September 5, 2012

SUBJECT: RFP 16-12 HealthChoices Behavioral Health Services for Bradford, Cameron, Centre, Clarion, Clearfield, Columbia, Elk, Forest, Huntington, Jefferson, McKean, Northumberland, Juniata, Mifflin, Montour, Potter, Schuylkill, Snyder, Sullivan, Tioga, Union, Warren, and Wayne Counties

Dear Prospective Bidder:

You are invited to submit a proposal for the above subject RFP for the Commonwealth of Pennsylvania, Department of Public Welfare in accordance with the attached Request for Proposal (RFP).

All proposals must be submitted as follows: Technical Proposal: One original and fourteen (14) paper copies of the technical submittal: one original and two paper copies each of the following: Disadvantage Business, Contractor Partnership Program and Mentor Protégé program. Applicants must also submit two complete and exact copies of proposed submittals to include DB, CPP, and MPP on CD-ROM in Microsoft Office or Microsoft Office compatible format to the Pennsylvania Department of Public Welfare, Division of Procurement, Room 525, Health and Welfare Building, 625 Forster Street, Harrisburg, PA 17120. Proposals must be received at the above address no later than two o’clock P.M. (2:00 P.M.) on October 18, 2012. Late Proposals will not be considered regardless of the reason.

All questions should be directed to Michael Jeffrey, Project Officer, Department of Public Welfare, Office of Medical Assistance Programs via e-mail mjeffrey@pa.gov no later than September 12, 2012.

In addition, a Pre-Proposal Conference will be held at 12:00 pm on Monday, September 17, 2012 at the Clothes Tree, Building #36, DGS Annex Complex, 25 Beech Drive, Harrisburg, PA 17110-3591. Proposals must be signed by an official authorized to bind the Offeror to its provisions. Also, please include your Federal Identification Number and the Point of Contact’s email address on the cover sheet of your proposal. Evaluation of proposals and selection of Offerors will be completed as quickly as possible after receipt of proposal.

Sincerely,

Daniel R. Boyd
Director
DPW Division of Procurement
Directions: DGS ANNEX COMPLEX (former HARRISBURG STATE HOSPITAL)

From Points East or Northeast (Using Turnpike):

Take Exit 247 Harrisburg East off the Turnpike, traveling 283 West to I-83/81. At the three-way split, stay in the middle lane and follow the signs to I-83 North. Stay on I-83 North, to I-81 interchange. As you approach I-81, move to the far left lane, and take I-81 South towards Carlisle. Move to the middle lane of I-81 South and take the Cameron St. Exit ramp to 22/322 East. Continue with the instructions below (From I-81 North or South).

From Points West or Northwest (Using Turnpike):

Take Exit 226 from Turnpike at Carlisle. Stay in the far left lane of the ramp, and follow the signs to Harrisburg, Route 11 East and I-81. At the end of the Exit ramp, turn right onto Route 11 East and the I-81 Interchange. At the I-81 Interchange, follow the signs to I-81 North entrance ramp. Follow I-81 North to the Cameron Street Exit and go South on Cameron St. Continue with the instructions below (From I-81 North or South).

From Points North, Northwest, or Northeast (Using Route 11/15 or 22/322):

Traveling South on Route 11/15 or East on Route 22/322, two alternate routes are available:

- At the interchange of 11/15 and 22/322, travel East on Route 22/322, across the Susquehanna River (Clarks Ferry Bridge). Continue on East 22/322 into Harrisburg. At the I-81 Interchange, stay in the far left lane and travel South onto Cameron St. Continue with instructions below (From I-81 North or South)
- At the Intersection of 11/15 and 22/322, travel South on Route 11/15 to I-81 at Harrisburg. At the I-81 Interchange, take I-81 North, crossing the Susquehanna River (George Wade Bridge). Continue with instruction below (From I-81 North or South)

From I-81 North or South:

Exit from I-81 at the Cameron St. Exit Ramp, and travel South on Cameron St. At the top of the ramp, move to the left lane. Go through the first traffic light at the intersection of Cameron St. and Elmerton Ave. (Farm Show Bldg. is on the right). Stay in the left lane, travel to the next traffic light and take a left into the Harrisburg State Hospital Grounds. (Old Entrance of the Farm Show Bldg. on Right and Agriculture Bldg. on left.)

Stay to the right, and veer right at the next intersection at the top of the hill onto Azalea Drive. Follow Azalea Drive, toward the Administration Bldg. Stay to the right as you pass the Administration Building. Continue through the parking area and stay to the right to pass behind the Beechmont Building. Clothes Tree will be on your left after Beechmont, and parking is also on the left just past the Clothes Tree.
Visitor Parking
for the Clothes Tree Parking Lot
DGS ANNEX COMPLEX - Harrisburg - Pennsylvania
Please provide your information to the
Office of Mental Health and Substance Abuse Services
to pre-register your visit:

NAME:

TeLe: Email:

ORGANIZATION:

Date & Times of Visit:

Meeting Name & Meeting Location:

CAR MAKE: MODEL:

CAR COLOR: CAR LICENSE NUMBER:

Please email completed form at least 24 hours prior to your meeting to
OMHSASAdmin@pa.gov for an advance
Parking space # assignment in the
Clothes Tree Parking Lot.
You will have a number assigned prior to your arrival and you **DO NOT**
need to stop in Admin Bldg, just proceed directly to the Clothes Tree
to pick up your pass for the day.
Parking permits will be available by **advance** registration only.
If you need additional information you may email
OMHSASAdmin@pa.gov
REQUEST FOR PROPOSALS FOR

HEALTHCHOICES BEHAVIORAL HEALTH SERVICES for
Bradford, Cameron, Centre, Clarion, Clearfield, Columbia, Elk, Forest,
Huntington, Jefferson, McKean, Northumberland, Juniata, Mifflin, Montour,
Potter, Schuylkill, Snyder, Sullivan, Tioga, Union, Warren, and Wayne Counties.

ISSUING OFFICE

COMMONWEALTH OF PENNSYLVANIA
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF FINANCIAL OPERATIONS
DIVISION OF PROCUREMENT
ROOM 402, HEALTH AND WELFARE BUILDING
625 FORSTER STREET
HARRISBURG, PA 17120

RFP NUMBER:

RFP# 16-12

DATE OF ISSUANCE

September 5, 2012
# REQUEST FOR PROPOSALS FOR

RFP# 16-12

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COMMONWEALTH OF PENNSYLVANIA
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<td>Deadline to submit Questions via email to <a href="mailto:mjeffrey@pa.gov">mjeffrey@pa.gov</a>. Additional</td>
<td>Potential Offerors</td>
<td>September 12, 2012</td>
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<td>questions will be accepted at the Pre-proposal Conference.</td>
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<tr>
<td>Pre-proposal Conference—Clothes Tree, Building #36, DGS Annex Complex,</td>
<td>Issuing Office/Potential</td>
<td>September 17, 2012 (12 pm to 4:30 pm)</td>
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<td>Offerors</td>
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<tr>
<td>Answers to Potential Offeror questions posted to the DGS website</td>
<td>Issuing Office</td>
<td>September 19, 2012</td>
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<td>(<a href="http://www.dgsweb.state.pa.us/RTA/Search.aspx">http://www.dgsweb.state.pa.us/RTA/Search.aspx</a>) no later than this date.</td>
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<td>Please monitor website for all communications regarding the RFP.</td>
<td>Potential Offerors</td>
<td>On-going</td>
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<tr>
<td>Sealed proposal must be received by the Issuing Office at Department’s</td>
<td>Offerors</td>
<td>Oct.18, 2012</td>
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<td>Procurement Section, Room 402, Health and Welfare Building, 625 Forster</td>
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PART I. GENERAL INFORMATION FOR THE OFFEROR

I-1. PURPOSE

This Request for Proposals (RFP) provides to those interested in submitting proposals for the subject procurement (Offerors) sufficient information to enable them to prepare and submit proposals for the Department of Public Welfare’s (Department or DPW) consideration on behalf of the Commonwealth of Pennsylvania (Commonwealth) to satisfy a need for behavioral health managed care services in a 23 county area (Project).

The purpose of this RFP is to solicit proposals, under a Centers for Medicare and Medicaid Services (CMS) Waiver of Section 1915(b) of the Social Security Act, from licensed, risk assuming private sector behavioral health managed care organizations (BH-MCOs) to become a Primary Contractor to manage the purchase and provision of Behavioral Health Services in the Commonwealth’s mandatory managed care program called HealthChoices for eligible MA recipients residing in the North/Central State Option (N/C SO) zone of Bradford, Cameron, Centre, Clarion, Clearfield, Columbia, Elk, Forest, Huntingon, Jefferson, McKean, Juniata, Mifflin, Montour, Northumberland, Potter, Schuylkill, Snyder, Sullivan, Tioga, Union, Warren, and Wayne Counties.

Within this 23 county geographic area Bradford/Sullivan, Cameron/Elk, Clearfield/Jefferson, Columbia/Montour/Snyder/Union, Forest/Warren, and Huntingdon/Mifflin/Juniata counties are organized as joiners for the delivery of county-administered mental health and drug and alcohol services.

At the Department’s option, it may expand the zone to include any of the following counties/joiners: Bedford, Blair, Cambria, Carbon, Clinton, Crawford, Erie, Franklin, Fulton, Lycoming, Mercer, Monroe, Pike, Somerset, and Venango as part of the N/C SO zone. If the Department elects to include any additional counties, the Department and the selected Offeror will investigate the effect of the additional service area on the Agreement to determine what if any modifications to the Agreement need to be made.

I-2. ISSUING OFFICE AND PROJECT OFFICER

This RFP is issued for the Commonwealth by the Department’s Procurement Division on behalf of the Office of Mental Health and Substance Abuse Services (OMHSAS). The sole point of contact in the Commonwealth for this RFP shall be:

Michael Jeffrey
Department of Public Welfare
Office of Mental Health and Substance Abuse Services
P.O. Box 2675
Administration Building #11
Harrisburg, Pennsylvania 17105
E-Mail: mjeffrey@pa.gov
FAX: (717) 787-5394

Please refer all inquiries to the Project Officer.

I-3. SCOPE

This RFP contains instructions governing the requested proposals, including the requirements for the information and material to be included; a description of the service to be provided; requirements which
Offerors must meet to be eligible for consideration; general evaluation criteria; and other requirements specific to this RFP.

I-4. PROBLEM STATEMENT

On February 1, 1997, the Commonwealth introduced a integrated and coordinated health care delivery system known as HealthChoices to provide medical, psychiatric and substance abuse services to Medical Assistance recipients. On January 1, 2007 the Commonwealth implemented the HealthChoices Behavioral Health capitated, mandatory managed care program in the 23 counties referenced in this RFP as the North/Central State Option (N/C SO) zone.

These counties are located across the Commonwealth and cover more than 250 miles from the northeast corner of Pennsylvania (Wayne County) to northwest Pennsylvania (Warren County) and approximately 150 miles from Potter County in the north to Huntingdon County in the south central part of the Commonwealth. The goals of the HealthChoices physical and behavioral health care programs are to improve the accessibility, continuity, and quality of services for Pennsylvania's Medical Assistance populations, while controlling the program's rate of cost increases.

The Department has implemented and will continue to operate the HealthChoices Behavioral Health Program consistent with a vision of service systems of the future and a set of expectations about what managed behavioral health care can accomplish. Currently, three distinct avenues for the funding and administration of mental health and drug and alcohol services provided to Medicaid recipients exist. They are: 1) The Medicaid Fee-for-Service and mandatory managed care programs; 2) the state mental hospital system administered by the Department's OMHSAS; and 3) the community-based mental health and drug and alcohol programs funded by OMHSAS and the Department of Drug and Alcohol Programs (DDAP). In seeking proposals, the Department is interested in contracting with an entity that will: 1) facilitate efficient coordination, continuity and integration in the provision of Behavioral Health Services; 2) coordinate the provision of Behavioral Health Services with physical health services; and 3) coordinate Behavioral Health Services with the broader array of publicly funded human service programs as well as the informal, community support systems of Members. Such broad-based coordination is essential to assuring appropriate access, services utilization and continuity of care for adults and older adults with serious mental illness and/or addictive diseases, and children and adolescents with serious emotional disturbances, and/or who abuse substances.

The HealthChoices program has a rich history of developing cost-effective alternative services that improve the health outcomes of high-risk Members. Provider networks have been expanded to make services more accessible even in the most rural areas. Counties and Behavioral Health Managed Care Organizations (BH-MCOs) have developed performance improvement plans targeted to improve the performance of selected indicators. Additionally, many counties and BH-MCOs are beginning to use new technology such as telepsychiatry to ensure access to psychiatrists and specialists in rural areas. Use of new technologies will be important to ensure access and enhance communication.

Some of the most effective improvements that are emerging from the HealthChoices Program are grounded in the principles of recovery. Recovery oriented services include psychiatric rehabilitation, peer support, and mobile medication, among other services. Understanding how to support recovery requires active on-going listening and feedback loops, and participation at all levels of decision making. In November 2004, the Pennsylvania Recovery Workgroup generated the following definition of recovery to guide system transformation which was endorsed by OMHSAS in 2005:

Recovery is a self-determined and holistic journey that people undertake to heal and grow.
Recovery is facilitated by relationships and environments that provide hope, empowerment, choices, and opportunities that promote people reaching their full potential as individuals and community members.

Responding to the unique needs of the counties in the area served will be important to the success of the program. The counties in the N/C SO zone are generally rural, have unique cultural and geographic differences, have challenges in gaining ready access to mental health professionals and specialized psychiatric expertise, have transportation challenges and often need to join with other counties to create shared services for more intensive specialized services. In some counties, county government is also a service provider. Many counties jointly manage their targeted use of state hospital inpatient beds. All counties have engaged in planning for consumers who are hospitalized in state mental hospitals with the goal of reducing the number of consumers hospitalized over two years. The planning has identified the services and supports needed to allow consumers to live successfully in their community. The HealthChoices Program when coordinated with county base funding, housing development initiatives and other human services supports creates a unified systems approach and financing strategy. The selected Offeror will have to be a partner with the Commonwealth and counties to support and enhance recovery-oriented services that specifically address the unique needs of children and their families, adults, and older adults with mental health and drug and alcohol treatment needs.

There will be a direct Agreement between the Commonwealth and the BH-MCO serving the zone. County government will serve in a partnership role with DPW in managing the HealthChoices Program. The selected Offeror, in collaboration with the counties and with approval of the Department, will develop a process for input and feedback including an identified entity with an advisory body or board that is responsible for representing the local needs of the counties for the purpose of planning and system development. The board is composed of county behavioral directors or their designee. In addition, there must be formal mechanisms for review, information sharing and identification of unmet and under met needs of Members.

The current model includes a structure that serves as a way to ensure collaborative oversight between the counties and the BH-MCO. It reflects the geographic diversity of this large region as well as the range of programmatic areas. The Primary Contractor allocates a portion of Capitation funding for county government oversight functions.

I-5. TYPE OF AGREEMENT

If DPW enters into an agreement as a result of this RFP, it will be a full risk captivated Agreement and will contain the Standard Grant Terms and Conditions as shown in Appendix B and the DPW Addendum to Standard Contract Terms and Condition as shown in Appendix C. A draft Agreement is in the Offeror’s Library. The Department shall select one Offeror for the N/C SO zone.

The priority order of documents will be:

A. Agreement with attachments;
B. The issued RFP; and
C. Selected Proposal.

The Department will enter into a full-risk capititated Agreement using a negotiated flat fee per Member in the HC-N/C SO counties. Once the Department has selected an Offeror for negotiations, it will provide an initial schedule of rates to the selected Offeror for Agreement discussions. The Department will meet with the selected Offeror to discuss the development of the initial rate schedule and will provide a final
rate schedule to the selected Offeror. If the selected Offeror does not accept the Department’s final rate schedule, the Department may reject the Offeror’s proposal and select another Offeror for negotiations.

Effective July 1, 2013, the selected Offeror will be responsible for all medically necessary In-Plan services provided to identified Members. Should the selected Offeror incur costs that exceed the Capitation payments, the Department will not be responsible for providing additional funds to cover the deficits. The method of payment is monthly; however, payments will be delayed by two months. Example: The program starts on July 1, 2013; the Capitation payment for the month of July 2013 will be made on or before September 15, 2013. The two month payment delay will be reconciled upon expiration, or termination of the Agreement.

The Department, in its sole and complete discretion, may undertake negotiations with Offerors whose proposals, in the Department’s judgment, show them to be qualified, responsible and capable of performing the Project.

Continuation of the HC BH Program is contingent upon receiving approval of amendments to the 1915(b) HealthChoices Waiver from the Centers for Medicare and Medicaid Services (CMS).

I-6. REJECTION OF PROPOSALS

The Department, in its sole and complete discretion, may reject any proposal received as a result of this RFP.

I-7. INCURRING COSTS

The Department is not liable for any costs incurred by Offerors in preparation and submission of their proposals, in participating in the RFP process or in anticipation of award of an Agreement.

I-8. PRE-PROPOSAL CONFERENCE

The Department will hold a Pre-proposal Conference as specified in the Calendar of Events. The purpose of this conference is to provide an opportunity for clarification of the RFP. Offerors should forward all questions to the Project Officer in accordance with Part I, Section I-9 to ensure adequate time for analysis before the Department provides an answer. Offerors may also ask questions at the conference. In view of the limited facilities available for the conference, Offerors should limit their representation to 5 individuals per Offeror. The Pre-proposal conference is for information only. Any answers furnished during the conference will not be official until they have been verified, in writing, by the Department. All questions and written answers will be posted on the Department of General Services’ (DGS) website as an addendum to, and shall become part of, this RFP. Attendance at the Pre-proposal Conference is optional.

I-9. QUESTIONS & ANSWERS

If an Offeror has any questions regarding this RFP, the Offeror must submit the questions by email (with the subject line “RFP 16-12 Question”) to the Project Officer named in Part I, Section I-2 of the RFP. If an Offeror has questions, they must be submitted via email no later than the date indicated on the Calendar of Events. The Offeror shall not attempt to contact the Project Officer by any other means. The Issuing Office will post the answers to the questions on the DGS website by the date stated on the Calendar of Events. An Offeror who submits a question after the deadline date for receipt of questions indicated on the Calendar of Events assumes the risk that its proposal will not be responsive or competitive because the Commonwealth is not able to respond before the proposal receipt date or in
sufficient time for the Offeror to prepare a responsive or competitive proposal. When submitted after the deadline date for receipt of questions indicated on the Calendar of Events, the Project Officer may respond to questions of an administrative nature by directing the questioning Offeror to specific provisions in the RFP. To the extent that the Department decides to respond to a non-administrative question after the deadline date for receipt of questions indicated on the Calendar of Events, the answer must be provided to all Offerors through an addendum.

All questions and responses as posted on the DGS website are considered as an addendum to, and part of, this RFP in accordance with RFP Part I, Section I-10. Each Offeror shall be responsible to monitor the DGS website for new or revised RFP information. The Department shall not be bound by any verbal information nor shall it be bound by any written information that is not either contained within the RFP or formally issued as an addendum by the Department. The Department does not consider questions to be a protest of the specifications or of the solicitation. The required protest process is described in Part I, Section I-27 of this RFP.

I-10. ADDENDA TO THE RFP

If the Department deems it necessary to revise any part of this RFP before the proposal response date, the Issuing Office will post an addendum to the DGS website at http://www.dgsweb.state.pa.us/RTA/Search.aspx. It is the Offeror’s responsibility to periodically check the website for any new information or addenda to the RFP. Answers to the questions asked during the Questions & Answers period also will be posted to the website as an addendum to the RFP.

I-11. RESPONSE DATE

To be considered for selection, hard copies of proposals must arrive at the Issuing Office on or before the time and date specified in the RFP Calendar of Events. The Department will not accept proposals by email or facsimile transmission. Offerors who send proposals by mail or other delivery service should allow sufficient delivery time to ensure timely receipt of their proposals. If, due to inclement weather, natural disaster, or any other cause, the Commonwealth office location to which proposals are to be returned is closed on the proposal response date, the deadline for submission will be automatically extended until the next Commonwealth business day on which the office is open, unless the Issuing Office otherwise notifies Offerors. The hour for submission of proposals shall remain the same. The Department will reject, unopened, any late proposals.

I-12. PROPOSAL

To be considered, Offerors should submit a complete response to this RFP to the Issuing Office, using the format provided in Part II, providing 15 paper copies of the Technical Submittal and two (2) paper copies of the Small Diverse Business (SDB) participation Submittal, two (2) paper copies of the Mentor Protégé Program Submittal, and two (2) paper copies of the Contractor Partnership Program Submittal. In addition to the paper copies of the proposal, Offerors shall submit two complete and exact copies of the entire proposal (Technical and SDB submittals, along with all requested documents) on CD-ROM or Flash drive in Microsoft Office or Microsoft Office-compatible format. The electronic copy must be a mirror image of the paper copy and any spreadsheets must be in Microsoft Excel. The Offerors may not lock or protect any cells or tabs. The CD or Flash drive should clearly identify the Offeror and include the name and version number of the virus scanning software that was used to scan the CD or Flash drive before it was submitted. Offerors should ensure that there is no costing information in the technical submittal. The Offeror shall make no other distribution of its proposal to any other Offeror or Commonwealth official or Commonwealth consultant. Each proposal page should be numbered for ease
of reference. An official authorized to bind the Offeror to its provisions must sign the proposal. If the official signs the Proposal Cover Sheet (Appendix A to this RFP) and the Proposal Cover Sheet is attached to the Offeror’s proposal, the requirement will be met. For this RFP, the proposal must remain valid for 180 days or until an agreement is fully executed. If the Department selects the Offeror’s proposal for award, the contents of the selected Offeror’s proposal will become, except to the extent the contents are changed through Best and Final Offers or negotiations, contractual obligations.

