpayments or improper payments, including overpayments related to Fraud, Abuse or waste of Medical Assistance funds, from non-administrative overpayments or improper payments made to

Network Providers.

L. The Department will provide the Contractor with immediate notice via electronic transmission or access to Medicheck listings or upon request if a Provider with whom the Contractor has entered into an agreement is subsequently suspended or terminated from participation in the Medicaid or Medicare Programs. Such notification will not include the basis for the Departmental action, due to confidentiality issues. Upon notification from the Department that a Provider with whom the Contractor has entered into an agreement is suspended or terminated from participation in the Medicaid or Medicare Programs, the Contractor shall immediately act to terminate the Provider from participation. Terminations for loss of licensure and criminal convictions must coincide with the effective date of the Department's action.

M. The Department may impose sanctions, penalties, or take other actions if it determines that the Contractor, Network Provider, employee, or subcontractor has committed Fraud or Abuse as defined in this Agreement or has otherwise violated applicable law.

N. The Contractor shall require that all Network Providers and all subcontractors take such actions as necessary to permit the Contractor to comply with the Fraud and Abuse requirements in this Agreement. The Contractor shall comply with Medical Assistance regulations and any enforcement actions directly initiated by the Department under its regulations, including termination and restitution actions, among others.

O. The Contractor agrees that to the best of its knowledge and belief that, within the last five (5) years, the Contractor has 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 or civil anti-trust investigation by any

federal, state or local prosecuting or investigative agency.

The Contractor must immediately notify the Department in writing of any change in the above circumstances.

9.10 Conflict of Interest

A. The Contractor hereby assures that it presently has no interest and shall not acquire any interest, direct or indirect, which would conflict in any manner or degree with its performance under this Agreement and that in the performance of this Agreement, it shall not knowingly employ any person having such interest.

B. The Contractor hereby assures that no member of its Governing Body or any of its officers or directors currently has or shall acquire any interest, direct or indirect, which would conflict in any manner or degree with the Contractor's performance under this Agreement.

9.11 Reporting Ownership and Controlling Interest

A. The Contractor must provide on its behalf and for its Providers or subcontractors with whom the Contractor has entered into an agreement, written disclosure to the Department of information on ownership and control, business transactions, and persons convicted of crimes in accordance with 42 CFR § 438.608 and 42 CFR Part 455, Subpart B.

The Contractor shall disclose information required by 42 CFR § 438.608 and by 42 CFR Part 455, Subpart B at the following times:

1. When the Contractor may submit a proposal in accordance with the Department’s procurement process, if any.

2. When the Department renews or extends this Agreement.

3. When the Contractor executes this Agreement.

4. Within 35 days after any change in ownership of the Contractor.

B. The Contractor must report to the Department a description of transactions between the Contractor and a party in interest (as defined in 42 U.S.C. § 300e-17(b)), including the following transactions:

1. Any sale, exchange, or leasing of any property between the Contractor and such a party.

2. Any furnishing for consideration of goods, services (including management services), or facilities between the Contractor and such a party, but not including salaries paid to employees for services provided in the normal course of their employment.

3. Any lending of money or other extension of credit between the Contractor and such a party.

The Contractor shall make the forgoing information available to Participants upon reasonable request.

9.12 Other Federal Requirements

A. Contracts, subcontracts, and sub-grants 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 U.S.C. § 7606), Section 508 of the Clean Water Act (33 U.S.C. § 1368), and Executive Order 1178.

B. The Contractor 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).

C. The Contractor shall be in compliance with Equal Employment Opportunity (EEO) provisions.

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

E. 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 Act.

F. The Contractor shall comply with the Byrd Anti-Lobbying Amendment. The Contractor may not use federal funds for lobbying, and shall certify this to the Department or CMS upon request.