Each Offeror submitting a proposal specifically waives any right to withdraw or modify it, except that the Offeror may withdraw its proposal by written notice received at the Issuing Office’s address for proposal delivery prior to the exact hour and date specified for proposal receipt. An Offeror or its authorized representative may withdraw its proposal in person prior to the exact hour and date set for proposal receipt, provided the withdrawing person provides appropriate identification and signs a receipt for the proposal. An Offeror may modify its submitted proposal prior to the exact hour and date set for proposal receipt only by submitting a new sealed proposal or sealed modification which complies with the RFP requirements.

I-13. SMALL DIVERSE BUSINESS INFORMATION

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

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

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

Questions regarding this Program can be directed to:

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

The Department’s directory of BSBO-certified minority-, women-, veteran- and service disabled veteran-owned businesses can be accessed from: http://www.portal.state.pa.us/portal/server.pt/community/under_construction__bureau_of_minority_and_women_business_opportunities/20986. The federal vendor database can be accessed at http://www.ccr.gov by clicking on Dynamic Small Business Search (certified companies are so indicated).
I-14. ECONOMY OF PREPARATION

Offerors should prepare proposals simply and economically, providing a straightforward, concise description of the Offeror’s ability to meet the requirements of the RFP.

I-15. ALTERNATE PROPOSALS.

The Department has identified the basic approach to meeting its requirements, allowing Offerors to be creative and propose their best solution to meeting these requirements. The Department will not accept alternate proposals.

I-16. DISCUSSIONS FOR CLARIFICATIONS

Offerors may be required to make an oral or written clarification of their proposals to the Department to ensure thorough mutual understanding and Offeror responsiveness to the solicitation requirements. The Project Officer will initiate requests for clarification. Clarifications may occur at any stage of the evaluation and selection process prior to agreement execution.

I-17. PRIMARY CONTRACTOR RESPONSIBILITIES

The Agreement will require the selected Offeror to assume responsibility for all services offered in its proposal whether it provides them itself or by subcontracts. The Department will consider the selected Offeror to be the sole point-of-contact with regard to Agreement matters.

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

I-18. PROPOSAL CONTENTS

a. Confidential Information. The Commonwealth is not requesting, and does not require, confidential proprietary information or trade secrets to be included as part of Offerors’ submissions in order to evaluate proposals submitted in response to this RFP. Accordingly, except as provided herein, Offerors should not label proposal submissions as confidential or proprietary or trade secret protected. Any Offeror who determines that it must divulge such information as part of its proposal must submit the signed written statement described in subsection c. below and must additionally provide a redacted version of its proposal, which removes only the confidential proprietary information and trade secrets, for required public disclosure purposes.

b. Commonwealth Use. All material submitted with the proposal shall be considered the property of the Commonwealth of Pennsylvania and may be returned only at the Department’s option. The Commonwealth has the right to use any or all ideas not protected by intellectual property rights that are presented in any proposal regardless of whether the proposal becomes part of an agreement. Notwithstanding any Offeror copyright designations contained on proposals, the Commonwealth shall have the right to make copies and distribute proposals internally and to
comply with public record or other disclosure requirements under the provisions of any Commonwealth or United States statute or regulation, or rule or order of any court of competent jurisdiction.

c. Public Disclosure. After the award of an agreement pursuant to this RFP, all proposal submissions are subject to disclosure in response to a request for public records made under the Pennsylvania Right-to-Know-Law, 65 P.S. § 67.101, et seq. If a proposal submission contains confidential proprietary information or trade secrets, a signed written statement to this effect must be provided with the submission in accordance with 65 P.S. § 67.707(b) for the information to be considered exempt under 65 P.S. § 67.708(b)(11) from public records requests. Financial capability information submitted in response to Part II, Section II-6 of this RFP is exempt from public records disclosure under 65 P.S. § 67.708(b)(26).

I-19. BEST AND FINAL OFFERS

A. While not required, the Department may conduct discussions with Offerors for the purpose of obtaining “best and final offers.” To obtain best and final offers from Offerors, the Department may do one or more of the following, in any combination and order:

1. Schedule oral presentations;

2. Request revised proposals; and

3. Enter into pre-selection negotiations.

B. The following Offerors will not be invited by the Department to submit a Best and Final Offer:

1. Those Offerors, which the Department has determined to be not responsible or whose proposals the Department has determined to be not responsive.

2. Those Offerors, which the Department has determined in accordance with Part III, Section III-5, from the submitted and gathered financial and other information, do not possess the financial capability, experience or qualifications to assure good faith performance of the contract.

3. Those Offerors whose score for their technical submittal of the proposal is less than 70% of the total amount of technical points allotted to the technical criterion.

The Department may further limit participation in the best and final offers process to those remaining responsible offerors which the Department has, within its discretion, determined to be within the top competitive range of responsive proposals.

C. The Evaluation Criteria found in Part III, Section III-4, shall also be used to evaluate the Best and Final offers.

I-20. NEWS RELEASES.

Offerors shall not issue news releases, Internet postings, advertisements or any other public communications pertaining to this Project without prior written approval of the Project Officer, and then only in coordination with the Department.
I-21. RESTRICTION OF CONTACT.

From the issue date of this RFP until the Department selects a proposal for award, the Project Officer is the sole point of contact concerning this RFP. Any violation of this condition may be cause for the Department to reject the offending Offeror’s proposal. If the Department later discovers that the Offeror has engaged in any violations of this condition, the Department may reject the offending Offeror’s proposal or rescind its award. Offerors must agree not to distribute any part of their proposals beyond the Issuing Office. An Offeror who shares information contained in its proposal with other Commonwealth personnel and/or competing Offeror personnel may be disqualified.

I-22. COMMONWEALTH PARTICIPATION

Offerors shall provide all services, supplies, facilities and other support necessary to complete the identified work, except as otherwise provided in this section. The Department will not provide office space, equipment, reproduction facilities, or other logistical support to the selected Offeror.

Project monitoring will be the responsibility of the OMHSAS, in collaboration with Office of Medical Assistance Programs (OMAP) and DDAP, and/or other Offices, as well as consumers, persons in recovery, family members and counties as determined by the Department. Designated staff will coordinate the project, provide or arrange technical assistance, monitor the selected Offeror for compliance with Agreement requirements, the approved Waiver, and program policies and procedures.

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

I-23. TERM OF AGREEMENT

The term of the Agreement will commence on the Effective Date anticipated to be July 1, 2013 and will end on June 30, 2018. The Issuing Office will fix the Effective Date once the agreement has been fully executed by the selected Offeror and by the Commonwealth and all approvals required by Commonwealth and federal contracting procedures have been obtained. The selected Offeror shall not start the performance of any work prior to the Effective Date and the Commonwealth shall not be liable to pay the selected Offeror for any service or work performed or expenses incurred before the Effective Date of the Agreement. At its option, the Department may extend the Agreement on the same terms and conditions for one additional period not to exceed three years. The Department will notify the selected Offeror of its intention to extend prior to the expiration of the Agreement.

The Department may delay the effective date of the Agreement for the HC-N/C SO zone beyond July 1, 2013. The Department will not pay any compensation or contemplate adjustments to rates for an implementation delay of less than 125 days.

I-24. OFFEROR’S REPRESENTATIONS AND AUTHORIZATIONS

By submitting its proposal each Offeror understands, represents and acknowledges that:

   A. All of the Offeror’s information and representations in the proposal are material and important, and the Department may rely upon the contents of the proposal in awarding the agreement. The Commonwealth shall treat any misstatement, omission or misrepresentation as fraudulent
concealment of the true facts relating to the Proposal submission, punishable pursuant to 18 Pa. C.S. § 4904.

B. The Offeror has not attempted, nor will it attempt, to induce any firm or person to refrain from submitting a proposal, or to submit any intentionally noncompetitive proposal or other form of complementary proposal.

C. The Offeror makes its proposal in good faith and not pursuant to any agreement or discussion with, or inducement from, any firm or person to submit a complementary or other noncompetitive proposal.

D. To the best knowledge of the person signing the proposal for the Offeror, the Offeror, its affiliates, subsidiaries, officers, directors, and employees are not currently under investigation by any governmental agency and have not in the last four years been convicted or found liable for any act prohibited by State or Federal law in any jurisdiction, involving conspiracy or collusion with respect to bidding or proposing on any public contract, except as the Offeror has disclosed in its proposal.

E. To the best of the knowledge of the person signing the proposal for the Offeror and except as otherwise disclosed by the Offeror in its proposal, the Offeror has no outstanding, delinquent obligations to the Commonwealth including, but not limited to, any state tax liability not being contested on appeal or other obligation of the Offeror that is owed to the Commonwealth.

F. The Offeror is not currently under suspension or debarment by the Commonwealth, or any other state, or the Federal government, and has not been precluded from participation in any federally funded health care program. If the Offeror cannot certify, then it shall submit along with the proposal a written explanation of why such certification cannot be made.

G. To the best of the knowledge of the person signing the proposal for the Offeror and except as otherwise disclosed by the Offeror in its proposal, the Offeror has no relationships which are prohibited by 42 C.F.R §438,610.

H. The Offeror has not, under separate contract with the Department, made any recommendations to the Commonwealth concerning the need for the services described in the proposal or the specifications for the services described in the proposal.

I. Each Offeror, by submitting its proposal, authorizes all Commonwealth agencies to release to the Commonwealth information related to liabilities to the Commonwealth including, but not limited to, taxes, unemployment compensation and workers’ compensation liabilities.

J. Until the Offeror receives a fully executed and approved written Agreement from the Department, there is no legal and valid Agreement, in law or in equity, and the Offeror should not begin to perform.

I-25. NOTIFICATION OF SELECTION

The Department will notify the selected Offeror in writing of its selection for negotiations after the Department has determined, taking into consideration all evaluation factors, the proposal that is the most advantageous to the Department. If the Offeror does not accept the Department's final rate offer, the Department may, in its sole discretion, reject the proposal and start negotiations with a remaining Offeror.
I-26. **OFFEROR DEBRIEFING**

Upon notification of award, Offerors whose proposals were not selected will be given the opportunity to be debriefed. The Project Officer will schedule the time and location of the debriefing. The Offeror will not be compared with other Offerors, other than the position of its proposal in relation to all other proposals. The exercise of the opportunity to be debriefed shall not constitute the filing of a protest under 62 Pa. C.S § 1711.1.

I-27. **RFP PROTEST PROCEDURE**

Any actual or prospective Offerer that believes it is aggrieved with the solicitation and award of the RFP may file a protest as provided in 62 Pa. C. S. § 1711.1.

Any protest filed in relation to this RFP must be delivered to:

Department of Public Welfare
Division of Procurement
Room 402 Health and Welfare Building
625 Forster Street
Harrisburg, Pennsylvania 17120
Attn: Daniel R. Boyd
Email address: dboyd@state.pa.us
Fax: 717-787-3560

Offerors and prospective Offerors may file a protest electronically or by facsimile but also must simultaneously send a hard copy of the protest to the address listed above.

I-28. **SITE INSPECTION/READINESS REVIEW**

Prior to of the selected Offeror assuming responsibility for the provision of services in the HC BH-N/C SO Zone, and periodically thereafter, the Department will conduct on-site readiness reviews of the selected Offeror and Subcontractors. The purpose of a readiness review is to document the status of the selected Offeror with respect to meeting work statement tasks and requirements described in Part IV of this RFP. In its sole and complete discretion, the Department may suspend or terminate implementation of the Agreement and/or Member enrollment if the Primary Contractor does not demonstrate to the Department's satisfaction, compliance with program standards.

I-29. **OFFERORS’ LIBRARY**

The Project Officer will make available documents relevant to this program for review at an Offerors' Library at the OMHSAS, Beechmont Building, Second Floor, 21 Beech Drive, Harrisburg, PA 17110. The documents available from the Department include but are not limited to:


B. Medical Assistance Eligibility Handbook
C. Fee-for-Service fee schedule and PROMISe FAQ’s
D. HealthChoices Behavioral Health Financial Reporting Requirements
E. Enrollment Assistance RFP
F. Child Protective Services Law, the Juvenile Act and applicable regulations
G. HEDIS Standards unavailable – can be purchased at www.ncqa.org
H. Mental health and drug and alcohol statutes, regulations, and guidelines
I. Managed Care Data Support Overview for Behavioral Health
J. HealthChoices Performance Outcome Measurement System (Draft)
K. HealthChoices Non-Financial Reporting Requirements
L. Denial Log and Complaint and Grievance Reporting Manuals
M. HealthChoices Requirements and Specifications Manual for Encounter Data/Alternative Payment Arrangement Financial Data
N. Transition Monitoring
O. Quarterly Monitoring Reports
P. HealthChoices N/C SO Readiness Review Draft Document
Q. Program Materials for Psychiatric Rehabilitation Services for Adults
R. Sample HC-Physical Health/Behavioral Health Coordination Agreement
S. Sample HC-Member Handbook
T. Draft HC-DPW Behavioral Health Agreement
U. HealthChoices Behavioral Health Policy Clarifications (applicable to all zones)
V. Recommended Clinical/Rehabilitation Standards of Practice: For Culturally Competent Services in Pennsylvania

I-30. CHANGES TO CERTAIN APPENDICES

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

- Appendix F: Fraud and Abuse Program Requirements
- Appendix L: Guidelines for Consumer/Family Satisfaction Teams and Member Satisfaction Surveys
- Appendix N: HealthChoices Behavioral Health Program Requirements for County Reinvestment Plans
- Appendix P: The HealthChoices Behavioral Health Financial Reporting Requirements
- Appendix V: The HealthChoices Behavioral Health Recipient Coverage Document
- Appendix Y: The HealthChoices Behavioral Health Services Reporting Classification Chart (BHSRCC) – BHSRCC is updated and distributed semi-annually to assist with appropriate coding of services for financial and encounter data for reporting HealthChoices.

I-31. LOBBYING CERTIFICATION AND DISCLOSURE

Commonwealth agencies will not contract with outside firms or individuals to perform lobbying services, regardless of the source of funds. With respect to an award of a federal contract, grant or cooperative agreement exceeding $100,000, or an award of a federal loan or a commitment providing for the United States to insure or guarantee a loan exceeding $150,000, all recipients must certify that they will not use federal funds for lobbying and must disclose the use of non-federal funds for lobbying by filing required documentation. The Primary Contractor must complete and return the Lobbying Certification Form along with the signed Agreement. See Lobbying Certification Form and Disclosure of Lobbying Activities Form attached as Appendix D.
I-32. **CONTRACTOR PARTNERSHIP PROGRAM (CPP)**

The Contractor Partnership Program (CPP) was created by DPW to create additional employment opportunities within the Commonwealth. The CPP is designed to leverage the economic resources of DPW to create jobs for individuals currently receiving Temporary Assistance to Needy Families (TANF) cash assistance by maximizing the recruitment, hiring and retention of those individuals by Commonwealth contractors, subcontractors and grantees. The CPP utilizes its partnerships with the local Workforce Investment Agencies (WIAs), County Assistance Offices (CAOs), service delivery providers and other community action agencies to advance this goal.

The CPP requires individuals contracting with DPW to make a commitment to fill their vacancies and new positions with individuals currently receiving TANF cash assistance. The CPP will work cooperatively to assist in these efforts by coordinating the resources of local service providers to assist in the identification of qualified individuals for employment opportunities.

Through CPP, DPW expects not only to increase the employment rate for individuals receiving TANF cash assistance, but to continue to contribute to the economic growth of the Commonwealth.

**Eligibility Requirements**

In order to receive credit toward meeting its CPP commitment, the selected Offeror must hire individuals receiving TANF cash assistance from DPW. This includes but it is not limited to individuals currently participating in any of DPW’s employment and training programs such as EARN (Work Support and Career Development), Supported Work, Supported Engagement, Industry Specific Initiatives, KEYS, as well as, those individuals in self initiated activities at the CAO. Individuals receiving medical assistance and/or foods stamps only are not eligible.

For more information about the CPP please contact:

- Contractor Partnership Program  
- PA Department of Public Welfare  
- Health & Welfare Building  
- 2nd Floor West  
- 7th & Forster Streets  
- Harrisburg PA 17105  
- Phone: 1-866-840-7214/Fax: (717) 787-4106  
- Email: RA-BETPCPP@state.pa.us

I-33. **MENTOR PROTÉGÉ PROGRAM (MPP)**

The MPP is a key element of DPW’s contracting goal to mentor and develop skills related to the services identified in this RFP and to assure that Small Diverse Businesses are provided access to opportunities generated under the resulting agreement. The MPP has been launched to achieve that objective.

The MPP encourages Offerors to make a commitment to establish a formal Mentor Protégé Program that will further develop the skills related to the services in this RFP with regard to the capacity and capability of Small Diverse Businesses. DPW is committed to assisting prime contractors who undertake this important small business growth and development initiative. Each contractor electing to participate in this program will identify DGS BMWBO certified MBE/WBE’s and Small Diverse Businesses to receive
mentorship assistance.

Refer to Section I-16 of this RFP for information concerning the identification of Small Diverse Businesses.

Offerors are encouraged to seek input and guidance from DPW's Bureau of Equal Opportunity – Mentor Protégé Plan (DPW BEO - MPP) concerning this program:

Diane A Jones, Equal Opportunity Specialist  
Bureau of Equal Opportunity (DPW BEO – MPP)  
Mentor Protégé Program  
Department of Public Welfare  
Commonwealth of Pennsylvania  
Phone: (717) 787-3336  
E-mail: djones@pa.gov

While DPW BEO - MPP will provide assistance, the Offeror is ultimately responsible for ensuring it commitment is met.
PART II. PROPOSAL REQUIREMENTS

Offerors must submit proposals in the format, including heading descriptions, outlined below. To be considered, a proposal must respond to all requirements in the RFP. The Offeror should provide any other information thought to be relevant, but not applicable to the enumerated categories, as an appendix to the Proposal. All Small Diverse Business costs data should be kept separate from and not included in the Technical Proposal. Each proposal shall consist of four (4) separately sealed submittals;

1. Technical Submittal, in response to RFP Section II-1 through Part II-7, as well as Domestic Workforce Utilization Certification in response to RFP Section II-9;

   The Offeror must submit only one Technical Submittal to the Department. If the Offeror is proposing significant differences in the Technical Submittal among the counties to be served, the differences for these county must be clearly described in the Technical Submittal.

2. Small Diverse Businesses Submittal, in response to RFP Section II-8;

3. Contractor Partnership Program Submittal, in response to RFP Section II-10; and.


The Department may request additional information which, in the Commonwealth’s opinion, is necessary to assure the Offeror’s competence, number of qualified employees, business organization, and financial resources are adequate to perform according to the RFP.

The Department may make investigations as deemed necessary to determine the ability of the Offeror to perform the Project, and the Offeror shall furnish to the Department all requested information and data. The Department may reject any proposal if the evidence submitted by, or investigation of, such Offeror fails to satisfy the Issuing Office that such Offeror is properly qualified to carry out the obligations of the RFP and to complete the Project as specified.

II-1. STATEMENT OF THE PROBLEM

State in succinct terms your understanding of the problem presented and the services required by the RFP.

II-2. MANAGEMENT SUMMARY

A. Executive Summary

The Offeror should describe its ability to further Departmental goals for this Project, including plans to control costs while improving the quality of care and improving the health outcomes for HealthChoices Members. The Offeror should describe how its organization expects to bring unique or highly specialized skills to bear in meeting program goals and objectives.

The executive summary should be written in succinct terms and provide an overview of the proposing organization and the proposal, including the services to be provided, with the Offeror's key strengths highlighted.
Areas of focus for the Executive Summary should include:

1. Plan for and experience to ensure effective implementation of the program and the development of strong partnerships with the Department and counties to be served.
2. Impact of the proposal to promote county behavioral health service system reform and to enhance the quality of services provided. Highlight major changes in county administered mental health and drug and alcohol programs.
3. Efforts to enhance and priorities established to ensure effective interface with other local systems of care for physical health and social services.
4. The manner in which input from families, including Parents of children and adolescents, consumers and persons in recovery are incorporated into the development of the proposal.
5. Plan for addressing the social/ethnic/cultural diversity of the population in each county included in the proposal.
6. Goals for improved technology, risk management and cost control.
7. Plan for development of oversight mechanism to ensure county participation and input in system enhancement and administration.

B. Background

This section should include a description of the ownership, background, and governance of the Offeror.

1. Ownership

Offerors should provide information on the ownership of the company (names and percent of ownership); date the company was established; and date the company began operations, the physical location of the corporate headquarters and the current size of the company. The Offeror should include a high-level corporate organizational chart.

The Offeror must submit (as an appendix), the Articles of Incorporation of the BH-MCO and provide documentation of its application for a license and Certificate of Authority to operate in counties of the HC-N/C SO zone.

2. Corporate Governance

The Offeror should describe the Board of Directors' composition and role in governance and policy making; identify Board members and their primary affiliations.

3. Plan Governance and Oversight

The Offeror should describe any experience with local government in managing Behavioral Health Services including how governance and policy making has been influenced by county government involvement. Given the large and diverse geographic area to be served, the Department is interested in soliciting ideas from Offerors about how to ensure county government and stakeholder inclusion in governance while minimizing administrative overhead.

a. Describe your proposed model for county oversight organizations, entities, or structures that you would use to ensure active participation of the counties in oversight of the plan and input into on-going plan development and enhancements. Describe the frequency and extent of involvement of these bodies.
b. Describe ways for involving local stakeholders in program oversight, service development and in improving health outcomes for Members. The proposal must contain specific plans for the involvement of minorities, consumers, persons in recovery, and families, including Parents of child and adolescent Members, in program oversight and quality management functions, including but not limited to, ongoing monitoring of consumer and family satisfaction, grievance and appeal system operations, and achievement of performance outcome measures.

4. Subcontracts

Provide a description of any major subcontractors which will assume responsibility for tasks required of the Offeror. These could include but are not limited to areas such as member services, complaint and grievance, utilization review, claims processing, and management information systems.

5. Emergency Preparedness

To support continuity of operations during an emergency, including a pandemic, the Department needs a strategy for maintaining operations for an extended period of time. One part of this strategy is to ensure that entities providing critical health care services for its consumers have planned for such an emergency and put contingencies in place to ensure that these critical services continue to be provided during an emergency.

1. Describe how you anticipate such a crisis will impact your operations.
2. Describe your emergency response continuity of operations plan. Please attach a copy of your plan, or at a minimum, summarize how your plan addresses the following aspects of emergency preparedness:
   
   • employee training (describe your organization’s training plan, and how frequently your plan will be shared with employees)
   • identified essential functions and key employees (within your organization) necessary to carry them out
   • contingency plans for:
     o How your organization will handle staffing issues when a portion of key employees are unable to perform their work.
     o How employees in your organization will carry out the essential functions if prevented from coming to the primary workplace.
   • How your organization will communicate with staff and consumers when primary communications systems are overloaded or otherwise fail, including key contacts, chain of communications (including providers), etc.
   • How and when your emergency plan will be tested, and if the plan will be tested by a third-party.

II-3. WORK PLAN

The Work Statement Questionnaire which follows provides a format for a Offeror's response to the task descriptions found in the Work Statement in Part IV of the RFP. Offerors should ensure that they are familiar with all of the requirements in the Work Statement, and that their responses to the items below have fully addressed all requirements for both mental health and substance abuse services.
Responses to the Work Statement Questionnaire should describe the Offeror’s approach to serving the Medical Assistance (MA) population and should demonstrate that the Offeror is capable of meeting all components of this RFP as specified in Part IV, Work Statement. For questions asking the vendor to describe their experience in providing services, the response should include a statement about whether those same programs, services, models, or innovations will be implemented in the HC-N/C SO zone. All responses should be formatted to follow the numbering and lettering in the Work Statement Questionnaire, and each response should be preceded by a restatement of the question.

For vendors who are not currently operating in Pennsylvania who are unfamiliar with terms or programs described in the Work Statement Questionnaire, please refer to the Appendices EE and FF for Definitions and Acronyms.

WORK STATEMENT QUESTIONNAIRE

1) In-Plan Services (RFP Section IV-4.A.)
   
a. Describe your model for delivering clinical services to populations, including adults with:
      1. serious mental illness,
      2. persons with co-existing psychiatric and addictive disorders, and
      3. older adults with behavioral health needs.

b. Describe your model for delivering clinical services to populations, including adults who abuse substances including:
   1. persons with addictive diseases,
   2. pregnant women and women with dependent children, and
   3. persons using intravenous drugs and persons with HIV/AIDS/

   c. Describe your model for delivering and coordinating clinical services to populations, including adults who:
      1. have intellectual disabilities and co-existing psychiatric or substance use disorders,
      2. require services in order to avert admissions or re-admissions to a State Hospital,
      3. have recognized behavioral health needs and are involved in the criminal justice system, including release from state and county correctional facilities.

For Questions 1d. through 1f., be sure to include ways in which children’s services that may include Behavioral Health Rehabilitative Services (BHRS) services are used to address any of the identified populations, are structured in a manner which encourages appropriate use of services, reduces dependency on the health care system, encourages family and community integration, supports evidenced-based practices, and maximizes cost-effective practices.

d. Describe your model for delivering and coordinating clinical services to children and adolescents:
   1. with serious emotional disturbances,
   2. diagnosed with ASD spectrum disorders, and
   3. with co-existing psychiatric and addictive disorders.

   e. Describe your model for delivering and coordinating clinical services to children and adolescents:
      1. who have a substance abuse disorder.

   f. Describe your model for delivering and coordinating clinical services to children and adolescents:
      1. with intellectual disabilities and behavioral disorders eligible for BHRS,
2. who have been involved with the juvenile justice or child welfare system.

g. Describe the disease management process by which the service manager will require that Members receive services based on their current condition, the effectiveness of previous treatment received, and individual preferences. Describe how the service manager will require that services are based on the history of the illness, its context, and include an outcome focus.

h. Describe how Members who require additional outreach or oversight in order to participate fully in their treatment programs receive the required intensity of service management. Include planned outreach activities and any specialized outreach for priority populations and Special Needs Populations such as persons from different cultural groups.

2) Coordination of Care (RFP Section IV-4.B.)

a. Describe how county administered Behavioral Health Services will be coordinated with In-Plan services authorized by the Offeror, including both mental health and drug and alcohol services. Explain the process and mechanisms established between the county and the Offeror for such referral and coordination. Include information on how the coordination would differ, if at all, for counties selected for the Human Services Block Grant.

b. Describe procedures to inform service managers and service providers of physical health benefits to assist Members in accessing required physical health services.

c. Describe the process for coordination of services with the Member's Physical Health Service System (PHSS). Address particularly how coordination and care management will occur for consumers with physical and mental health co-morbidities such as asthma, diabetes, chronic obstructive pulmonary disease, coronary artery disease, congestive health failure and serious mental illness. Address the process for coordination of Early Periodic Screening, Diagnostic and Treatment (EPSDT) covered services.

d. Describe any processes to monitor physical health practitioners and BH-MCO providers in their coordinated approach of the selection and use of prescription drugs in treating Members.

e. Describe the process for coordination of services with other human service agencies (e.g., developmental disability, aging, early intervention, etc.) which may be serving the Member. Describe previous experience in developing these relationships. Include planned coordination with the adult judicial systems and law enforcement agencies. Include documentation of any preliminary discussions.

f. Describe the process for working with the county children and youth agency, the juvenile justice system, schools, social service agencies, and families in meeting the needs of children and adolescents, especially those in substitute care. Include documentation of any preliminary discussions.

g. Describe outreach and education activities for Members, families, providers and other organizations and other action steps planned to assure a smooth transition to a new Agreement. Indicate the specific action steps to be taken regarding the transition plans for Priority Populations and Special Needs Populations, including persons receiving BHRS services.

h. Describe the procedures to ensure continuity of care for Members who may move into the cov-
erred area who have received services elsewhere, as well as for those who are moving out of the HealthChoices service area or to another county within the area but require continued care.

i. Describe the strategies used to coordinate with the state mental hospital and county mental health authority in the development and implementation of admission and discharge planning to ensure appropriateness and continuity of treatment and to plan for community service needs of persons hospitalized over two years.

3) Member Services (RFP Section IV-4.C.)

a. Describe the organization and role of your Member Services group. Indicate how the "point of contact" will be determined and in what department this person will be located. If the point of contact is not a care manager, describe how this person will interact with the care manager(s).

b. Describe the development of Member communication materials, including a Member handbook, notification of Member rights, public education programs, and outreach. Provide a draft copy of the Member handbook used in other service areas or an outline of a proposed handbook.

c. Describe Member orientation, tailored to the needs of populations served, related to: access to Routine, Urgent and Emergency Services, limitations or exclusions, obtaining authorization for services, obtaining medically necessary transportation, and use of the grievance and appeals process.

4) Complaint and Grievance System (RFP Section IV-4. E.)

a. Identify how Complaints and Grievances will be resolved at the lowest possible level while protecting Member rights to further pursue Complaints and Grievances if they are not satisfied with the outcome at the first level. Include a draft of the Member services literature, policy and procedure as an attachment.

b. Describe how Members and their families will be involved participants in the BH-MCO Complaint and Grievance system and how the BH-MCO will accommodate them in attending Complaint and Grievance hearings.

c. Describe the process to be used for the grievance of denied requests for authorization for services by Members. Specifically address the process for expedited Complaints and Grievances, the process related to denials of BHRS for children and adolescents, and continuity of services during a Grievance.

d. Describe the process to inform Providers of grievance rights. Include information on the Provider Complaint and Grievance process.

5) Executive Management/Administration (RFP Section IV-5.A., B. and C.)

a. Offerors should describe its structure which affords the opportunity for Department and county oversight for BH-MCO activities in the N/C SO zone, including:
   i. Frequency and location of meetings;
   ii. County representation on BH-MCO committees
   iii. Review of network development, including development of cost effective alternative services;
v. Dissemination of reports; and
vi. Any other areas of importance.

b. Describe the process for the implementation of the Agreement, including acquisition and/or development of the location, hiring and training of staff, protocol/procedure development, and steps/timelines for Provider contracting. Include length of time from developmental phase to full service provision.

c. Discuss the ways in which Child and Adolescent Service System Program (CASSP), Community Support Program (CSP), and recovery principles, and DDAP Treatment Philosophy for Substance Abuse and Dependency will be incorporated into the operation of the program and how they will be addressed in program implementation.

d. Describe the process to determine priorities based on input from counties, stakeholders, and DPW, and to implement reinvestment plans from shared savings achieved as a result of effective management of care.

e. Describe how consumers, persons in recovery, and family members, including Parents/custodians of children and adolescents, representative of different cultural and ethnic groups were involved in the development of this proposal and the plan for their inclusion in program development, monitoring, and oversight of this Agreement. Include any previous experience related to involving consumers, persons in recovery and family members in program development, monitoring and oversight.

f. Discuss the role of the Medical Director in the day-to-day operations of the program.

g. Describe mechanisms which would be used to coordinate with and provide information to the Enrollment Assistance Program to ensure Members are aware of available services and how to access services.

h. Describe the process to be used to assess the initial and ongoing training and technical assistance requirements for internal use as well as for Providers. Include specific information concerning training on Priority Populations, ASD, Cultural Competency, relapse prevention, and recovery.

i. Describe how the requirements of the Fraud and Abuse activities outlined in Appendix F will be met.

6) Provider Networks and Management  (RFP Section IV-5.D. and 5.E.)

a. Explain how the Provider network capacity will be assessed and monitored to ensure access according to HC requirements, including the capacity for Providers to serve culturally diverse priority populations and persons with special needs such as older adults and persons diagnosed with ASD.

b. Describe the process and timeframe for all behavioral health Providers to be credentialed and have signed agreements ninety (90) days prior to the July 1, 2013 anticipated implementation date.

c. Explain Provider credentialing and recredentialing requirements, including for practitioners who are experienced with persons with special needs. Describe the counties’ role in network
development and credentialing.

d. Describe any “preferred provider” models you are using. Provide information on the types of providers and populations served. Include the measures used to assess whether providers qualify and how you ensure that the model does not limit access to services inappropriately.

e. Include details on how Complaint monitoring and resolution will be incorporated, in the event of Complaints against Providers, into the overall Provider performance monitoring system.

f. Discuss the strategies proposed for network development to implement Supplemental Services that are cost effective alternatives to In-Plan Services, specifying the services proposed for implementation. Describe any past efforts or efforts anticipated as a part of this plan to develop a more complete continuum of care which can offer high quality, cost-effective services, or services which are provided in a less restrictive environment with a focus on rural service development.

g. Describe methods used to monitor the Provider network for complete, valid reporting of encounter data, performance outcome data including status updates for Priority Populations, critical incidents data and data to monitor for fraud or abuse.

h. Describe how performance requirements or financial mechanisms in BH-MCO contracts with BH Services Providers will provide service access for Members with the most serious and chronic illnesses, including Members who may not respond to more traditional service delivery systems and approaches.

7) Service Access (RFP Section IV-5.F.)

a. Describe how 24 hours a day, 7 days a week referral and crisis/Emergency Services will be provided. Include information concerning automated systems available to facilitate this process.

b. Describe how Members will have a reasonable range of choice among Providers, including alternatives when the initial selection of a Provider proves unsatisfactory to the Member.

c. Describe how the network will include Providers currently contracting with county programs, such as those contracting with children and youth agencies who have experience with the foster care and residential placement population and who have been providing services to children and youth in substitute care.

d. Describe the system proposed to monitor the referral system to ensure that it is functioning properly, including the tracking of applicable time frames (Part IV-5.F.1 and 2).

e. Describe the process to access BHRS for children and adolescents, including mechanisms to:

   i) monitor Provider compliance with access standards;
   ii) monitor BHRS utilization and collect monthly provider BHRS service data;
   iii) secure alternative Providers when capacity has been reached and services would be delayed;
   iv) address capacity issues if network capacity is determined inadequate to meet need. Process to determine if actions to be taken achieve desired outcome;
   v) conduct periodic Provider audits to ensure compliance with BHRS Bulletins; and
   vi) ensure availability of providers with specialized treatment expertise such as applied
behavioral analysis, expertise in early childhood development, and services for persons
diagnosed with ASD.

f. Describe the transition plan and the process for authorization of services for Members who are
receiving covered services from network or out-of-network Providers at the time of Agreement
implementation.

g. Describe the process for identification and authorization of services which are medically
necessary but are not available within the Provider network. Address the procedures for approval
of out-of-network or out-of-area services in the event of an emergency.

h. Describe the arrangements for Members seeking or being referred for evaluation to determine
need for involuntary emergency treatment pursuant to Section 302 of the Mental Health
Procedures Act.

8) Utilization Management (RFP Section IV-5.G.1 and G.2)

a. Describe the BH-MCO structure for Utilization Management. Include structures of teams, types
of reviews and populations addressed within those teams, and oversight of team performance.

b. Describe the process of Prior Authorization, concurrent, and retrospective reviews of services to
ensure timeliness, appropriateness and medical necessity. Include:

i) methods to ensure appropriate use of clinical criteria;

ii) use of any clinical algorithms to identify questionable service requests (including for BHRS
services). Describe any data used to develop these algorithms for each service.

iii) the role of physicians or peer advisors in this clinical decision making process; and

iv) processes or methods used to reduce administrative burden on providers.

c. Discuss any processes to identify high risk members and how the utilization management process
is structured to address individuals with complex needs or who utilize large amounts of services.

d. Does your system include the use of clinical outcomes in conducting reviews for reauthorization
of service? If so, please describe how that process occurs and for which populations or services.

e. Describe the minimum level of education, training and experience required for staff authorized to
act as care managers. Describe the location of care managers and requirements to ensure that
individuals providing care management services are culturally competent and understand the
unique needs of Priority and Special Needs Populations.

f. Provide the criteria to be used to review Medical Necessity for all In-Plan services. Indicate re-
search and/or national models upon which the criteria are based, if other than the Department's
guidelines (e.g., Pennsylvania Client Placement Criteria and American Society of Addiction Med-
icine criteria must be used for drug and alcohol services for adults and children and adolescents,
respectively).

g. Discuss the procedures used to ensure the confidentiality of clinical records and Member
information. Include ways in which staff is trained on federal and state requirements regarding
confidentiality.
9) Quality Management (RFP Section IV-5.G.3)

a. Describe the BH-MCO structure for Quality Management (QM). Include committee structures and responsibilities and describe how QM activities and information will be integrated into the BH-MCO operations. Proposals should also describe how the BH-MCO QM processes will be interfaced with the counties in the zone and with the Department.

b. Provide procedures for monitoring internal BH-MCO processes and overall plan performance. Discuss specifically the following:

   i) telephone access standards;
   ii) responsiveness and accuracy of Member services;
   iii) referral access standards;
   iv) adverse incidents;
   v) Complaints, Grievances and appeals; and
   vi) coordination with the PHSS and other human service agencies and schools.

c. Discuss the capacity of the QM system to provide utilization and clinical data necessary to effectively evaluate programs or services. Include, at a minimum:

   i) accuracy and appropriateness of authorization determinations based on clinical criteria;
   ii) over- or under-utilization of services as a result of BH-MCO authorization determinations;
   iii) aggregation and use of outcomes (as identified in Section 10 below) as a part of utilization review, provider contracting, or other BH-MCO activities.

d. Provide procedures planned for profiling Provider performance. Discuss specifically if any of the following will be monitored and how:

   i) quality of individualized service plans and treatment planning;
   ii) provider utilization patterns and trends;
   iii) recidivism and relapse rates;
   iv) treatment outcomes;
   v) adverse incidents;
   vi) administrative compliance;
   vii) compliance with Complaint and Grievance and appeals procedures; and
   viii) coordination with physical health Providers, other human service programs and schools.

e. Describe any performance improvement projects in which you have participated. Include results achieved and barriers identified. How have the results from the project(s) been used to improve your overall program?

f. Discuss how you use Consumer/Family satisfaction teams to improve the quality of your services. Include any plans to establish and/or expand Consumer/Family Satisfaction Teams.

10) Program Outcomes (RFP Section IV-6 and Appendix K)

a. Describe how the organization will meet the requirements for outcome measurements as described in Appendix K. Address particularly the process that will be used for collecting quarterly status updates on priority populations from Providers with automated systems as well as those with non-automated systems.
For responses below, the Department is interested in learning about specific programs or initiatives which are outcomes based. Please do not include information such as POMS measures which are part of the standardized reporting measures.

b. For any of the initiatives you have developed for adults with serious mental illness that you believe improved the quality of life, ability to function independently in the community, or ability to achieve life goals:
   i.) Identify any particular group of adults to which these programs were targeted and how you identified that group for the intervention.
   ii.) Describe how you measured the outcomes of the program.
   iii.) Include information on the cost impact of these programs, both in terms of expenditures as well as related community based costs.
   iv.) Include the extent to which these programs would be implemented in the N/C SO zone. If the programs were implemented in urban or suburban areas, describe how you would implement them in a largely rural area.

c. For any of the initiatives you have developed for children that you believe improved the quality of life and their ability to function within their home, school or community:
   i.) Identify any specific groups of children to which these programs were targeted and how you determined to intervene with that group of children. Specifically address any outcome approaches you have developed to address outcomes for children receiving BHRS services.
   ii.) Describe how you measured the outcomes of the program.
   iii.) Include information on the cost impact of these programs, both in terms of expenditures as well as related community based costs.
   iv.) Include the extent to which these programs would be implemented in the N/C SO zone. If the programs were implemented in urban or suburban areas, describe how you would implement them in a largely rural area.

d. For any of the initiatives you have developed for adults or children with substance abuse that you believe improved the quality of life or the ability to function productively in their home, school or community:
   i.) Identify any particular group of substance users to which these programs were targeted and how you identified that group for the intervention.
   ii.) Describe how you measured the outcomes of the program.
   iii.) Include information on the cost impact of these programs, both in terms of expenditures as well as related community based costs.
   iv.) Include the extent to which these programs would be implemented in the N/C SO zone. If the programs were implemented in urban or suburban areas, describe how you would implement them in a largely rural area.

e. For any of the initiatives you have implemented for persons with co-existing mental health and intellectual abilities, describe how you measured the outcomes of the program in terms of quality of life as well as cost effectiveness.

f. For any of the initiatives you have implemented to improve the quality of life and the effectiveness of services for persons with co-existing behavioral health and physical health disorders, provide outcome information that you have collected which supports the effectiveness of the programs.
g. Describe any initiatives you have implemented with Providers which encourage quality treatment services as well as cost effectiveness in their approaches. Please describe how you measured the impact of these programs as well as provider response to the initiatives.

h. Describe any experience with collecting provider developed outcome data to support the effectiveness of treatment services.

i. Identify any additional outcomes measurements or performance improvement plans which the Offeror has developed and would provide which demonstrate an innovative approach to outcomes measurement.

11) Claims Payment and Processing (RFP Section IV-7.D)

a. Describe the claims processing and MIS functions, and capacity to enroll and serve program Members. Describe the MIS capacity to support electronic fund transfers for payment of services to Providers.

b. Describe the claims processing cycle, including receipt, log-in of claims, processing deadlines, edits, adjudication and explanation of benefits. Attach a flow chart showing the way in which claims will be processed including any subcontracted functions.

c. Describe the methodology for estimating and tracking Incurred But Not Reported claims (IBNRs) and received but unpaid claims (RBUCs).

d. Define the processes which will be used to provide instructions and training on the completion of the CMS 1500 and UB 92 forms, and electronic billing via 837I and 837P, how often they will be processed, and what edits will be applied. Identify any training and support which will be available to Providers for claims adjudication questions and problems. Identify your readiness for ICD-10 requirements.

e. Describe policy and procedures for resolving pending and denied claims including, but not limited to how Providers will be notified, time frames, reentry of corrected data, and adjudication and reporting process.

f. Provide the policy for recovery of third party liability. Include a flow chart and a written description of how the system will support a cost avoidance/recovery methodology for Third Party Liability (TPL).