ARTICLE X: REPORTS

10.1 Reporting Requirements

The Contractor shall submit the following reports to the Department by the specified deadlines and in the formats set forth by the Department, including electronic transmission of data. The Contractor shall, in addition, participate both financially and programmatically in any data collection or survey activities for which the Department requests the Contractor's participation. The Contractor shall make all collected data available to the Department and upon request to CMS. All reports and

data submitted shall be accompanied by a written certification of the Executive Director, Chief Financial Officer, or an individual who reports directly to the Executive Director or Chief Financial Officer with delegated authority to sign for the Executive Director or Chief Financial Officer so that the Executive Director or Chief Financial Officer is ultimately responsible for the certification. The certification must attest that based on best knowledge, information, and belief the documentation and data is accurate, complete, and truthful.

A. Financial Reports

The Contractor shall submit financial reports specified in this Section to the Department in the frequency, format and detail prescribed by the Department based on the Department's fiscal year (July 1 through June 30). Administrative start-up and development costs shall be specifically and separately identified. Reports and reporting frequency may be modified by the Department.

1. Quarterly Financial Reports due within forty-five (45) days of the end of each quarter for quarters one (1) through three (3) and within ninety (90) days of the end of the quarter for quarter four (4) (see Attachment II).

2. Annual Financial Statement due within one-hundred eighty (180) days of the end of the fiscal year.

3. Annual Financial Statements of Related Entities within one-hundred eighty (180) days of the end of the fiscal year.

4. MLR experience for the MLR reporting year calculated in accordance with the requirements in 42 CFR § 438.8, within two hundred forty (240) days of the end of the fiscal year, in a format provided by BSASP, which includes an attestation to the accuracy of the calculation of the MLR in accordance with the requirements in 42 CFR § 438.8.

5. Entity-wide Annual Audit, based on industry accepted practices (including related party disclosure), and conducted in accordance with generally accepted accounting principles and generally accepted auditing standards, within two hundred forty (240) days of the end of the fiscal year being audited. The Annual Audit must include the following:

   a. Review of financial statements specific to ACAP.

   b. Profit sharing repayment/recoupment calculation. Additional information about this arrangement is included in Appendix L.

c. MLR report as described above.

B. Quarterly Reports (due within thirty (30) days of the end of each quarter)

1. Enrollment Report, which includes:

a. The number of referrals received from BSASP

b. The number of Team evaluations completed

c. The number of Applicants determined ineligible for ACAP (broken out by reason for denial)

d. The number of Applicants determined eligible for ACAP

e. The number of Participants enrolled in ACAP

f. The number of Applicants choosing to not enroll (include reason)

g. The number of voluntary disenrollments (attach discharge summaries)

h. The number of involuntary disenrollments (attach discharge summaries)

i. The number of Participant deaths

j. The number of total Participants

2. Complaint/Grievance Report, which includes:

a. The number of Complaints received

b. The number of Complaints resolved

c. The number of Grievances received

d. The number of Grievances resolved

3. TPL Report, which includes:

a. The number of times Participants have gained, lost, or changed TPL coverage, including the date the information was faxed to the Department

b. The number of TPL recoveries (attach documentation)

c. The amount of money recovered

d. The number of possible TPL tort cases (attach documentation)

4. Services Report, which includes:

a. Network Provider characteristics including zip code of location, number of Participants served, total encounters year to date, and number of Complaints year to date.

b. Out-of-Network Provider characteristics including zip code of location, number of Participants served, total encounters year to date, and number of Complaints year to date.

c. Services furnished to Participants, including LTSS furnished to Participants.

C. Yearly Reports (due within thirty (30) days of the end of each fiscal year)

1. Ownership and control report, which includes the information on ownership and control described in 42 CFR § 455.104 for the Contractor and Network Providers.

2. Overpayment report, which includes the amount the Contractor has recovered from Network Providers as a result of overpayments to Network Providers and the reason for each overpayment.

D. Person Level Encounter Data Reports

1. The Contractor must maintain a system for the collection and maintenance of Participant encounter data that allows for the identification of the Provider who delivers any item(s) or service(s) to a Participant.

2. The Contractor must provide encounter data and Fee-for-Service data (as appropriate) to the actuary responsible for developing the Capitation Rate yearly. The encounter data must include data for the three (3) most recent and complete years prior to the year for which the Capitation Rate is being calculated.