12) Performance Management Information System and Reporting (RFP Section IV-7.K)

This section addresses the overall Management Information System (MIS) and the ability of the Offeror to respond to the data reporting requirements of the Department as well as to integrate all components of the BH-MCO's internal operations. The Department requires an automated MIS at the time of the Readiness Review. The Department will use Encounter and Alternative Payment Arrangement Data to monitor access to care, quality of care, set future Capitation rates, and compliance with Program requirements. The selected Offeror must be able to provide complete and accurate data which conforms to the Department's standardized definitions for Behavioral Health Type of Service, Procedure Code and Units of Service, as described in Behavioral Health Services Reporting and Classification Chart included in Appendix Y.
a. Describe the system hardware configuration in the context of Member eligibility, service authorization, service utilization, Complaints and Grievances, Member call center, Provider credentialing, Provider enrollment, claims processing, encounter data reporting and outcome measurement. In addition, discuss the configuration in terms of processing speed, storage capacity, throughput and staffing.

b. Describe the current and planned capacity of the system (e.g., number of records, percentage of resources currently utilized). If the system processes data for other accounts, include the capacity of the system which will be available for the HC BH Program. Also include information on any projected expansion of the MIS. If the BH-MCO performs work for other accounts, a description of how HealthChoices data will be segregated from other data must be provided. Include plans for system testing for both newly implemented and legacy systems. If the MIS is functioning in another account, indicate the number of covered lives it processes, the HealthChoices compliance modifications which are needed and plans for system testing.

c. Describe the type(s) of software which is being utilized, including report writers. Provide a detailed explanation that shows how the software will provide integration of service authorization, Provider profiling, claims processing, including the identification of TPL resources, encounter data reporting and membership management. If the system is operational at another site, provide the name of facility and contact person. Describe software ownership arrangements. If software is leased, provide a copy of license agreement. Describe the plan for a transition if there is a change in Subcontractors. Describe how data will be converted and made available to the new Subcontractor.

d. Attach a flow chart of the data system which includes all HealthChoices requirements, i.e., Member Complaint and Grievance, Membership enrollment, Provider profiling.

e. Attach an MIS staffing chart, which lists position title, job function and indicates whether the position is filled.

f. Attach an MIS staff training plan.

g. Describe Provider on-line access, if any, for eligibility, enrollment and Prior Authorization inquiries. Describe any provisions to allow Providers to submit bills electronically.

h. Describe procedures for capturing all data elements included in the files listed in Appendix M (HealthChoices Data Reporting Requirements (non-Financial), and for submitting these files to the Department.

i. Attach the procedure for maintaining recipient enrollment and eligibility data. Include a procedure for reconciliation of data discrepancies between Offeror’s eligibility database and the Department’s Eligibility Verification System (EVS), Client Information System (CIS), and daily and monthly eligibility file transfers.

j. Provide the data security and access policy. Address mechanisms to ensure confidentiality. Describe disaster recovery plan and back-up procedures.

k. Provide the plan for the electronic submission of data to the Department, including acceptable sources (POSNet, e-government, etc.), as well as DPW’s PROMISe contractor.
I. Explain any modifications to your existing systems which would be needed to meet the requirements of encounter data submission. Describe timeframes needed to achieve the modifications. Provide information that explains how you have successfully met complex requirements for data submission as a part of a contract start-up.

II-4. PRIOR EXPERIENCE:

This section should describe the history and relevant experience of the Offeror and its major Subcontractors. A major Subcontractor is defined as an organization undertaking more than 10% of an Offeror’s projected costs of the work associated with this RFP.

The Offeror should describe:

a. Any past or current experience providing behavioral health managed care services to Medicaid populations. If the Offeror has no experience with Medicaid populations, other relevant experience should be described.

b. Any past or current working relationships with behavioral health, physical health and social service systems, provider agencies and other community organizations which will enhance its ability to fulfill the requirements of this RFP. Include specific experience with populations similar to those covered in the Project area, including Members with physical and mental health co-morbidities.

c. Experience as a fiscal intermediary for third party billing systems, with MA and private sector managed care systems, and any other experience relevant to this project; e.g., experience in providing or administering services for priority and Special Needs Populations.

d. Experience with Commonwealth agencies or other state agencies and reference any special techniques, skills, or abilities it considers critical to accomplish the requirements outlined in the RFP. If the Offeror has no prior experience as referenced above, explain what qualification or past experiences may serve as an equivalent. Only experience of individuals and company subsidiaries who/which will be assigned to this project should be included.

e. If similar work was performed by contract, identify the name, address, and telephone number of the previous contract officer of the company or agency which held the contract. Provide the name, address, telephone number and contact person for three firms that can provide a corporate reference for the Offeror. If the Offeror has a current contract with another state's Medicaid program, provide the state contact person's name, address and telephone number.

II-5. PERSONNEL

a. Key Personnel

In this section, the Offeror should identify the name and position of the person who will have ultimate responsibility and accountability for the Agreement.

Reference checks will be conducted for the Project Director and key administrative personnel of the Offeror. Provide the name, address, and telephone number for three persons that can provide a reference for each of the Project Director and key personnel. If the BH-MCO has or has had a contract with another state, one of the references must be from the state agency responsible for overseeing compliance with the contract. Offerors should attach resumes which include
identification of mental health and substance abuse professional credentials of the following key administrative personnel as an appendix to the Technical Submittal:

- Chief Executive Officer
- Medical Director
- Chief Financial Officer
- Director of Quality Management/Utilization Management
- Director of Member Service
- Director of Management Information Systems
- Other key staff you wish to identify

Indicate the position under this Agreement that each person will hold if different from their resume.

The Offeror must inform the Department, in writing, within seven business days of staffing changes to any key administrative positions.

b. Plan Level Organizational Structure

Submit an organizational chart in sufficient detail to describe the organizational structure including proposed Full-Time Equivalents (FTE), the location of services centers, and the number of staff and their function within service centers. For any proposed units or teams in service centers, identify high-level functions (for example, claims processing, care management, provider contracting) assigned to the unit/team. Ensure that the information is clear regarding where and in which units activities such as administrative services, service management, customer service, provider relations, network development, quality assurance, information management, claims processing, or other activities occur. The organization chart should include any additional staff proposed to serve the N/C SO zone from the corporate office or other locations such as existing service centers for other contracts.

Attach in an appendix, corresponding job descriptions that include minimum education and training requirements for each type of staff position identified in the proposed organizational structure for this Agreement.

If you are proposing to utilize existing service center(s) outside the zone, include the functions performed in each location. Describe how that location is fully able to meet the need of the N/C SO zone and the location of functions at that site is administratively or financially advantageous to the Department.

II-6. FINANCIAL CAPABILITY

This section address the ownership and financial viability of a BH-MCO, and its ability to assure the Commonwealth that it has sufficient experience and resources to manage the risk associated with the Agreement. Provide a response to each of the items listed, using the assigned number and letter designation and restating the question.

A. Provide evidence of your ability to comply with the financial requirements as identified in Part IV-7 throughout the term of an Agreement. Any deviations from these requirements must be identified, and a justification provided. Indicate your agreement to receive the first month’s Capitation payment in September 2013, or in the third month of implementation, should the
implementation date be delayed.

B. Include information on the identity of a related party which may have submitted a proposal. Compliance with this requirement does not require a Offeror to seek out information that it does not already have. Explain how the other party meets the definition of a Related Party.

C. Describe how the Offeror will meet the equity requirements and insolvency arrangements described in Part IV-7, A.2) b. and c.

D. Provide the information on the proposing entity described below as an appendix to the submittal. If any information requested is not applicable or not available, explain the reason(s). Appropriate documentation may be submitted to support information provided.

1. Provide audited financial statements prepared on a Generally Accepted Accounting Principles (GAAP) basis for the most recent fiscal year for which statements are available. The statements must include a balance sheet, statement of revenue and expenses, and a statement of cash flows. Statements must include the auditor's opinion, and the notes to the financial statements. If no audited financial statements are available, explain the reason and submit unaudited financial statements.

2. Provide the three (3) most recent annual audited financial statements submitted to the Department of Insurance, including management letters. These financial statements must be based on Statutory Accounting Principles (SAP) or GAAP with reconciliation to SAP.

3. Provide unaudited financial statements for the period between the last month covered by the audited statements required in 4) a. above and the second month before the proposal is submitted.

4. If applicable, provide information on state of incorporation and type of organization, as for profit or not-for-profit.

5. If applicable, provide A.M. Best, Weiss, and Standard and Poor rating for life/health, bond ratings.

6. Provide documentation of any lines of credit that are available, including maximum credit limit and amount available.

E. Explain how your response to Item D above provides proof of fiscal solvency.

F. Identify each entity that owns at least five percent (5%) of the proposing entity. Provide the information requested in D.1.. through 6. above for each entity identified in this section.

G. The Offeror should explain how it will fund development and start up costs, including the source of funds. Provide information and documentation to enable the Department to conclude whether sources have been or are committed to providing the expected funds.

H. The Offeror should explain how it will fund administrative costs and services costs during the two months the Capitation payments will be delayed, including sources of fund. Provide information and documentation to enable the Department to conclude whether resources have been or are committed to providing these funds.
I. The Offeror must provide documentation that it meets (if a licensed entity), or will meet (if licensure is in process), prior to the signing of an Agreement, the minimum $1.5 million SAP-base equity criterion in Part IV-7 A.2) b. Acceptable documentation includes a copy of the most recent quarterly filing, or annual filing if it is more recent than a quarterly filing, submitted to the Department of Insurance, or a copy of the applicable licensure application form submitted to the Department of Insurance which indicates the equity of the Offeror.

J. Subcontracts
   1. The Offeror must give the full name and address of the organizations with which it proposes to Subcontract for any management, administrative or related services.
   
   2. List the full name and address of any Subcontractors that have a 5% or more ownership interest in the Offeror’s organization, as well as any financial interest the Offeror’s organization has with Subcontractors.
   
   3. Copies of proposed subcontractual arrangements are to be included as an appendix.

K. Provide information about any pending litigation.

II-7. OBJECTIONS AND ADDITIONS TO STANDARD CONTRACT TERMS AND CONDITIONS

The Offeror will identify which, if any, of the terms and conditions contained in Appendix B or Appendix C it would like to negotiate and what additional terms and conditions the Offeror would like to have included in the standard Agreement. The Offeror’s failure to make a submission under this paragraph will result in its waiving its right to do so later, but the Department may consider late objections and additional requests if to do so, in the Department’s sole discretion, would be in the best interest of the Department. The Department may, in its sole discretion, accept or reject any changes requested by the Offeror. The Offeror may not request or accept changes to other RFP provisions, nor shall the Offeror request to completely substitute its own terms and condition for Appendices B and C. All terms and conditions must appear in one integrated Agreement. The Department will not accept references to the Offeror’s, or any other, online guides or online terms and conditions contained in any proposal.

Regardless of any objections set forth in its proposal, the Offeror must submit its proposal on the basis of the terms and conditions set forth in Appendices B and C. The Department will reject any proposal that is conditioned on the negotiation of terms and conditions set out in Appendices B or C or to any other RFP provision.

II-8. SMALL DIVERSE BUSINESSES SUBMITTAL

A. To receive credit for being a Small Diverse Business or for subcontracting with a Small Diverse Business (including purchasing supplies and/or services through a purchase agreement), an Offeror must include proof of Small Diverse Business qualification in the Small Diverse Business participation submittal of the proposal, as indicated below:

   1. A Small Diverse Business certified by BSBO as an MBE/WBE/VBE/SDVBE must provide a photocopy of their active BSBO certificate. A Small Diverse Business certified by BSBO in more than one category should indicate for which category it wishes its participation to be counted for program recordkeeping purposes.
2. Businesses certified by the U.S. Small Business Administration pursuant to Section 8(a) of the Small Business Act (15 U.S.C. § 636(a)) as an 8(a) Small Disadvantaged Businesses must submit proof of U.S. Small Business Administration certification. The owners of such businesses must also submit proof of United States citizenship.

3. All businesses claiming Small Diverse Business status, whether as a result of BSBO certification, or U.S. Small Business Administration certification as an 8(a) small disadvantaged business, must attest to the fact that the business has no more than 100 full-time or full-time equivalent employees. This can be accomplished by including copies of IRS Form 941s or a letter from the small diverse business attesting to the number of employees.

4. All businesses claiming Small Diverse Business status, whether as a result of BSBO certification, or U.S. Small Business Administration certification as an 8(a) small disadvantaged business, must submit proof that their gross annual revenues are less than $20,000,000 ($25,000,000 for those businesses in the information technology sales or service business). This can be accomplished by including a recent tax return, audited financial statement or a letter from a CPA attesting to the annual revenues.

B. In addition to the above verifications, the Offeror must include in the Small Diverse Business participation submittal of the proposal the following information:

1. All Offerors must include a numerical percentage which represents the total percentage of Project administration (as a percentage of the total estimated administrative costs excluding Gross Receipts Tax) to be performed by the Offeror and not by subcontractors and suppliers.

2. All Offerors must include a numerical percentage which represents the total percentage of the administrative dollars (excluding Gross Receipts Tax) that the Offeror commits to Small Diverse Businesses (SDBs) as subcontractors. To support its total percentage SDB subcontractor commitment, Offeror must also include:
   a) The percentage of administrative dollars of each subcontract commitment to a SDB [Complete SDB Commitment Worksheet, Appendix U for 2a)]
   b) The name of each SDB. The Offeror will not receive credit for stating that after the agreement is awarded it will find a SDB.
   c) The services or supplies each SDB will provide.
   d) The location where each SDB will perform services.
   e) The timeframe for each SDB to provide or deliver the goods or services.
   f) A signed subcontract or letter of intent for each SDB. The subcontract or letter of intent must identify the specific work, goods or services the SDB will perform and how the work, goods or services relates to the project.
   g) The name, address and telephone number of the primary contact person for each SDB.

3. The total percentages and each SDB subcontractor commitment will become contractual obligations once the agreement is fully executed.

4. The name and telephone number of the Offeror’s project (contact) person for the SDB information.

C. The Offeror is required to submit two copies of its SDB participation submittal. The submittal shall be clearly identified as SDB information and sealed in its own envelope, separate from the remainder of the proposal.
D. A SDB can be included as a subcontractor with as many prime contractors as it chooses in separate proposals.

E. An Offeror that qualifies as a SDB and submits a proposal as a prime contractor is not prohibited from being included as a subcontractor in separate proposals submitted by other Offerors.

II-9. **DOMESTIC WORKFORCE UTILIZATION CERTIFICATION**

Complete and sign the Domestic Workforce Utilization Certification contained in Appendix R of this RFP. Offerors who seek consideration for this criterion must submit in hardcopy the signed Domestic Workforce Utilization Certification Form in the same sealed envelope with the Technical Submittal.

II-10. **CONTRACTOR PARTNERSHIP PROGRAM (CPP) SUBMITTAL**

Regardless of whether you propose a strategy to recruit individuals for CPP, the following general information must be included in the CPP Submittal of the proposal:

a. Offeror’s name, telephone number and mailing address.
b. County where the Offeror’s headquarters is located if in Pennsylvania.
c. The name, title, telephone number, mailing and email address of the contact person for the CPP.
d. Mailing address for all satellite offices located in Pennsylvania including the county.
e. Type of business entity. (i.e. not for profit, government entity, public corporation, university etc.)
f. If a subcontractor will provide the primary service of the contract, list the company name and mailing address for offices located in Pennsylvania including the county.
g. Type of services being provided.
h. Type of positions needed for this project. Please specify management vs. non-management positions.

In addition to the above requested information; in order to receive credit for a response to the CPP, Offerors must provide a written narrative that address the following statements and include the information in the CPP Submittal of the proposal. All of the statements listed below pertain to the hiring of individuals that are receiving TANF cash assistance.

1. Identify the anticipated number of employees that will be assigned to this project including vacancies.
2. Identify the number of management and non-management employees.
3. State the number of TANF cash assistance recipients that will be hired. Please do not include percentages.
4. Describe the strategy that will be employed to identify and recruit individuals that meet the eligibility requirements for the Contractor Partnership Program.
5. Describe the methods that will be used to retain TANF recipients once they are employed.
6. Provide a brief explanation of the efforts that will be made to ensure TANF hiring commitments are met and remain in effect throughout the existence of the contract.

II-11. **MENTOR PROTÉGÉ PROGRAM (MPP) SUBMITTAL.**
To receive credit for a response, the following information must be included in the MPP Submittal of the Proposal:

a. Offeror’s name, telephone number and mailing address
b. County where the Offeror’s headquarters is located
c. The name, title, telephone number, mailing and e-mail address of the contact person for the MPP.
d. Mailing address for all satellite offices located in Pennsylvania including county.
e. Type of business entity: (i.e. not for profit, government entity, public corporation, university, etc.)

In addition to the above requested information; in order to receive credit for a response to the MPP, Offerors must provide a written Mentor Protégé Plan that includes:

a. The Protégé company's name and address
b. Protégé company’s contact person, title, telephone number, mailing and e-mail address
c. A Mentor Protégé Plan describing the type of mentoring that will be provided to the Protégé(s) along with information concerning meeting dates, time frames, goal setting, performance expectations and outcomes. Mentoring may include, but is not limited to the following areas:
   1) Technical Assistance.

   2) Budget Infrastructure. Assistance pertaining to general business management or corporate infrastructure, provided by the Mentor, may include the following:

   a) Organizational planning management: strategic planning, business planning, legal/risk management, proposal development
   b) Business development/marketing/sales: market research, product forecasting, web-based marketing, e-commerce.
   c) Human Resource management
   d) Financial management
   e) Contract management
   f) Facilities and plant management: security, health and safety
   g) Any other assistance designed to develop the capabilities of the Protégé
PART III. CRITERIA FOR SELECTION

III-1. MANDATORY RESPONSIVENESS REQUIREMENTS

To be eligible for selection, a proposal must be:

a. Timely received from an Offeror;
b. Properly signed by the Offeror by an official authorized to bind the Offeror.

III-2. TECHNICAL NONCONFORMING PROPOSALS

The two (2) Mandatory Responsiveness Requirements set forth in Section III-1 above (a-b) are the only RFP requirements that the Commonwealth will consider to be non-waivable. The Department, in its sole discretion, may (1) waive any other technical or immaterial nonconformities in an Offeror’s proposal, (2) allow the Offeror to cure the nonconformity, or (3) consider the nonconformity in the scoring of the Offeror’s proposal.

III-3. EVALUATION

The Department has selected a committee of qualified personnel to review and evaluate timely submitted proposals. Independent of the committee, BSBO, MMP and the CPP will evaluate the SDB, MMP and CPP Submittals respectively and will provide the Department with a rating for its component of each proposal. The Department will notify in writing of its selection for negotiations the responsible Offeror, whose proposal is determined to be the most advantageous to the Commonwealth, as determined by the Department after taking into consideration all of the evaluation factors.

III-4. EVALUATION CRITERIA

The following criteria will be used in evaluating each proposal:

- Technical – 80%
- Small Diverse Business Participation – 20%
- Domestic Workforce Utilization – Up to 3% in Bonus Points
- Contractor Partnership Program – Up to 5% in Bonus Points
- Mentor Protégé Program – Up to 3% in Bonus Points

A. Technical Proposal

The Department has established the weight for the Technical criterion for this RFP as 80% of the total points. Evaluation will be based upon the following in order of importance:

1. Work Plan

This criterion focuses on the proposed approach, including but not limited to the evaluation of the array of In-Plan services, coordination of care, Member services, Complaint and Grievance processes, executive management, administration, Provider network relations, service access, Utilization Management, Quality Management, confidentiality safeguards, program outcomes,
reporting mechanisms, and fiscal management. Of equal importance is whether the Offeror has been completely responsive to all specifications and requirements contained in the Work Statement in a manner which meets Department objectives. Evaluation of the soundness of approach will take into account all information provided by the Proposer.

2. Personnel

This criterion will include but is not limited to evaluation of key personnel as well as the personnel assigned to the HealthChoices NC-SO project. Staffing patterns and location of staff will be considered.

3. Management Summary

This criterion focuses on but is not limited to the evaluation of the Offeror’s ownership and governance models, financial situation, experience working with state and local governments, model for inclusion of county input into plan oversight, model for including consumer and family input, as well as capabilities to ensure on-going operations in emergencies.

4. Prior Experience

This criterion includes but is not limited to the evaluation of the organization’s prior history in managing Medicaid or similar behavioral health programs, its experience in interfacing with other agencies that serve the Medical Assistance populations, and its experience with third party billing systems.

5. Statement of the Problem

The final Technical scores are determined by giving the maximum number of technical points available to the proposal with the highest raw technical score. The remaining proposals are rated by applying the Technical Scoring Formula set forth at the following website: [http://www.portal.state.pa.us/portal/server.pt/community/rfp_scoring_formulas_overview/20124](http://www.portal.state.pa.us/portal/server.pt/community/rfp_scoring_formulas_overview/20124).

B. Small Diverse Business Participation:

BSBO has established the weight for the Small Diverse Business (SDB) participation criterion for this RFP as 20% of the total points. Each SDB participation submittal will be rated for its approach to enhancing the utilization of SDBs in accordance with the below-listed priority ranking and subject to the following requirements:

1. A business submitting a proposal as a prime contractor must perform 60% of the total contract value to receive points for this criterion under any priority ranking.
2. To receive credit for an SDB subcontracting commitment, the SDB subcontractor must perform at least fifty percent (50%) of the work subcontracted to it.
3. A significant commitment is a minimum of five percent (5%) of the total estimated administrative cost.
4. A commitment less than five percent (5%) of the total administrative cost value is considered nominal and will receive reduced or no additional SDB points depending on the priority ranking.
**Priority Rank 1:** Proposals submitted by SDBs as prime offerors will receive 1500 points. In addition, SDB offerors that have significant subcontracting commitments to additional SDBs may receive up to an additional 500 points (2000 points total available).

Additional subcontracting commitments to SDBs are evaluated based on the proposal offering the highest total percentage SDB subcontracting commitment. All other Offerors will be scored in proportion to the highest total percentage SDB subcontracting commitment within this ranking. *See formula below.*

**Priority Rank 2:** Proposals submitted by SDBs as prime contractors, with no or nominal subcontracting commitments to additional SDBs, will receive 1500 points.

**Priority Rank 3:** Proposals submitted by non-small diverse businesses as prime contractors, with significant subcontracting commitments to SDBs, will receive up to 1000 points. Proposals submitted with nominal subcontracting commitments to SDBs will receive points equal to the percentage level of their total SDB subcontracting commitment.

SDB subcontracting commitments are evaluated based on the proposal offering the highest total percentage SDB subcontracting commitment. All other Offerors will be scored in proportion to the highest total percentage SDB subcontracting commitment within this ranking. *See formula below.*

**Priority Rank 4:** Proposals by non-small diverse businesses as prime contractors with no SDB subcontracting commitments shall receive no points under this criterion.

To the extent that there are multiple SDB Participation submittals in Priority Rank 1 and/or Priority Rank 3 that offer significant subcontracting commitments to SDBs, the proposal offering the highest total percentage SDB subcontracting commitment shall receive the highest score (or additional points) available in that Priority Rank category and the other proposal(s) in that category shall be scored in proportion to the highest total percentage SDB subcontracting commitment. Proportional scoring is determined by applying the following formula:

\[
\frac{SDB\ %\ Being\ Scored}{\text{Highest}\ %\ SDB\ Commitment} \times \frac{\text{Points/Additional}}{\text{Points Available}} = \frac{\text{Awarded/Additional}}{\text{SDB Points}}
\]

*Priority Rank 1 = 500 Additional Points Available*
*Priority Rank 3 = 1000 Total Points Available*

Please refer to the following webpage for an illustrative chart which shows SDB scoring based on a hypothetical situation in which the Commonwealth receives proposals for each Priority Rank: [http://www.portal.state.pa.us/portal/server.pt/community/rfp_scoring_formulas_overview/20124](http://www.portal.state.pa.us/portal/server.pt/community/rfp_scoring_formulas_overview/20124)
C. Domestic Workforce Utilization:

Any points received for the Domestic Workforce Utilization criterion are bonus points in addition to the total points for this RFP. The maximum amount of bonus points available for this criterion is 3% of the total points for this RFP.

To the extent permitted by the laws and treaties of the United States, each proposal will be scored for its commitment to use domestic workforce in the fulfillment of the contract. Maximum consideration will be given to those Offerors who will perform the contracted direct labor exclusively within the geographical boundaries of the United States or within the geographical boundaries of a country that is a party to the World Trade Organization Government Procurement Agreement. Those who propose to perform a portion of the direct labor outside of the United States and not within the geographical boundaries of a party to the World Trade Organization Government Procurement Agreement will receive a correspondingly smaller score for this criterion. See the following webpage for the Domestic Workforce Utilization Formula:
http://www.portal.state.pa.us/portal/server.pt/community/rfp_scoring_formulas_overview/20124.

Offerors who seek consideration for this criterion must submit in hardcopy the signed Domestic Workforce Utilization Certification Form in the same sealed envelope with the Technical Submittal. The certification will be included as a contractual obligation when the contract is executed.

D. Contract Partnership Program

During the evaluation process, CPP will evaluate each Submittal for its approach in enhancing employment opportunities for eligible CPP participants. Any points received for the CPP criterion are bonus points in addition to the total points for this RFP. The maximum bonus points for this criterion are 5% of the total points for this RFP.

E. Mentor Protégé Program (MPP)

During the evaluation process, DPW BEO – MPP will evaluate each Submittal for its approach to mentoring and developing skills related to the services identified in this RFP. Any points received for the MPP criterion are bonus points in addition to the total points for this RFP. The maximum bonus points for this criterion are 3% of the total points for this RFP.

III-5. OFFEROR RESPONSIBILITY

To be responsible, an Offeror must submit a responsive proposal and possess the capability to fully perform the agreement requirements in all respects and the integrity and reliability to assure good faith performance of the agreement.

In order for an Offeror to be considered responsible for this RFP and therefore eligible for selection for best and final offers or selection for negotiations:

1. The total score for the technical submittal of the Offeror’s proposal must be greater than or equal to 70% of the available technical points; and

2. The Offeror’s financial information must demonstrate that the Offeror possesses the financial capability to assure good faith performance of the agreement. The Department will review the Offeror’s previous three financial statements, any additional information received from
the Offeror, and any other publicly-available financial information concerning the Offeror, and assess each Offeror’s financial capacity based on calculating and analyzing various financial ratios, and comparison with industry standards and trends.

An Offeror which fails to demonstrate sufficient financial capability to assure good faith performance of the Agreement as specified herein may be considered by the Department, in its sole discretion, for Best and Final Offers or negotiation contingent upon such Offeror providing performance security for the first project year cost proposed by the Offeror in a form acceptable to the Department. Based on the financial condition of the Offeror, the Department may require a certified or bank (cashier’s) check, letter of credit, or a performance bond conditioned upon the faithful performance of the Agreement by the Offeror. The required performance security must be issued or executed by a bank or surety company authorized to do business in the Commonwealth. The cost of the required performance security will be the sole responsibility of the Offeror and cannot increase the Offeror’s cost to the Commonwealth.

Further, the Issuing Office will award an Agreement only to an Offeror determined to be responsible in accordance with the most current version of Commonwealth Management Directive 215.9, Contractor Responsibility Program.

III-6. FINAL RANKING AND AWARD.

After any best and final offer process is conducted, the Department will combine the evaluation committee’s final technical scores, BSBO’s final small diverse business participation scores, and (when applicable) the domestic workforce utilization, Contract Partnership Program, and Mentor Protégé Program (MPP) scores in accordance with the relative weights assigned to these areas as set forth in this Part.

A. The Department will rank responsible offerors according to the total overall score assigned to each, in descending order.

B. The Department must select for contract negotiations the offeror with the highest overall score.

C. The Issuing Office has the discretion to reject all proposals or cancel the request for proposals, at any time prior to the time an Agreement is fully executed, when it is in the best interests of the Commonwealth. The reasons for the rejection or cancellation shall be made part of the file.
PART IV. WORK STATEMENT

IV-1. OVERVIEW

The goals of the HC BH programs are to improve the accessibility, continuity, and quality of services for Pennsylvania's Medical Assistance populations, while controlling the program's rate of cost increases. The Department intends to achieve these goals by enrolling eligible MA recipients in BH-MCOs which provide a specified scope of benefits to each enrolled Member in return for a capitated payment made on a per Member per month basis. The selected Offeror will be responsible for developing cost effective alternative services based on input from the Department and counties served in the zone. Savings achieved will be identified for shared reinvestment opportunities in the zone.

IV-2. OBJECTIVES

A. General

The Department is interested in securing proposals from private sector BH-MCOs to administer the mandatory HealthChoices Behavioral Health Program in the N/C SO zone.

It is anticipated that an agreement will be signed prior to the end of March 2013. The selected selected Offeror will be responsible for service implementation on July 1, 2013.

B. Specific Objectives

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

1) Structural Objectives

   a. To have the Department contract directly with a Private Sector BH-MCO to manage the purchase and provision of Behavioral Health Services in the N/C SO zone.

   b. To include county government in the N/C SO zone as partners with the Department in the oversight of the program.

   c. To develop alternative cost effective services and opportunities for shared reinvestment among counties served.

2) Program Objectives

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

      i. evidence-based;

      ii. outcomes-directed; and

      ii. cost-effective.

   b. To create systems of Care Management that are developed based on input from and are responsive to the needs of consumers, persons in recovery, and their families and which are representative of the various cultures and ethnic groups in the counties, who depend on public services.
c. To provide incentives to implement Utilization Management techniques resulting in expanded use of less restrictive services while assuring appropriateness of care, and increasing prevention and early diagnosis and treatment.

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

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

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

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

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

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

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

k. To develop community-based treatment services which facilitate the administration's state mental hospital rightsizing efforts.

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

m. To develop a structure or entity that would serve to ensure collaborative oversight with the counties. It should reflect the geographic diversity of this large region as well as the range of programmatic issues which need to be addressed. Current required coordination activities between the BH-MCO and the counties include but are not limited to: monitoring meetings to review program performance in quality management, network development, financial and regulatory compliance; regional service system transformation to review and determine need for network expansion or transformation; quality care management meeting to review the quality management plan and progress on
indicators; performance evaluation program summary to review the program standards and requirements for MCO compliance; consumer and family satisfaction team meetings to review the consumer/family run satisfaction survey process looking at Provider results areas for improvements and other feedback; Member/family advisory committee meetings to solicit feedback on how services are being delivered, access to services and other issues; reinvestment committee to review progress on developing, implementing and monitoring reinvestment plans and projects; rate setting activities to participate in activities around rate setting; and Provider meetings to solicit feedback from Providers. The Primary Contractor will be required to allocate a portion of Capitation funding for county government oversight functions.

n. To work in concert with county government and the provider network to ensure that administrative, programmatic, and financial decisions support movement toward evidenced-based practices, are recovery-oriented, include review of program outcomes, and incorporate feedback from consumers, families and persons in recovery.

IV-3. NATURE AND SCOPE OF THE PROJECT

The HealthChoices Program will ensure that enrolled Members have access to quality Behavioral Health Services while allowing the Commonwealth to stabilize the rate of growth in health care costs. The selected Offeror will be responsible for locating, coordinating, and monitoring the provision of designated Behavioral Health Services on behalf of Members in the N/C SO zone.

A. Enrollment

Members are enrolled in the BH-MCO operating in their county of residence on or after being determined eligible for Medical Assistance. As Members are enrolled, information about the Member will be forwarded to the BH-MCO. The BH-MCO must establish mechanisms to inform the County Assistance Office (CAO) of any change or update to the Member's residency or eligibility status within ten (10) days of the date of learning of the change.

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

B. HealthChoices Program Eligible Groups

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

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

b. **Healthy Beginnings:** An MA program which covers children and adolescents born after September 30, 1983, and women during pregnancy and the postpartum period.

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

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

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

e. **SSI-Related:** An MA category which has the same requirements as the corresponding category of SSI. Persons who receive MA in SSI-Related categories are aged, blind or disabled. This includes Medically Needy Only and Non-Money Payment.

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

2) **Eligibility Determination**

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

3) **Guaranteed Eligibility**

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

4) **Involuntary Mental Health Commitment**
Whenever a Member of a HealthChoices Program county is subject to a behavioral health emergency involuntary examination and treatment in another HealthChoices county, the BH-MCO in the county in which the HealthChoices member resides shall be responsible for the cost of examination and involuntary treatment provided in the other county. The BH-MCO in which the HealthChoices Member resides will abide by the examination and involuntary treatment decisions made in the county in which services are rendered. The BH-MCO in the county where the Member receives examination and/or treatment shall notify the Member’s BH-MCO within twenty-four (24) hours of commitment.

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

6) Children and Adolescents in Substitute Care Issues (see Appendix V).

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

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

9) The BH-MCO will be required to pay for medically necessary Behavioral Health Services for Members provided within a private ICF/MR facility within the HC Zone.

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

C. Rating Period

A rating period coincides with the term of an Agreement period, i.e., the period for which Capitation rates are developed and negotiated for the Agreement. The Department will provide rates to the selected Offeror that will apply to the initial rating period July 1, 2013 to June 30, 2014.

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

1) Changes in medical costs;
2) Changes in utilization patterns; or
3) Programmatic changes that affect theselected Offeror and/or its BH-MCO's delivery or coverage of benefits.
In the event that no adjustments are made, pursuant to C.1), 2) or 3) above, the rates applicable to the previous rating period will apply. The Department will disclose to the selected Offeror the basis and assumptions of its determination with respect to adjustments to the second, fourth and fifth rating period rates.

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

If the Department exercises its option to renew the Agreement for an additional three (3) year period, pursuant to Section I-23, rate negotiations will commence promptly after notice of same.

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

D. Termination/Cancellation

The Department may terminate or cancel the Agreement as provided in Appendix B Standard Grant Terms and Conditions, for failure to secure/retain necessary federal contract and/or Waiver approvals, or for changes in applicable federal or Commonwealth law, regulation, public policy.

DPW requires the selected Offeror to provide a minimum of 180 day notice of its intent to terminate the Agreement. Upon Termination/Cancellation or expiration of the Agreement resulting from this RFP, the selected Offeror must:

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

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

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

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

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

During the final quarter of the Agreement resulting from this RFP, the selected Offeror will work cooperatively with, and supply program information to, the Department and any subsequent BH-MCO.
E. Compliance with Federal and State Laws, Regulations, Department Bulletins and Policy Clarifications.

The selected Offeror must require that network Providers delivering In-Plan Services participate in the MA program and, in the course of such participation, provide those services essential to the care for individuals being served, and comply with all federal and state laws generally and specifically governing participation in the MA Program. The selected Offeror and Behavioral Health Service Providers must comply with all applicable Department regulations, and policy bulletins and clarifications. The Offerors' Library contains a copy of the laws, regulations and bulletins which govern the provision of services and supplies of the type furnished through the BH-MCO. Appendix BB identifies the portions of Departmental regulations and bulletins which are not applicable to the HC BH program.

The selected Offeror and its Subcontractors must comply with all applicable federal and state laws and regulations including but not limited to: Title VI and VII of the Civil Rights Act of 1964 (42 U.S.C. Section 2000d et seq. and 2000 e. et seq.); Section 504 of the Rehabilitation Act of 1973 (29 U.S.C. Section 701 et seq.); the Age Discrimination Act of 1975 (42 U.S.C. Section 6101 et seq.); Title II of the Americans with Disabilities Act (42 U.S.C. Section 12101 et seq.); Health Insurance Portability and Accountability Act of 1996 (HIPAA), as amended; the Pennsylvania Human Relations Act of 1955 (71 P.S. Section 941 et seq.); the Pennsylvania Managed Care Consumer Protection Act (Act 68) of 1998 (Article XXI of the Insurance Company Law of 1921, as amended, 40 P.S. 991.2101 et seq.); the Title IX of the Education Amendment of 1972 (regarding education programs and activities), 45 CFR Parts 160 and 164 (Standards for privacy of Individually Identifiable Health Information) and 45 CFR Part 74, Appendix A.

The selected Offeror will comply with future changes in federal and state law, federal and state regulations, and Department requirements and procedures related to changes in the Medicaid program resulting from Health Care Reform.

The selected Offeror will comply with the requirements mandating Provider identification of provider-preventable conditions as a condition of payment, as well as the prohibition against payment for provider-preventable conditions as set forth in 42 CFR §438.6 and §447.26.

F. False Claims

The selected Offeror recognizes that payments by the Department to the Offeror will be made from federal and state funds and that any false claims or statements or any concealment of material fact may be a cause for prosecution under applicable federal and state laws. Payments are contingent upon availability of state and federal funds.

G. Major Disasters or Epidemics

In the event of a major disaster or epidemic as declared by the Governor of the Commonwealth, the selected Offeror shall require Providers to render all services provided for in the Agreement as is practical within the limits of Providers' facilities and staff which are then available.

H. Performance Standards and Damages

1) Performance Standards for the HC BH Program
Performance standards for the HC BH Program are included throughout this RFP. Additional standards may be developed for inclusion in subsequent related Agreements. The selected Offeror may develop performance standards consistent with this RFP. The Department may institute incentive payments related to performance standards in the future.

2) Sanctions

The Department may impose sanctions for non-compliance with, or failure to meet, performance and program standards indicated in this RFP and/or subsequent related agreements.

Sanctions may be imposed by the Department in a variety of ways to include but not be limited to:

a. Requiring the selected Offeror to submit a corrective action plan.
b. Imposing monetary assessments, including suspension or denial of payments.
c. Terminating the Agreement.

3) Profit and Reinvestment Arrangement

a. Plans for shared reinvestment must be priorities for the unmet and under met needs of MA recipients as described in Appendix N. The selected Offeror will establish a Reinvestment Fund which will hold funds available for shared reinvestment opportunities in the counties being served under the Agreement. The reinvestment sharing arrangement will be proposed by the selected Offeror and the counties and approved by the Department. Under current reinvestment sharing, the first 2% goes to the selected Offeror; and 1% goes to counties for reinvestment.

b. The BH-MCO as the selected Offeror is permitted to retain profit. Profit will be monitored by DPW and will be a factor in future rate adjustments and negotiations.

I. Small Diverse Business Participation Contract Requirements

All contracts containing Small Diverse Business participation must also include a provision requiring the selected Offeror to meet and maintain those commitments made to Small Diverse Businesses at the time of proposal submittal or contract negotiation, unless a change in the commitment is approved by the BSBO. All contracts containing Small Diverse Business participation must include a provision requiring Small Diverse Business Subcontractors to perform at least 50 percent of the subcontracted work.

The selected Offeror’s commitments to Small Diverse Businesses made at the time of proposal submittal or negotiation shall, to the extent so provided in the commitment, be maintained throughout the term of the Agreement and through any renewal or extension of the Agreement. Any proposed change must be submitted to BSBO, which will make a recommendation as to a course of action to the contracting officer.

If the Agreement is assigned to another entity, the new entity must maintain the Small Diverse Businesses participation of the original.
The selected Offeror shall complete the Prime Contractor’s Quarterly Utilization Report (or similar type document containing the same information) and submit it to the Project officer of the Department and BSBO within ten (10) workdays at the end of each quarter the Agreement is in force. This information will be used to determine the actual dollar amount paid to Small Diverse Business Subcontractors and suppliers. This information also will serve as a record of fulfillment of the commitment the selected Offeror made and for which it received Small Diverse Business points. If there was no activity, the form must also be completed, stating “No activity in this quarter.”

NOTE: EQUAL EMPLOYMENT OPPORTUNITY AND CONTRACT COMPLIANCE STATEMENTS REFERRING TO COMPANY EQUAL EMPLOYMENT OPPORTUNITY POLICIES OR PAST CONTRACT COMPLIANCE PRACTICES DO NOT CONSTITUTE PROOF OF DIVERSE BUSINESS STATUS OR ENTITLE AN OFFEROR TO RECEIVE CREDIT FOR SMALL DIVERSE BUSINESS UTILIZATION.

IV-4. WORK STATEMENT TASKS

A. In-Plan Services

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

1) The Primary Contractor shall provide timely access to diagnostic, assessment, referral, and treatment services for Members for the following benefits:

a. Inpatient psychiatric hospital services, except when provided in a state mental hospital.
b. Inpatient drug and alcohol detoxification.
c. Psychiatric partial hospitalization services.
d. Inpatient drug and alcohol rehabilitation.
e. Non-hospital residential detoxification, rehabilitation and half-way house services for drug/alcohol abuse or dependence.
f. Psychiatric outpatient clinic, licensed psychologist and psychiatrist services.
g. Behavioral health rehabilitation services (BHRS) for children and adolescents with psychiatric, substance abuse or intellectual disabilities disorders.
h. MH residential treatment services for children and adolescents (accredited and non-accredited).
i. Outpatient drug and alcohol services, including Methadone Maintenance Clinic services.
j. Methadone, when used to treat narcotic/opioid dependency and dispensed by an In-Plan drug and alcohol services Provider.
k. Clozapine support services.
l. Laboratory and diagnostic studies and procedures for the purposes of determining response to behavioral health medication and/or treatment ordered by Behavioral Health Services Providers acting within the scope of their license.
m. Crisis intervention services (telephone and mobile with in-home capability).
n. Family-based mental health services for children and adolescents.
o. Targeted mental health case management (intensive case management and resource coordination).
p. Mobile Mental Health Treatment.
q. Peer Support Services.

2) The selected Offeror must require that network Providers offer hours of operation that are no less than the hours of operation offered to commercial members or comparable to Medicaid Fee-for-Service, if the Provider serves only Medicaid Members. Hours of operation should be flexible in order to accommodate the particular scheduling needs of Members (i.e. inclusion of evening and/or weekend hours).

3) The selected Offeror must have procedures for authorization and payment for In-Plan Services, which are required but not available within the Provider network or for providing Emergency Services for Members who are temporarily out of the HealthChoices Zone.

   a. An Offeror that would otherwise be required to provide, reimburse, or provide coverage of, a counseling or referral service, is not required to do so if it objects to the service on moral or religious grounds.
   b. If the selected Offeror elects not to provide, arrange for the provision of, or make payment for a counseling or referral service because of an objection on moral or religious grounds, it must:
      • furnish information to the Department describing the service;
      • include this information as a part of its Technical Submittal;
      • notify the Department whenever it adopts the policy during the term of the Agreement;
      • notify Members within thirty (30) days of adopting this policy and identify the excluded service(s); and,
      • be consistent with the provisions of 42 CFR § 438.10.