3. The Contractor must submit encounter data to the Department on a semiannual basis. Each submission must be submitted using the format specified in Attachment III of the Agreement and is due ninety (90) days after the last day of

December and June, unless the due date falls on a weekend. If the due date falls on a weekend, the encounter data is due the next business day. The submission must include encounter data for the six (6) month period ending the last day of December or June.

4. The Contractor must submit any other encounter data requested by the Department.

E. Ad Hoc Reports

The Contractor shall provide any additional information that the Department needs as determined necessary by the Department, to substantiate the above reports, or monitor effectiveness of the Plan.

The Contractor shall ensure that data received from Network Providers and included in any report is accurate and complete by verifying the accuracy and timeliness of reported data; screening the data for completeness, logic, and consistency; and collecting the data in a standardized format to the extent feasible and appropriate, including utilizing secure information exchanges and technologies utilized by the Department for quality improvement and care coordination efforts.

10.2 Completion of Assessment Instrument

At the Department's direction, the Contractor shall use an assessment instrument(s) designated by the Department, to complete an assessment on a regular basis (as determined by the Department) for each Participant for the purpose of comparing the ACAP population to the ICF/ID, ICF/ORC, and waiver populations. The Contractor shall transmit the results of the assessments to the Department or its designee in an electronic format specified by the Department. The Contractor shall purchase the software required to transmit the data and attend any training needed in order to comply with this requirement.

10.3 Participant Satisfaction Surveys

The Contractor shall annually evaluate Participant and family/caregiver satisfaction with services provided under this Agreement through the use of Participant and family/caregiver satisfaction surveys. Surveys shall be developed by the Contractor and approved by the Department. The Contractor shall provide to the Department with a report of the results of the survey 90 days after the end of each calendar year.

ARTICLE XI: TERMINATION OF AGREEMENT

11.1 Failure to Conform

In the event of the Contractor's failure to conform to the requirements set

forth in Section 8.1, the Department may terminate this Agreement upon thirty (30) days written notice in accordance with Section 11.3.A.

11.2 <u>Termination without Notice</u>

The Department may terminate this Agreement immediately upon any of the following events:

A. The Contractor's:

1. Application for or consent to the appointment of a receiver, trustee, or liquidator for itself or any of its property;

2. Admission in writing that it is unable to pay its debts as they mature;

3. Assignment for the benefit of creditors; or

4. Commencement of a proceeding under any bankruptcy, reorganization, insolvency, or readjustment of debt provision of federal or state law or answer admitting the material allegations of a petition filed against the Contractor in any such proceedings.

B. Commencement of an involuntary proceeding against the Contractor under any bankruptcy, reorganization, insolvency, or readjustment of debt provision of federal or state law, which is not dismissed within sixty (60) days.

C. The Contractor loses any of the following:

1. Licensure at any of the Contractor's facilities;

2. Any federally required certification(s); or

3. State or federal approvals of the Contractor.

D. Cessation of state or federal funding of Title XIX programs, provided that termination for this reason shall occur no earlier than the last day of the month in which such funding ceases.

11.3 <u>Termination with Notice</u>

Either party may terminate this Agreement upon any of the following events:

A. Breach by a party of any duty or obligation under this Agreement which breach continues un-remedied for thirty (30) days after written

notice thereof by the other party.

B. Written notice by one party to the other of its intent to terminate this Agreement within one hundred and twenty (120) days of such notice.

11.4 Continuance of Contractor's Obligations at Termination

A. Notwithstanding the termination of this Agreement for any reason, including insolvency, the Contractor's obligations to each Participant at the time of such termination shall continue in effect until the Contractor finds other services for the Participant.

B. Upon termination of this Agreement for any reason, all finished or unfinished documents, data, studies and reports prepared by the Contractor under this Agreement shall become the property of the Department.

C. Upon termination of this Agreement for any reason, the Contractor shall cooperate with the Department in the development and implementation of a transition plan.