4) Member Liability

   a. The selected Offeror may not hold Members liable for:
      i. In-Plan Services provided to the Member for which the Department does not pay.
      ii. In-Plan Services provided to the Member for which the Department does not pay the individual or health care Provider that furnishes the services under a contractual, referral, or other arrangement.
      iii. In-Plan Services to the extent that those payments are in excess of the amount that the Member would owe if the selected Offeror provided the services directly.

b. In situations where a network Provider is not available to provide an In-Plan Service, the selected Offeror must have procedures to coordinate with Out-of-Network Providers and must ensure that cost to the Members (if any) is no greater than it would be if the services were furnished by a network Provider.

5) The selected Offeror is encouraged to develop and purchase cost effective Supplemental Services which can be provided in a less restrictive setting and/or which would result in improved outcomes for Members.

6) The selected Offeror must provide comprehensive service management, with clear access and lines of authority. Each Member's plan of care, including the commencement, course,
and continuity of treatment and support services, must be documented in such a way as to permit effective review of care and demonstrate care coordination with services covered by the selected Offeror.

7) For Priority Populations (see Appendix Q), the selected Offeror must provide a clearly defined program of care which incorporates longitudinal and disease state management. In addition, evidence of a coordinated approach must be demonstrated for those persons with: co-existing mental health and drug and alcohol conditions, older adults with psychiatric and substance use disorders (particularly those with co-existing physical impairments) and other Special Needs Populations who experience mental health and/or drug and alcohol disorders (e.g., persons with mental retardation, homeless persons, persons diagnosed with ASD, persons discharged from correctional facilities, persons with HIV/AIDS and physical disabili-

8) The selected Offeror is required to maintain 24 hour telephone accessibility, staffed at all times by qualified personnel, to provide information to Members and Providers, and to provide screening and referral, as necessary.

   a. There must be 24 hour capacity for service authorization.
   b. There must be 24 hour access to a physician for psychiatric and drug and alcohol clinical consultation and review.
   c. All Member and Provider calls must be answered within 30 seconds.
   d. The Member line must be answered by a live voice at all times.
   e. The selected Offeror may establish a regional network with one telephone line for Member calls and one line for Provider calls.
   f. Separate record keeping must be established for tracking and monitoring of both Provider and Member phone lines.

9) The selected Offeror must have procedures for reminders, follow-up, and outreach to Members including:

   a. Home visits and other methods to encourage use of needed services by Members who do not keep appointments, including notification of upcoming appointments.
   b. Population groups with special needs and groups who under use needed Behavioral Health Services, such as older persons, persons who are homebound or homeless and adults with intellectual disabilities, and persons diagnosed with ASD.
   c. Administrative mechanisms for sending copies of information, notices and other written materials to an additional party upon the request and signed consent of the Member.

10) The selected Offeror must have procedures to determine the EPSDT screen status for children receiving BH Services. Referral to the child’s Primary Care Physician (PCP) must be made for children whose EPSDT screens are not current, based on the American Academy of Pediatrics periodicity schedule. The selected Offeror must have procedures to collect and report EPSDT screen referral and status information.

B. Coordination of Care

1) The Primary Contractor is required to develop and implement written agreements with Physical Health Service Systems (PHSS) regarding the interaction and coordination of
services provided to Members. These agreements must be submitted to and approved by the Department. A sample PH-BH coordination agreement (which does not include all required procedures) is in the HealthChoices Library. Complete agreements, including operational procedures, must be available for review by the Department at the time of On-Site Reviews. The agreements must be submitted for final review and approval to the Department at least thirty (30) days prior to the provision of services by the selected Offeror in the zone. The written agreements should include, but not be limited to:

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

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

c. Procedures for the exchange of relevant enrollment and health-related information among the selected Offeror, the PHSS, the PCP, and BH and PH service Providers in accordance with federal and state confidentiality laws and regulations (e.g., periodic treatment updates with identified primary and relevant specialty Providers).

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

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

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

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

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

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

j. Procedures for the coordination of laboratory services.

k. Mechanisms and procedures to ensure coordination between the selected Offeror service managers, Member services staff and Provider network with the PHSS.

l. Procedures for the PHSS to provide physical examinations required for the delivery of BH Services, within designated timeframes for each service.

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

   i) All pharmacy services are the payment responsibility of the Member’s PHSS. All prescribed medications are to be dispensed through PHSS network pharmacies. This includes drugs prescribed by both the PHSS and the selected Offeror’s Providers. The only exception is that the selected Offeror is responsible for the payment of methadone when used in the treatment of substance abuse disorders and when prescribed and dispensed by selected Offeror’s service Providers;

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

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

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

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

   c) The drug is prescribed by a behavioral health Provider identified as not having a signed Provider Agreement with the selected Offeror; or

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

iii) BH-MCO representation on each HC PH-MCO’s panel of physician and other clinicians selecting the PH-MCO formulary.

iv) Procedures for monitoring behavioral health pharmacy services provided by the PHSS;

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

vi) Procedures for the timely resolution of any disputes which arise from the payment for or use of pharmaceuticals (e.g., use of anti-convulsant medication as a mood stabilizer) including a mechanism for timely impartial mediation when
resolution between the PHSS and selected Offeror does not occur;

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

viii) Policies and procedures to collaborate in adhering to a drug utilization review (DUR) program approved by the Department. This system is based on federal statute/regulations; and

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

The selected Offeror is required to provide the PHSS, upon request, a listing of the physicians in its initial Provider network and, on a quarterly basis, changes including Terminations and additions.

2) The selected Offeror must require through its Provider Agreements that its Providers interact and coordinate services with the PHSS and their PCPs.

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

   a. Ascertain the Member's PCP, and/or relevant physical health specialist, or behavioral health clinician and obtain applicable releases to share clinical information.

   b. Make referrals for social, vocational, educational, or human services when a need for such service is identified through assessment.

   c. Provide health records to each other, as requested.

   d. Comply with the agreement between the selected Offeror and the PHSS to assure coordination between behavioral and physical health care including resolution of any clinical dispute.

   e. Be available to each other for consultation.

3) The selected Offeror must establish procedures, which include referrals and interagency service planning, to coordinate In-Plan Service delivery with services delivered outside the scope of services covered by the selected Offeror:

   a. Supplemental Services

In addition to the In-Plan mental health, drug and alcohol and behavioral health services listed in IV-4 A.1), supplemental mental health and drug and alcohol services may be made available to Members when the selected Offeror determines the service to be clinically appropriate. Supplemental Services are MA eligible services which are not part of the capitated, In-Plan benefit package. The selected Offeror may, but is not required to, choose to purchase such services, in lieu of or in addition to an In-Plan Service. Further information regarding Supplemental Services is contained in Appendix N. HC BH Supplemental Services forms can be found at:
http://dpwintra.dpw.state.pa.us/omhsas/healthch/provider.asp
b. Medical Care

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

i) privately-operated intermediate care facilities for persons with mental retardation (ICF/MR), and intermediate care facilities for persons with other related conditions (ICF/ORC);
ii) mental health residential treatment facilities;
iii) acute and extended acute psychiatric inpatient facilities;
iv) non-hospital residential detoxification, rehabilitation and half-way house services for drug/alcohol abuse or dependence; and
v) juvenile detention facilities for up to thirty-five (35) days.

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

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

c. Public Psychiatric Hospitalization

Civil and forensic psychiatric hospitalizations at a state mental hospital are not covered by the selected Offeror. The selected Offeror, must coordinate with the state mental hospital and county mental health authorities, as applicable, to develop and implement admission and discharge planning to assure appropriate admissions and timely discharges and continuity of care for the Member.

d. Emergency Services: Coverage and Payment

The selected Offeror may not deny payment for Emergency Services obtained when its representative instructs the Member to seek Emergency Services (See Part IV, Section IV-4 B for information regarding Emergency Room coverage responsibilities).

The selected Offeror may not limit what constitutes an Emergency Medical Condition on
the basis of lists of diagnoses or symptoms.

The selected Offeror may not refuse to cover Emergency Services based on the emergency room Provider, hospital or fiscal agent not notifying the Member’s BH-MCO of the Member’s screening and treatment within ten (10) calendar days of presentation for Emergency Services.

The selected Offeror may not hold a Member who has an Emergency Medical Condition liable for payment of subsequent screening and treatment needed to diagnose the specific condition or stabilize the patient. Responsibility for inpatient admission will be based upon the Member’s primary diagnosis.

The attending emergency physician, or the Provider actually treating the Member, is responsible for determining when the Member is sufficiently stabilized for transfer or discharge and the determination is binding on the selected Offeror.

4) The selected Offeror must enter into a written agreement with the CCYAs to include, at a minimum:

a. Procedures for referral, authorization and coordination of care, including overall requirements for children and adolescents in substitute care and specific requirements for referral, review of medical necessity prior to admission to and coordination of care following discharge from accredited and non-accredited RTF services, and D&A non-hospital residential rehabilitation and detoxification programs.

b. Liaison relationships for individual cases and administration.

c. Release of records and BH-MCO representation in court.

d. Procedures to assure continuity of behavioral health care for children in substitute care at the time of program start-up.

e. Procedures to communicate denials of service by the selected Offeror.

f. Provision of BH-MCO Provider directories, including electronic transmission where children and youth agency capacities exist.

5) For children and adolescents who are served by multiple child serving systems, the selected Offeror must:

a. Have well publicized written policies and procedures explaining the selected Offeror is available to attend or convene Interagency Team meetings, at the request of or with the consent of the Parent or custodian.

b. Treat as a formal request for service a prescriber's request for services pursuant to an Interagency Team recommendation, with the deadlines and Complaint, Grievance and DPW Fair Hearing rights outlined in Appendix H.

c. At the Parent or custodian’s or agency’s request, serve on an Interagency Team to develop a comprehensive interagency plan which identifies the service, the responsible agency to deliver the service, and the source of funding for the service.

d. Coordinate specialized treatment plans for children and adolescents with special health needs, including early intervention.

6) The selected Offeror is required to coordinate service planning and delivery with human services agencies. The selected Offeror is required to have letters of agreement with:
a. Area Agencies on Aging.

b. County Juvenile Probation Offices (including the same components as the agreement with the CCYA in IV-4.B.4)).

c. County Drug and Alcohol Agencies, including:
   i) A description of the role and responsibilities of the Single County Authorities (SCA).
   ii) Procedures for coordination with the SCAs for placement and payment for care provided to Members in residential treatment facilities outside the HC Zone.

d. County offices of MH and MR, including coordination with the Health Care Quality Unit (HCQU).

e. Each school district in each county.

f. County Prisons, County Probation Offices, Department of Corrections and Pennsylvania Board of Probation and Parole to ensure continuity of care and enhanced services for individuals as they enter and leave the criminal justice system.

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

7) The selected Offeror must have in place written agreements with the Primary Contractors in the Commonwealth to ensure continuity of care for Members who relocate from one HC zone to another. The selected Offeror must also have in place procedures to ensure continuity of care for Members who relocate to a county outside of the HC NC/SO Zone or out-of-state on a temporary or permanent basis as well as disenrollment described below.

C. Member Services/Member Rights

1) The selected Offeror must comply with any applicable federal and state laws that pertain to Members’ rights and ensure that their staff takes those rights into account when furnishing services to Members.

2) Member Orientation
   a. In consultation with the Department, the Primary Contractor must develop and distribute culturally and disability sensitive materials for Members regarding program features, policies, and procedures.
   b. The selected Offeror must conduct education sessions for Members and families to inform them of the benefits available and the access procedures. Such sessions must be in locations readily accessible and at times convenient for Members and families.
   c. The selected Offeror must provide to Members, within five (5) days of enrollment, the names, locations, telephone numbers of, and non-English languages spoken by, network Providers in the Member’s service area, including identification of Providers that are not accepting new patients. In addition, the selected Offeror must provide a list of current in-plan behavioral health network Providers to the Member upon the Member’s request. The selected Offeror must make a good faith effort to give written notice of terminated contracts within fifteen (15) days after receipt or issuance of a Termination notice, to each Member who receives primary care from or was seen on a regular basis by the terminated Provider.
   d. The selected Offeror must provide each Member with the name of one individual in
the program to be the Member's "point of contact" to explain plan services and assist the Member to access services.

e. The selected Offeror must publish and distribute a Member handbook, the method of distribution and process requiring prior approval by the Department, with input from the counties served. The selected Offeror must distribute to all Members within five (5) days of enrollment and make it available to other interested parties, upon request. In addition, the Primary Contractor must notify all Members of their right to request and obtain information related to the Provider network, benefits, Member rights and protections, and Complaint, Grievance, and DPW Fair Hearing procedures at least once a year. The handbook must be written at no higher than a fourth grade reading level, delineating a Member's rights and responsibilities, as well as covering the following information:

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

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

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

iv) any required DPW approved co-pay or cost sharing obligation by the Member;

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

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

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

viii) the counseling or referral services the Primary Contractor does not cover because of moral or religious objections. The Primary Contractor must inform Members that the Department will furnish information on how and where to obtain the service;

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

x) explanation of the procedures for accessing BH Services, including self-referred and Prior Authorized Services;

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

xii) information concerning methods for coordinating services for Members;

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

xiv) phone numbers of the clinical sentinel and BH advocacy agencies;

xv) phone number of the Department’s Fraud and Abuse hotline;

xvi) information on “Advance Directives” (durable power of attorney and living wills), including the following:

a) written policies and procedures per State mandates and requirements;

b) the description of State law;

c) the process for notifying the Member of any changes in State law. The information must reflect changes in state law as soon as possible but no later than ninety (90) days after the effective date of the State law change;

d) any limitation the selected Offeror has regarding implementation of advanced directives as a matter of conscience;

e) the process for Members to file a Complaint concerning noncompliance with the advanced directive requirements with the plan and the State survey
xvii) information to adult Members regarding Member rights.
xviii) explanation of the operation of the BH-MCO.
xix) explanation of how Members are assisted in making appointments and obtaining
services including the explanation of procedures for accessing self-referred and
Prior Authorized Services.
xx) explanation of how Members are assisted to obtain transportation through
MATP.
xxi) explanation of how Member Complaints and Grievances are handled.
xxii) explanation of rights, which must include the following:
   a) each Member will be treated with respect and with due consideration for his
      or her dignity and privacy;
   b) each Member will receive information on available treatment options and
      alternatives, presented in a manner appropriate to the Member’s condition
      and ability to understand;
   c) each Member will participate in decisions regarding his or her health care,
      including the right to refuse treatment unless the individual meets criteria
      for involuntary treatment under the MH/MR Act of 1966;
   d) each Member has the right to be free from any form of restraint or seclusion
      used as a means of coercion, discipline, convenience or retaliation, as
      specified in other federal regulations on the use of seclusion and restraint;
   e) each Member may request and receive a copy of his or her medical records
      and request that they be amended or corrected in accordance with the
      Federal Privacy Law;
   f) each Member is free to exercise his or her rights and that the exercise of
      those rights does not adversely affect the way the selected Offeror,
      Providers or any state agency treats the Member. Specifically, Members are
      given the opportunity to file Complaints for concerns related, but not limited
      to, their sex, race, ethnicity, sexual orientation, gender identity and gender
      expression;
   g) each Member has the right to request a second opinion from a qualified
      health care professional within the Provider network. The selected Offeror
      must provide for a second opinion from a qualified health care professional
      within the network, or arrange for the ability of the Member to obtain one
      outside the network, at no cost to the Member.
xxiii) restrictions on the Member’s freedom of choice among Providers.
xxiv) an explanation of the option for continuity of care when:
   a) The selected Offeror terminates a contract with a participating Provider for
      reasons other than for cause and the Member is in an ongoing course of
      treatment with the Provider. Member shall be allowed to continue the
      course of treatment with the same Provider, for a transition period of up to
      sixty (60) days from the date the Member was notified by the selected
      Offeror of the termination or pending termination.
   b) A new Member in an ongoing course of treatment with a nonparticipating
      Provider which is not otherwise covered by the terminated coverage.
      Member shall be allowed to continue services with the non-participating
      provider, for a transitional period of up to sixty (60) days from the effective
      date of enrollment with the Primary Contractor. The selected Offeror, in
      consultation with the Member and Provider, may extend the transitional
      period if determined to be clinically appropriate.
c) The selected Offeror will require non-participating and terminated Providers to agree to the same terms and conditions which are applicable to the selected Offeror’s participating Provider.

f. In addition to including the following information in the Member handbook, the selected Offeror must provide each Member written notice of any Department-approved changes to the following at least thirty (30) days before the intended date of the change:

i) Complaint, Grievance, and DPW Fair Hearing procedures and timeframes (as provided in Appendix H) including:

a) For DPW Fair Hearings.
   i) the right to a hearing.
   ii) the method for obtaining a hearing.
   iii) the rules that govern representation at the hearing.

b) The right to file Complaints and Grievances

c) The requirements and timeframes for filing a Complaint or Grievance by phone.

d) The availability of assistance in the filing process.

e) The toll-free numbers that the Member can use to file a Grievance or an appeal by phone.

f) The fact that, when requested by the Member, benefits will continue if the Member files a Complaint (one of the five Complaints that allow for continuation of benefits, as specified in Appendix H), Grievance or request for DPW Fair Hearing within the timeframes specified for filing.

g) Any appeal rights that the Department chooses to make available to Providers to challenge the failure of the organization to cover a service.

ii) Instructions for obtaining care in an emergency, including:

a) locations of any emergency settings and other location at which Providers and hospitals furnish Emergency Services;

b) the use of the 911 telephone system or its local equivalent;

c) what constitutes an Emergency Medical Condition and Emergency Services;

d) the fact that Prior Authorization is not required for Emergency Services;

e) the fact that the Member has a right to use any hospital or other setting for Emergency Services.

3) The selected Offeror must develop and implement programs for public education and prevention including behavioral health education materials and activities.

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

D. Member Disenrollment

1) General Authority

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

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

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

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

4) A Member's termination from enrollment becomes effective on a date specified by the Department. The selected Offeror must have policies and procedures to comply with any Department enrollment termination and for the Member's continuity of care as described in IV-4.B.7.

E. Complaint and Grievance System

1) General

The selected Offeror must establish Complaint and Grievance mechanisms through which Members and Providers can seek redress. The selected Offeror may not take any adverse action against a Provider for assisting a Member in understanding or filing a Complaint or Grievance under the Member Complaint and Grievance System.

2) Member Complaint and Grievance System

The selected Offeror must develop, implement, and maintain a Complaint and Grievance System which provides for resolution of Member Complaints and Grievances at the most efficient administrative level. The Complaint and Grievance system must conform to the conditions set forth in Appendix H.

a. The selected Offeror must provide Members and Parents or custodians of children and adolescents (for children in substitute care, both Parents, if whereabouts are known and county CCYA must receive information) with documents that plainly and clearly outline rights and responsibilities as Members, including the right to file a Complaint or Grievance and/or to request a DPW Fair Hearing. This information must include a toll-free telephone number for Members to facilitate the communica-
tion of a Complaint or Grievance.

b. The selected Offeror must ensure that any Subcontractor, with authority to approve and disapprove service requests, complies with the Complaint and Grievance procedures and reporting requirements established by the selected Offeror.

c. Denials of service or coverage must be in writing, notifying the Member or Parent or custodian of a child or adolescent of the reason for the denial, alternative treatments available, the right to file a Grievance and/or request a DPW Fair Hearing and the process for doing so.

d. The selected Offeror must integrate its Complaint and Grievance system with the QM process in terms of review, corrective action, resolutions, and follow-up.

e. The selected Offeror must have a data system in place capable of processing, tracking, and aggregating data to discern trends in Complaints and Grievances.

f. The selected Offeror must provide all required Member Complaint and Grievance information to the Enrollment Assistance Program as requested.

g. The selected Offeror’s Grievance system may not be a prerequisite to or replacement for the Member’s right to request a Fair Hearing to the Department (in accordance with 42 CFR Part 431, Subpart E) when the Member is adversely affected by an administrative decision rendered by the selected Offeror. The selected Offeror must cooperate with and adhere to the Department’s procedures and decisions.

h. Complaints or Grievances resulting from any action taken by oversight agencies responsible for fraud, abuse, and prosecution activities must be directed to the respective agency. Oversight agencies include the Department’s Office of Medical Assistance Programs, Bureau of Program Integrity, the Office of the Attorney General’s Medicaid Fraud Control Section, the Pennsylvania State Inspector General, and HHS/CMS’s Office of Inspector General, and the United States Justice Department.

3) Denial of Authorization

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

The selected Offeror may not deny authorization or reduce the amount, duration, or scope of a required service solely because of a Member’s diagnosis, type of illness or condition. If a service for which the request for authorization is denied is viewed by the prescriber and the Member as an Urgent or Emergency Service, the selected Offeror must have a process for expedited review of such Grievances to occur within 48 hours of the request.

Any time the selected Offeror denies a request for authorization for service, it must notify the Member or the Parent or custodian of a child or adolescent, in writing. The written notification must include:

a. Specific reasons for the denial with references to the program provisions;

b. A description of alternative services recommended on the basis of placement criteria, e.g., Adult Placement Criteria for Drug and Alcohol Services.

c. A description of the Member’s right to file a Grievance and/or request a DPW Fair Hearing.
Hearing.
d. Information for the Member describing how to file a Grievance and/or request a DPW Fair Hearing.
e. An offer by the selected Offeror to assist the Member in filing a Grievance and/or DPW Fair Hearing.

4) Provider Complaint System

The selected Offeror must develop, implement and maintain a Provider Complaint system which provides for informal mediation and settlement of Provider Complaints at the lowest administrative level and a formal Complaint process when informal resolution is not possible.

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

The Department's Bureau of Hearings and Appeals may not be used by Providers to appeal decisions of the selected Offeror.

IV-5. REQUIREMENTS

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

A. General

1. Offerors must be BH-MCOs licensed by the Commonwealth as HMOs or as risk assuming Preferred Provider Organizations (PPO) with operating authority for the covered county/counties, or have made application for operating authority from the Departments of Health and Insurance. The application date must be no later than the proposal submission date specified in the cover letter to this RFP and the operating authority must be received no later than May 15, 2013. The Department will hold the selected Offeror responsible for all financial risk. Financial risk arrangements must be clearly identified in all incorporating documents.

2. The selected Offeror's administrative offices, from which the program is operated, must be located within the Commonwealth of Pennsylvania in close geographic proximity to the counties in which In-Plan Services are provided and ensure maximum efficiency of administrative cost while being responsive to the counties and Members in the N/C SO zone.

3. Where the Primary Contractor changes ownership or undergoes a major restructuring, including any major change to the submitted organizational chart or acquisition of another MCO, such change must be reported to the Department thirty (30) days prior to the change or within forty-eight (48) hours of confirmation of the change. Major organizational changes may result in the Department conducting a complete readiness review to assess continued adherence to the terms of the Agreement by the new structure. Continuation of the Agreement is contingent on a finding of the readiness review that the terms of the Agreement will be adhered to under the change/restructuring.
B. Executive Management

1. The development of the behavioral health managed care program is a broad based process. The selected Offeror must include consumers, persons in recovery and family members, including Parents of children and adolescents, as well as county drug and alcohol, mental health and intellectual disabilities, children and youth, juvenile justice, and Area Agency on Aging programs and school districts in the development of the behavioral health managed care program.

2. Subcontract Relationships and Delegation

For each Subcontract, the selected Offeror must require that:

   a. The Subcontractor has been evaluated and determined competent to perform the activities delegated.
   b. The Subcontractor has been engaged pursuant to a written agreement that specifies the activities and reporting responsibilities delegated to the Subcontractor; and provides for revoking delegation or imposing other sanctions if the Subcontractor’s performance is inadequate.
   c. Performance monitoring will be conducted on an ongoing basis and the Subcontractor will be subject to formal review according to a periodic schedule established by the Department, consistent with industry standards or State MCO laws and regulations.
   d. Deficiencies or areas for improvement will be identified and corrective action will be required

3. The selected Offeror is required to contract with Consumer/Family Satisfaction Teams in the counties served or establish such teams if they do not exist.

4. The selected Offeror is required to allocate a portion of Capitation funding for county government oversight functions. The technical proposal must include a description of how the funding would be spent and include any structures, mechanisms, entities or organizations that would be funded to ensure county participation in the oversight and development of the program.

5. The selected Offeror is required to place all HealthChoices Capitation payments in a separate, restricted account(s).

6. The selected Offeror is required to place Reinvestment Funds in a separate restricted account. A plan for expenditures from that account must be prior approved by DPW with input from the counties served. The selected Offeror must have prior approval from DPW to carryover Reinvestment Funds from one Agreement year into a subsequent Agreement year; however, DPW approved reinvestment plan funds must continue to be tracked separately. Reinvestment Funds for DPW approved reinvestment plans can be retained for up to six (6) months after the time period delineated in the approved reinvestment plan, unless such date is otherwise extended by the Department. This includes reinvestment plans that cover more than one (1) year. After that time, unexpended Reinvestment Funds must be returned to the Department. Any funds remaining in the reinvestment account at the time of Agreement
Termination or expiration must be returned to DPW.

The selected Offeror may combine functions or assign responsibility for a function across multiple departments, as long as it demonstrates the following duties and functions are carried out:

a. A Chief Executive Officer with clear authority over the entire operation.
b. A Medical Director who is a board certified psychiatrist licensed in the Commonwealth with at least five (5) years combined experience in mental Health and substance abuse services. The responsibilities of the Medical Director include:
   i) development of clinical practice standards, policies, procedures, and performance;
   ii) review and resolution of quality of care problems;
   iii) participation in Complaint and Grievance processes related to service denials and clinical practice;
   iv) development, implementation, and review of the internal Quality Management and Utilization Management programs;
   v) oversight of the referral process for specialty and Supplemental Services;
   vi) oversight and management of the behavioral health rehabilitation and residential services for children and adolescents;
   vii) leadership and direction in the clinical staff recruitment, credentialing, and privileging activities;
   viii) leadership and direction in the Prior Authorization and utilization review processes;
   ix) leadership and direction of policies and procedures relating to confidentiality of clinical records; and
   x) participation in any meetings called by the Department.
c. A Chief Financial Officer to oversee the budget and accounting system
d. Quality Management
e. Utilization Management
f. Management Information Systems
g. Prior Authorization to include:
   i) assessment and substantiation of need for psychiatric and behavioral services provided by a mental health professional;
   ii) assessment and substantiation of need for drug and alcohol treatment services provided by a Drug and Alcohol Addictions Professional.
h. Member Services to communicate with Members, act as Member advocates, and coordinate Members' use of the Complaint and Grievance processes.
i. Provider Services to coordinate communications between the selected Offeror and its Providers.

7. The selected Offeror must organize and deliver services in accordance with principles established through the CASSP, the CSP; and DDAP's Principles of Effective Treatment and OMHSAS’ Cultural Competency Principles; see Appendices I, J, and CC respectively.

8. The selected Offeror must have written agreements with the county mental health, mental retardation and drug and alcohol authorities assuring availability and access to In-Plan and Supplemental Services. Agreements must include provisions for the integration of crisis intervention services and the admission of any Member to a state mental hospital consistent with the established state mental hospital bed allocation assigned to the county as well as pro-
visions for appropriate, coordinated response and dispute resolution processes related to court orders for behavioral health involuntary treatment services.

C. Administration

1) Administrative duties related to the daily operation of the program and interaction with Providers and Members such as those related to Member services, Provider services, Quality Management and Utilization Management, must be conducted in an administrative office in a location(s) approved by the Department.

2) The HealthChoices Program, along with the Enrollment Assistance Program (EAP), provides Members with information regarding the HC-BH program.

The selected Offeror must have policies and procedures for the coordination with the EAP. The selected Offeror must have informational materials, e.g. pamphlets and brochures, which can be used by the EAP to assist the Member’s access to BH Services. Any informational materials developed for this project by the selected Offeror must have the Department’s prior written approval. The selected Offeror will be required to print and provide the EAP with an adequate supply of approved materials on a continuing basis.

3) Training and Professional Development

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

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

5) The selected Offeror must work in partnership with the designated county/municipal health department, and primary care practitioner as applicable, to ensure that conditions identified in accordance with Chapter 25, Disease Prevention and Control Law (35 P.S. § 521.1 et seq.) are reported (e.g., tuberculosis, hepatitis).

6) Records Retention

a. General

The selected Offeror and BH Services Providers must maintain books and records relating to the HC BH Program services and expenditures, including reports to the Department and source information used in preparation of these reports. These records include but are not limited to financial statements, records relating to quality of care, medical re-
cords, and prescription files.

The selected Offeror and BH Services Providers also must comply with all standards for record keeping specified by the Commonwealth. Operational data and medical record standards are described below, and complete standards are available in the HealthChoices Library.

The selected Offeror and BH Services Providers must, at their own expense, make all records available for audit, review or evaluation by the Commonwealth, its designated representatives, or federal agencies. Access shall be provided either on-site, during regular business hours, or through the mail. During the record retention period, these records shall be available at the selected Offeror's chosen location(s), subject to approval of the Department. All mailed records shall be sent to the requesting entity in the form of accurate, legible, paper copies, unless otherwise indicated, within fifteen (15) calendar days of such request and at no expense to the requesting entity.

The selected Offeror and BH Services Providers shall maintain books, records, documents, and other evidence pertaining to all revenues, expenditures and other financial activity pursuant to the Agreement as well as to all required programmatic activity and data pursuant to the Agreement. Records, other than medical records, may be kept in an original paper state or preserved on micro media or electronic format. Medical records shall be maintained in their original form or legally reproduced form for a period of at least five (5) years.

Financial books, records, documents, and other evidence shall be available for review, audit or evaluation by authorized Commonwealth personnel or their representatives up to five (5) years after the date of the last payment under the Agreement, except if an audit is in progress or audit findings are yet unresolved, in which case, records shall be kept until the resolution of all findings are complete.

b. Operational Data Reports

The selected Offeror must retain the source records for its data reports for a minimum of seven (7) years and must have written policies and procedures for storing this information.

c. Clinical Records

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

The selected Offeror must have written policies and procedures for the maintenance of clinical records so that those records are documented accurately and in a timely manner, are readily accessible, and permit prompt and systematic retrieval of information.

The Department considers the clinical record as an important component of good patient care, for use in evaluating the quality of care rendered to Members. Therefore, the selected Offeror must have written standards for clinical record documentation which
reflect legibility, accuracy, completeness, and that chronologically reflect the evaluation, appropriateness of treatment, and Medical Necessity within the plan of care for the Member. A complete list of standards to follow are contained in 55 Pa. Code Chapter 1101 general MA regulations and the HealthChoices clinical record components document located in the HealthChoices Library.

Clinical records must be legible, signed, dated, preserved, and maintained for a minimum of five (5) years from the date of the last payment under the Agreement. Clinical records must be maintained in paper form for at least two (2) years before conversion to any other form and records in all forms must be readily available for review.

D. Provider Network/Relations

1) The selected Offeror must provide access to all covered services for Members through a network of qualified professionals and facilities. The Provider network, and cost effective alternative services, will be established with the input of the Department and the counties served. The Provider network must have the following features in place and documented:

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

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

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

d. Timely access to covered services and needed specialists including but not limited to the evaluation and treatment of: child and adolescent psychiatric, substance abuse and behavioral disorders; including disorders arising out of psychological and sexual abuse; co-existing psychiatric and substance abuse disorders; psychiatric or substance abuse disorders among older adults (particularly those with co-existing medical conditions); persons with mental retardation with co-existing substance abuse or mental health disorders; persons diagnosed with ASD, persons with psychiatric or substance abuse disorders who are also homeless, pregnant or have HIV/AIDS.

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

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

g. Evidence of a cooperative relationship between the selected Offeror and its Provider network, for example, inclusion of Providers in the development of clinical protocols and Provider profiling.

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

i. The anticipated MA members accepted by providers who limit their practices.

j. Consideration of the expected utilization of services, taking into consideration the characteristics and health care needs of the specific MA populations represented.

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

l. Consideration of the geographic location of Providers and Members, including distance, travel time, the means of transportation ordinarily used by Members, and physical access for Members with disabilities.
2) The selected Offeror must manage the Provider network through agreements which include the following provisions:

   a. Maintenance of clinical records which conform to program specific regulations and release of clinical records in conformance with applicable federal and state confidentiality laws and regulations.
   b. Criteria for Provider's clinical privileges, as applicable.
   c. Clinical performance standards and data reporting requirements.
   d. Financial performance standards and data reporting requirements.
   e. Complaint procedures for Providers.
   f. Requirements for referral, coordination of treatment planning, and consultation (including participation during Interagency Team meetings) in the diagnosis and treatment of psychiatric, substance abuse and behavioral disorders.
   g. Requirements for coordination and continuity of care of Behavioral Health Services with social services; e.g., intellectual disabilities, area agencies on aging, juvenile probation, housing authorities, schools, child welfare, juvenile and county and state criminal justice.
   h. Requirements for coordination, credentialing, and continuity of care with PCPs or prior approved specialist (in accordance with the Department of Health Technical Advisory #95-1 or most current reference).
   i. Procedures for approving demonstration projects for In-Plan Service and treatment alternatives/innovations.
   k. Compliance requirements for criminal background checks.
   l. Authorization of In-Plan Services in accordance with DPW approved Medical Necessity criteria and Prior Authorization procedures.
   m. Requirement that Providers delivering In-Plan Services to Members via a Subcontractual arrangement with a network Provider meet the same requirements and standards as a network Provider.
   n. Procedure to provide access to client records for quality of care and access reviews.
   o. Prohibition against the use of prone restraints by Child Residential and Day Treatment Providers (both in and out of network).

3) The selected Offeror must have policies and procedures to monitor that the access standards are met by each Provider in each level of care. The selected Offeror must monitor the network to assure that Providers conform to expected referral and utilization patterns, conditioned upon accepted local and national practice, and deliver services that result in expected treatment outcomes based upon empirical data.

4) The selected Offeror must maintain procedures for response, reporting, and monitoring of significant Member incidents for trend and case analysis and must make incident records and reports immediately available to the Department upon request.

5) The selected Offeror must maintain procedures for immediate response and appropriate reporting of any suspected or substantiated fraud or abuse to the Department's OMAP, Bureau of Program Integrity.

6) The selected Offeror must notify the Department promptly of any changes to the compo-
sition of its Provider network that affect its ability to make available all In-Plan Services or respond to the special needs of a Member or population group in a timely manner.

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

No payments will be made by the selected Offeror for Provider-preventable conditions, as identified in the State plan and will require that all Providers agree to comply with reporting requirements in 42 CFR §447.26 as a condition of payment. The selected Offeror will comply with such reporting requirements to the extent it directly furnishes services.

8) The selected Offeror must maintain a plan of orientation and ongoing training for network Providers. Training shall include but not be limited to:

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

E Provider Enrollment - Credentialing/Recredentialing

1) In maintaining the Provider network, the selected Offeror must establish written credentialing and recredentialing policies and procedures. The selected Offeror must adhere to credentialing requirements under the Pennsylvania Department of Health regulations at 28 Pa. Code Sections 9.761 and 9.762 for all In-Plan Services provider types as well as for Providers of Supplemental Services in the BH-MCO Provider network. Provider types interested in participating as a Provider within the network must obtain credentialing from the selected Offeror who will ensure the service is within the Provider’s scope of practice. The selected Offeror must submit a program description to OMHSAS for review for any new Supplemental Services being proposed. Upon approval of the service description, OMHSAS will determine the code that will be used in the HealthChoices Program only, and the Provider will report encounter data for this service under their existing Provider type designation. Credentialing policies and procedures must include, but not be limited to, the following criteria:

- Applicable license or certification as required by Pennsylvania law.
- Verification of enrollment in good standing with Medicaid (Providers of Supplemental Services must be enrolled in the MA program).
c. Verification of an active MA Provider Agreement.
d. Evidence of malpractice/liability insurance.
e. Disclosure of any past or pending lawsuits/litigations.
f. Board certification or eligibility, as applicable.

2) Except as provided by 42 CFR 438.12, the selected Offeror may not discriminate for the participation, reimbursement or indemnification of any Provider who is acting within the scope of his or her license or certification under applicable State law, solely on the basis of that license or certification. If the selected Offeror declines to include individuals or groups of Providers in its network, it must give the affected Providers written notice of the reason for its decision.

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

4) The selected Offeror may not prohibit, or otherwise restrict a health care professional acting within the lawful scope of practice, from advising or advocating on behalf of a Member who is his or her patient, for the following:
   a. any information the Member needs in order to decide among all relevant treatment options.
   b. for the risk, benefit and consequences of treatment and non-treatment.
   c. for the Member’s right to participate in decisions regarding his or her health care, including the right to refuse treatment, and to express preferences about future treatment decisions.
   d. for Member’s health status, medical care or treatment options, including any alternative treatment that may be self-administered.

5) The selected Offeror, and its Subcontractors may not employ or contract with Providers excluded from participation in federally-funded health care programs.

6) The selected Offeror shall have a process in place, approved by the Department, for consulting with the counties served regarding Providers to be enrolled in the network and those recredentialed.

7) Any Provider that has been terminated from a federally funded health care program, including Medicare program or from another State’s Medicaid program will be terminated from participation in the HC BH program.

F. Service Access

1) The Provider network must provide face-to-face treatment intervention within one hour for emergencies, within twenty-four (24) hours for Urgent situations, and within seven (7) days for routine appointments and for specialty referrals. Upon the initial face-to-face intervention, the implementation of treatment services must adhere to the prescribed treatment plan, including the Start Date and frequency of treatment services. Prior Authorization of emergency inpatient and emergency outpatient services is not permitted.

The selected Offeror must have a notification process in place with Providers for the referral of a Member to another Provider, if a selected Provider is not able to schedule the referred
Member within the applicable access standard.

2) The selected Offeror must maintain a Provider network which is geographically accessible to Members. All levels of care must be accessible in a timely manner. The access standard for ambulatory services to which the Member travels is at least two (2) Providers for each In-Plan Service:

   a. Within 30 minutes travel time in Urban areas.
   b. Within 60 minutes travel time in Rural areas.

The access standard for inpatient and residential services is at least two (2) Providers for each In-Plan Service, one of which must be:

   a. Within 30 minutes travel time in Urban areas.
   b. Within 60 minutes travel time in Rural areas.

The access standard for in plan crisis intervention services (telephone and mobile) is a minimum of one (1) Provider. The access standard for Drug and Alcohol Halfway House services is two (2) Providers, regardless of gender segregation. That is, the selected Offeror does not need to require two Providers each for halfway house services for both males and females.

Network Providers are not required to be located within N/C SO zone. Adherence to the travel time requirements may be facilitated by the selected Offeror's inclusion of out-of-zone BH Services Providers in its network.

The selected Offeror must obtain DPW approval for policies and procedures to cover situations in which the selected Offeror determines that a Member is in need of a specialized In-Plan Service and a Provider is not available within the travel timeframes. The policy and procedures shall ensure the appropriate delivery of services and the availability of local supports for the Member.

3) The selected Offeror must have a service authorization system that includes verification of eligibility and a coordinated, expedited decision-making process in accordance with Appendix T for admission, continued stay and discharge for all In-Plan Services. The selected Offeror's service authorization system must include procedures for informing Providers and Members of authorization decisions.

4) The selected Offeror must have written policies and procedures which comply with MA Bulletins 99-96-01 and 99-03-13 and Appendix V, to authorize care and transition Members to network Providers for Members who are in care at the time of the Agreement implementation. (Note: Bulletin 99-96-01 is specific to continuity of Prior Authorized Services for Members under age 21.) Policies and procedures must specifically address priority and Special Needs Populations. Protocols for authorization, denial of authorization, and transfer to alternative facilities or Providers must also be included. Where disruption of services would have a significant negative impact on the Member, the Primary Contractor must have provisions for the authorization and payment of services delivered by Out-of-Network Providers. A transition monitoring plan must be developed to ensure that procedures and protocols governing transition into service are being followed and that transition problems are identified and corrected. The transition plan should also address the selected Offeror’s staff
recruitment and training prior to start-up and supervisory support during initial implementation. Planning must also address network Provider credentialing, contracting and training; the Primary Contract or telephone capacity related to both Member services and service management functions; and MIS backup.

5) The selected Offeror must have procedures for accessing Out-of-Network, but In-Plan Services in emergency or unique situations including services for children and adolescents in substitute care.

6) The selected Offeror must have procedures to assure continuity of care for Members affected by either Provider terminations or loss of the Member's MA eligibility when Medical Necessity continues at the same or other level of care.

7) If 5% or more of the MA recipients in a County Assistance Office or a district office within the county speak a language other than English as a first language, the selected Offeror must make available in that language all information that is disseminated to English speaking Members. This information includes, but is not limited to, Member handbooks, hard copy Provider directories, education and outreach materials, marketing materials, written notifications, etc. Interpreter services must be available, as practical and necessary, by telephone and/or in person to ensure Members are able to communicate with the selected Offerors and Providers, and receive covered benefits in a timely manner. The selected Offeror must have policies and procedures for ensuring language assistance services for people who have limited proficiency in English.

In addition, the selected Offeror must comply with the Americans with Disabilities Act (ADA) (42 U.S.C. Section 12101 et seq.) concerning the availability of appropriate alternative methods of communication for Members who are visually impaired, deaf or hard of hearing. Such appropriate alternative methods include, but are not limited to, Braille, audio tapes and/or computer diskettes. The selected Offeror must provide Text Telephone Typewriter (TTY) and/or Pennsylvania Telecommunication Relay Services for communicating with Members who are deaf or hard of hearing, and comply with the ADA concerning access for Members with physical disabilities.

8) The selected Offeror will refer any Member in need of any routine and specialized medical and/or social service not provided by the selected Offeror to an appropriate agency/organization.

9) The selected Offeror and its Provider network are required reporters for suspected instances of child abuse pursuant to 23 Pa. C.S. Section 6311.