11.5 Responsibilities

If this Agreement is terminated or is not renewed for any reason:

A. The Contractor shall be responsible for notifying all Participants in writing within five (5) days of the Department's notice of termination or non-renewal of this Agreement of the date of termination and the process by which those Participants will continue to receive Covered Services;

B. The Contractor shall promptly return any payments advanced to the Contractor for periods after the effective date of termination;

C. The Contractor shall provide Participants with copies of their medical records, including assessment scores according to the time frame stated in the Department's notice of termination or non-renewal of this Agreement; and

D. The Contractor shall promptly supply all information to the Department necessary for the reimbursement of any outstanding Medical Assistance Program claims.

ARTICLE XII: EFFECTIVE TERM, RENEGOTIATION, AND MODIFICATION

12.1 Effectiveness of Agreement

A. This Agreement is subject to:

1. Availability of federal and state funds appropriated by the Commonwealth of Pennsylvania and certified by the Comptroller each fiscal year (July 1-June 30) that are necessary to discharge the Department's payment obligations under this Agreement, and

2. Approval of state officials as required by statute, regulation or administrative order.

In the absence of such appropriation and certification in any fiscal year, or in the event such funding is withdrawn from the Commonwealth for any reason, this Agreement shall be terminated without Department liability for damages, penalties or other charges because early termination, but without prejudice to such rights and obligations as may have accrued prior to such subsequent fiscal year.

B. The Contractor may not enroll Participants until it receives written verification from the Department that it has met the requirements of the Department's readiness review process.

12.2 Term of Agreement

This Agreement will continue for a period of one year from the effective date and will be extended for subsequent years in the absence of a notice by the Department to the Contractor to terminate or not renew the Agreement.

12.3 Renegotiation

Renegotiation of this Agreement may commence at any time. The Contractor shall supply the Department with any information necessary to assess the Contractor's performance under this Agreement and the appropriateness of the Capitation Payments.

12.4 Amendments

The parties agree to negotiate in good faith to cure any omissions, ambiguities, or manifest errors in this Agreement. By mutual consent, the parties may amend this Agreement where such amendment does not violate state or federal laws, regulations, or waiver requirements provided that such amendment is in writing, signed by both parties, and attached to this Agreement.

12.5 Sanctions

A. The Department may apply sanctions to the Contractor for noncompliance with or nonperformance or unsatisfactory performance of the terms of this Agreement or noncompliance with applicable state and

federal law and regulations.

B. The Department will give the Contractor ten (10) days advance written notice before it applies sanctions to the Contractor for noncompliance with or nonperformance or unsatisfactory performance of the terms of this Agreement or noncompliance with applicable state and federal law and regulations.

C. The following sanctions may be applied at the discretion of the Department for non-compliance with or non-performance or unsatisfactory performance under this Agreement or noncompliance with applicable state and federal law and regulations as determined by the Department:

1. A warning that future noncompliance with or nonperformance or unsatisfactory performance under this Agreement or noncompliance with applicable state and federal law and regulations will result in actions such as those as stated in 2, 3, and 4 of this paragraph.

2. Withholding all or part of the Capitation Payments or State-Funded Residential Habilitation Subsidies.

3. Suspension of new enrollment or restriction of current enrollment.

4. Fines or penalties consistent with those applied to nursing facilities or ICFs/ID in the Commonwealth.

12.6 Notices

Notices to the parties as to any matter for which notice is required under this Agreement will be sufficient if given in writing and sent by certified mail, postage prepaid, or delivered by hand to:

For the Contractor:
President and CEO
Keystone Autism Services 4391 Sturbridge Drive
Harrisburg, PA 17110

For the Department:
Commonwealth of Pennsylvania
Department of Human Services
Office of Developmental Programs
Bureau of Supports for Autism and Special Populations
Adult Community Autism Program (ACAP)
P.O. Box 2675
Harrisburg, PA 17105-2675

IN WITNESS HEREOF, the parties have caused this Agreement to be executed under Seal by their duly authorized officers or representatives as of the day and year stated:

The Contractor	Commonwealth of Pennsylvania Department of Human Services
By: Kristine C. Saylor	By:
(Signature)	(Signature)
Vice President Finance KHS	Deputy Secretary, Office of Developmental Programs
(Official Title)	(Official Title)
05/11/2023	6/22/2023
(Date)	(Date)