10) The selected Offeror must assure that Members are provided reasonable access to Behavioral Health Services provided by Federally Qualified Health Clinics (FQHC), wherever FQHC Behavioral Health Services are available, within travel of 30 minutes (Urban) and 60 minutes (Rural).

11) In all agreements with health care professionals, the Primary Contractor must comply with the requirements specified in 42 CFR §438.214, which includes selection and retention of Providers, credentialing and recredentialing requirements, exclusion of providers excluded from participation in federal health care programs and nondiscrimination.
G. Utilization Management and Quality Management (UM/QM)

1) General

The selected Offeror must adhere to Department of Health Regulations at 28 Pa. Code Chapter 9, Subchapter G. The selected Offeror must have written policies and procedures to monitor use of services by its Members and to assure the quality, accessibility, and timely delivery of care being provided by its network. Such policies and procedures must:

a. Conform to state Medicaid plan QM requirements.
b. Include UM/QM committee meetings on a regular basis.
c. Provide for regular UM/QM reporting to management and its Provider network (including profiling of Provider utilization patterns) as well as reports of joint UM/QM activities/studies conducted with the PHSS.
d. Provide opportunity for Member (including representation for Members in Special Needs Populations), persons in recovery, family (including Parents/custodians of children and adolescents) and county participation in program monitoring.

2) Utilization Management (UM)

The selected Offeror must have Department approved written UM policies and procedures that include protocols for prior approval (in accordance with Appendix AA), determination of Medical Necessity, Concurrent Review, Denial of Services, hospital discharge planning, Provider profiling, and Retrospective Review of claims. As part of its UM function, the selected Offeror must have processes to identify over-or under-utilization, as well as service utilization problems and undertake corrective action.

UM practices should focus on the evaluation of the necessity, level of care, appropriateness, and effectiveness of BH services, procedures, and use of facilities.

The selected Offeror is required to have criteria and review procedures. Mental health review criteria must be compatible with guidelines provided in Appendix T. Drug and alcohol reviews must be conducted in accordance with the PCPC for adults issued by the Department of Health and for children and adolescents, with criteria compatible with those of the ASAM. The selected Offeror will distribute the review and UM criteria to all Providers in its Provider network and to any new Provider who signs a Provider agreement with the selected Offeror. The selected Offeror must also provide the criteria to Members, upon request.

3) Quality Management

a. The selected Offeror will implement a Quality Management Program that includes a Continuous Quality Improvement (CQI) process. The selected Offeror will fully comply with the Department’s Quality Management and Utilization Management standards. The selected Offeror may not structure compensation to individuals or entities that conduct Utilization Management activities so as to provide incentives for the individual or entity to deny, limit, or discontinue authorization for medically necessary services to any Member. In the event that CMS specifies performance measures and topics for performance improvement projects, the selected Offeror and its Subcontractors must cooperate fully in implementing these performance measures and projects.
b. Performance Improvement Projects

The selected offeror is required to conduct performance improvement projects that are designed to achieve, through ongoing measurements and interventions, significant improvement, sustained over time, in clinical care and non-clinical care areas that are expected to have a favorable effect on health outcomes and Member satisfaction.

The performance improvement projects must involve the following:

2. Implementation of system interventions to achieve improvement in quality.
3. Evaluation and initiation of activities for increasing or sustaining improvement.

The selected offeror is required to report the status and results of each project to the Department, as requested.

The selected offeror must have a written QM plan that includes quality assessment and performance improvement processes designed to monitor, assure, and improve the quality of care delivered over a range of clinical and health service delivery areas. The continuous quality improvement process places emphasis on, but need not be limited to, high volume and high risk services and treatment and behavioral health rehabilitation services for children and adolescents.

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

4) Confidentiality

The selected offeror must have written policies and procedures which comply with federal and state law and regulations for maintaining the confidentiality of data, including clinical records and Member information.

5) Member Satisfaction

The selected offeror must have systems and procedures to routinely assess Member satisfaction. These systems and procedures should include but not be limited to the use of ongoing consumer/family satisfaction teams (in accordance with Appendix L).

The selected offeror shall contract with existing consumer/family satisfaction teams (C/FST),
or establish such teams if they do not exist, to conduct satisfaction surveys for HC BH Members. The Subcontract shall ensure technical support of the C/FST in report writing, conducting interviews and include funds for travel and staff development. The Department will approve the C/FST Subcontracts established.

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

6) Provider Satisfaction

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

7) Department Review

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

8) Performance-Based Contracting

The selected Offeror must complete each performance improvement project in a reasonable time period so as to generally allow information on the success of performance improvement projects, in the aggregate, to produce new information on quality of care every year.

9) External Independent Assessment

On at least an annual basis, the selected Offeror must provide necessary documentation in order to comply with independent external quality review organization (EQRO) activities. The review shall include:

   a. Validation of the selected Offeror’s quality improvement projects.  
   b. Validation of the selected Offeror’s performance measures.  

The selected Offeror must provide, as necessary, a review of its compliance with state structural and operational standards. Information included in the EQRO must be derived from an assessment of compliance with standards that occurred within the last three (3) years.
IV-6. **Program Outcomes and Deliverables**

A. **Outcome Requirements**

The selected Offeror must show evidence that it assesses the outcome of the treatment services delivered. The focus of outcomes will include the effectiveness of treatment services in enhancing the consumer’s ability to function effectively in their homes, families, and communities. The selected Offeror will utilize methodologies which have been identified as evidence-based and will develop mechanisms to measure the effectiveness of programs in supporting recovery and resiliency goals of consumers. and may develop, with Department approval, reimbursement methodologies (Alternative Payment Arrangements) which support outcome-focused treatment approaches.

B. **Outcome Reporting**

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

The selected Offeror must provide quarterly reports summarizing the findings, and actions taken in response to the findings of the C/FST as well as an annual report summarizing the findings and follow-up actions taken pursuant to the annual Member satisfaction survey conducted pursuant to Appendix L.

The selected Offeror must have a plan in place to review the DDAP client eligibility data for accuracy and completeness and a plan to work with their Providers to that end.

C. **Deliverables**

Deliverables submitted by the selected Offeror include, but are not limited to:

1) **Member Services**

   - Marketing materials; Member handbooks; educational materials; Complaint and Grievance policies and procedures; Prior Authorization and access policies and procedures; listing of Providers.

2) **Administration**

   - Letters of agreement; Provider contracts/Subcontracts; Provider Complaint system procedures; Provider network and staff development plans; Provider directory; Provider enrollment procedures; reimbursement methodology and rates; billing instructions and forms; encounter/referral forms; coordination agreements; Complaint and Grievance data; clinical records; work space for evaluation teams; procedures and monitoring mechanisms for adhering to confidentiality laws and regulations.

3) **Quality Management /Utilization Management**

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

4) Data

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

5) Behavioral Health Rehabilitation Services for Children and Adolescents

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

6) Other

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

IV-7. FINANCIAL AND REPORTING REQUIREMENTS

A. Financial Standards

To measure the program's capacity to assume and manage risk as well as meet fiscal requirements related to account management and claims processing, the selected Offeror must provide the Department with financial reports as requested and on a regular basis. It must also cooperate with any Department or external, independent assessment of performance under the Agreement, including any federally required cost-effectiveness review or other audit.

1) General

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

2) Equity, Risk Protection and Insolvency Requirements

a. Risk Protection for High Cost Cases

The Department seeks to minimize risks that valid claims, submitted to BH-MCOs by providers, for costs incurred by a recipient above a certain monetary threshold, might not be paid. Effective July 1, 2013, the selected Offeror must have a risk protection arrange-
ment in place until the Agreement expires. This risk protection arrangement must include individual stop loss reinsurance that covers, at a minimum, eighty percent (80%) of inpatient costs incurred by one (1) Member during one (1) year in excess of $75,000. The Department may alter or waive the reinsurance requirement if the Primary Contractor submits an alternative risk protection arrangement that the Department determines is acceptable.

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

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

The selected Offeror may not change or discontinue the risk protection arrangement without prior approval from DPW. The selected Offeror must notify DPW forty-five (45) days prior to any change in the risk protection arrangement. The Department reserves the right to review such risk protection arrangements and require changes based on the Department's assessment of the selected Offeror's overall financial condition.

b. Equity Requirements

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

To pass the On-site Review, the selected Offeror must provide documentation that it meets the minimum $1.5M SAP-based equity requirement. In addition, prior to completion of the Readiness Review, the selected Offeror must provide its business plan to meet the equity requirements below during the first four quarters of the Agreement. Capitation revenues received from all Agreements held by a selected Offeror will be summed when evaluating the necessary minimum equity amounts.

The selected Offeror must maintain minimum SAP-based equity equal to the greater of $1,500,000 or 5% of annual HealthChoices Capitation revenue net of the Gross Receipt Tax obligations paid as of the end of each reporting quarter. Annual HealthChoices Capitation revenue refers to amounts paid by DPW to the selected Offeror. The requirement may be phased in during the first four calendar quarters of the period. The following phase-in calculation, which will be reviewed for compliance every quarter during the first Agreement period, will be computed as follows:

End of 1st Quarter:
The greater of [$1.5M] or [Average annual Capitation revenue net of Gross Receipt Tax (derived by averaging the first 3 months and then annualizing)]
multiplied by 2%].

End of 2nd Quarter:
The greater of [$1.5M] or [Average annual Capitation revenue net of Gross Receipt Tax (derived by averaging the first 6 months and then annualizing) multiplied by 3%].

End of 3rd Quarter:
The greater of [$1.5M] or [Annual Capitation revenue net of Gross Receipt Tax (derived by averaging the first 9 months and then annualizing) multiplied by 4%].

End of 4th Quarter:
The greater of [$1.5M] or [Annual Capitation revenue net of Gross Receipt Tax (derived by averaging the first 12 months and then annualizing) multiplied by 5%].

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

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

If the selected Offeror fails to comply with the equity requirements, the Department may take any or all of the following actions:

- Discuss fiscal situation with selected Offeror’s management;
- Require the submission and implementation of a corrective action plan to address fiscal problems;
- Suspend enrollment of some or all recipients into the HC BH Program.
- Terminate the Agreement effective the last day of the calendar month after Notice of Termination.

c. Insolvency Arrangement/Secondary Liability

The selected Offeror must submit its plan, prior to the beginning of negotiations, to provide for payment to Providers by a secondarily liable party after a default in payment to Providers resulting from bankruptcy or insolvency. The secondarily liable party must insure payment to Providers for all services performed by the Primary Contractor's Providers through the last day for which the DPW paid a Capitation premium to the Primary Contractor. The insolvency arrangement must be at a minimum, the equivalent of two months’ worth of paid claims, when determinable, or two months of expected Capitation revenue, in the absence of claims
history. The requirement may be met by submitting one or more of the following arrangements:

i) insolvency insurance;
ii) an irrevocable, unconditional and automatically renewable letter of credit for the benefit of DPW which is in place for the entire term of the Agreement;
iii) a guarantee from an entity, acceptable to the Department, with sufficient financial strength and credit worthiness to assume the payment obligations of the Offeror in the event of a default in payment resulting from bankruptcy or insolvency; or
iv) other arrangements, satisfactory to the Department, that are sufficient to ensure payment to providers in the event of a default in payment to Providers in the event of a default in payment resulting from bankruptcy or insolvency.

DPW may consider alternative insolvency protection arrangements before or during negotiations.

The financial instrument(s) submitted for consideration must clearly reflect that the instrument(s) is to be attached only in the event of a bankruptcy or insolvency.

DPW must approve all such arrangements prior to the signing of an Agreement. Such approval will include approval of the financial strength of the secondarily liable parties and approval of all legal forms for secondary liability.

The selected Offeror must be in compliance with the insolvency arrangement provision prior to completion of the Readiness Review, during which final documents must be provided to DPW and verification of the arrangement will take place.

The selected Offeror will be required to submit its insolvency arrangement to DPW annually. Any proposed changes must be submitted to DPW for approval at least forty-five (45) days prior to any change becoming effective.

d. The selected Offeror will maintain revenues paid by the Department under the Agreement in a specific bank account or accounts. These accounts will not contain funds unrelated to the Agreement. The selected Offeror will prudently invest funds in the account and retain any interest or dividend for use in funding the costs of the Agreement.

e. The selected Offeror must maintain separate fiscal accountability for Medicaid funding under the Waiver apart from mental health and substance abuse programs funded by state, county, and/or other federal program moneys, or any other lines of business. The selected Offeror shall demonstrate during the Readiness Review that it has procedures for accurately recording, tracking and monitoring HealthChoices revenues and expenses separately from other lines of business, and by county for each county that is a part of the Agreement.

3) If DPW is obligated as a result of litigation to pay a Provider for a service rendered under the Agreement, the selected Offeror will have an obligation to DPW in the same amount. DPW may offset an obligation it has to the selected Offeror by this amount, or may demand
payment from the selected Offeror.

4) Limitation of Liability

In accordance with 42 CFR §438.106, the selected Offeror must provide that MA recipients will not be liable for the selected Offeror’s debts if it becomes insolvent, and for covered services for which the Department fails to pay the selected Offeror, or for which the selected Offeror or the Department fail to pay providers.

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

5) Behavioral Health Service Cost Accruals

The selected Offeror must have actuarial services available to provide rate and other support services needed under the Agreement and must provide DPW with an actuarial certification of liabilities at least annually. As part of its accounting and budgeting function, the BH-MCO must establish an actuarially sound process for estimating and tracking incurred but not reported claims (IBNRs). The BH-MCO must reserve funds by major categories of service (e.g., inpatient; outpatient) to cover both IBNRs and received but unpaid claims (RBUCs). As part of its reserving methodology, the BH-MCO will conduct annual reviews and reconciliations to assess its reserving methodology and make adjustments as necessary. The methodology will be reviewed during the Readiness Review, and a copy of the methodology must be provided to the Department.

6) Financial Performance

The Department will monitor the financial performance of the selected Offeror and any major Subcontractors. Monitoring will include, but not be limited to, financial viability, profit, and appropriateness of medical and administrative expenditures.

7) Reporting

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

B. Acceptance of Department Capitation Payments
The selected Offeror is capitated for all In-Plan Services. The obligation of the Department to make payments is limited to Capitation payments. The Department shall make Capitation payments on a monthly basis in the following manner:

- On the first day of each month, the Department will identify Members, and for each Member whose enrollment is effective on the first of the month, as indicated on CIS, the Department shall make a PMPM payment as payment in full for any and all services provided to the Member that constitutes covered services. Payment will be released no later than the 15th day of the second month following the month of coverage, however, the Department at its sole discretion, may delay until July, all payments that would otherwise occur in June. Enrollment on the first of the month that is added to CIS after the first of the month will result in a Capitation payment at a later date.

- For Members whose enrollment is effective at any time after the first day of the month, Capitation will be prorated and paid at a later date. Capitation payments for the second and subsequent months will be paid in the manner described above.

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

- The Capitation payment will be equal to the amount negotiated with the selected Offeror. Monthly Capitation rates will be changed to equivalent per diem amounts for the purpose of payments.

The Agreement will provide for rates for SSI Members who have Medicare Part A benefits that are distinct from rates for SSI Members who do not have Medicare Part A benefits. If the Department’s TPL file is updated to indicate Medicare Part A coverage within four (4) months prior to the current month for a Member at an SSI without Medicare rate, the Department will adjust the payment to reflect the rating group appropriate to the Members, provided the TPL file indicates Part A coverage as of the first day of coverage by the selected Offeror for this Member during the program month for which payment was made. If the Department’s TPL file is updated to adjust or delete indication of Medicare Part A coverage within four (4) months of a payment to the selected Offeror for a Member at an SSI with Medicare or Healthy Horizons rate, the Department will adjust the payment to reflect the rating group appropriate to the Member, provided the TPL file does not indicate Part A coverage as of the first day of coverage by the selected Offeror for this Member during the program month for which payment was made. The Department will provide information to the selected Offeror on this type of payment adjustment on an electronic file. The selected Offeror will utilize this information to adjust its payments to Providers and instruct its Providers to bill Medicare.

The Department will recover Capitation payments made for the Members who were later determined to be ineligible for managed care for up to twelve (12) months after the service month for which payment was made. The Department will recover Capitation payments made for deceased Members for up to eighteen (18) months after the service month for which payment was made. (See Appendix V, HealthChoices BH Recipient Coverage Document).

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

1. Automated Clearing House

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

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

C. Physician Incentive Arrangements

The selected Offeror may operate a physician incentive plan only in accordance with federal requirements including but not limited to 42 CFR section 438.6(h) for physician incentive plans.

D. Claims Payment and Processing

1) Payments to Providers

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

The selected Offeror will negotiate and pay rates to FQHCs and Rural Health Clinics (RHCs) comparable to other Providers who provide comparable services in the the selected Offeror’s Provider network. The selected Offeror cannot pay annual cost settlements or prospective payments. The Primary Contractor may require that an FQHC comply with case management procedures that apply to other entities that provide similar benefits or services.

The selected Offeror shall not be obligated to pay Providers of authorized BH services unless bills for such services are submitted within one hundred and eighty (180) days from the date of service.

The selected Offeror shall follow federal and state law on invoicing requirement, including uniform claims, including the CMS 1500 and UB92, and HIPAA regulations for electronic billing via the 837 I and 837 P.

2) The selected Offeror shall Adjudicate 90% of all Clean Claims within 30 days, 100% of Clean Claims within 45 days, and 100% of all claims within 90 days. The selected Offeror shall provide the Department with a monthly report that supplies summary information on
claims processed. This reporting requirement applies to claims processed by the the selected Offeror or its Subcontractor, as well as Capitation payments to Providers or Subcontractors of Behavioral Health Services. The specific report contents and claims processing timeliness standards are detailed in the HealthChoices Behavioral Health Financial Reporting Requirements (See Appendix P, Report #8), and are also available in the HealthChoices Library.

E. Retroactive Eligibility Period

The selected Offeror will not be responsible for any payments owed to Providers for services that were rendered prior to a Member’s effective date of enrollment.

F. Financial Responsibility for Dual Eligibles

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

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

For Medicare services that are not covered by MA or the selected Offeror, the selected Offeror must pay cost-sharing to the extent that the payment made under Medicare for the service and the payment made by the selected Offeror do not exceed 80% of the Medicare-approved amount. In the event Medicare does not cover a service, the selected Offeror may require Prior Authorization as a condition of payment for the service.

The selected Offeror must provide that a Member who is eligible for both Medicaid and Medicare benefits has the right to access a Medicare product or service from the Medicare Provider of his/her choice, regardless of whether that Provider is enrolled in the selected Offeror’s network. The selected Offeror may establish policies and procedures for their networks that maximize opportunities for consumers to have a choice of Medicare Providers.

G. Return of Funds

The selected Offeror must return any unexpended Reinvestment Funds to the Department within six (6) months from the time period approved for expenditure unless such date is otherwise extended by the Department.

In the event that the Agreement with the Department ends and is not renewed, all funds available for shared reinvestment, except those in DPW approved reinvestment plans, or Reinvestment Funds in a plan submitted to DPW but which DPW has not taken action, must be returned to the Department within fourteen (14) months from the expiration or termination of the Agreement.
H. In-Network Services

1) In-Network Providers

The selected Offeror will be responsible for making timely payment for medically necessary, In-Plan Services rendered by in-network Providers when:

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

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

   c. Services were rendered under the terms of the selected Offeror’s contract with the Provider; or

   d. Services were prior authorized.

The selected Offeror will not be financially liable for services rendered in a hospital emergency room other than for emergency room evaluations for voluntary or involuntary commitments pursuant to the Mental Health Procedures Act of 1976.

2) Out-of-Network Providers

The selected Offeror will be responsible for making timely payments to Out-of-Network Providers for medically necessary, In-Plan Services when:

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

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

   c. Services were prior authorized by the selected Offeror; or

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

The selected Offeror will not be financially liable for services rendered in a hospital emergency room other than for emergency room evaluations for voluntary or involuntary commitments pursuant to the Mental Health Procedures Act of 1976.

The selected Offeror must require that Out-of-Network Providers coordinate with physical health payors and TPL with respect to payment. The selected Offeror must require that cost to Members is no greater than it would be if services were provided within the Provider network.
An Out-of-Network Provider, which is an enrolled MA Provider and which is billing the selected Offeror for covered HealthChoices In-Plan Services, shall not balance bill the Member.

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

3) Liability During an Active Provider Complaint

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

I. Third Party Liability (TPL)

The selected Offeror must comply with the Third Party Liability (TPL) procedures defined by 42 U.S.C. §1396a(a)(25) and implemented by the Department. Under the Agreement, the TPL responsibilities of the Department will be allocated between the parties as indicated below.

1. Cost Avoidance Activities

   a. The selected Offeror has primary responsibility for cost avoidance through the Coordination of Benefits (COB) relative to federal and private health insurance-type resources including, but not limited to, Medicare, private health insurance, Employees Retirement Income Security Act of 1974 (ERISA), 29 U.S.C.A. 1396a(a)(25) plans, and workers compensation. Except as provided in I.1) b., the selected Offeror must attempt to avoid initial payment of claims, whenever possible, where federal or private health insurance-type resources are available. All cost-avoided funds must be reported to the Department via encounter data submissions and financial report 11. The use of the appropriate HIPAA 837 Loop(s) for Medicare, and the Other Insurance Paid (OIP) shall indicate that TPL has been pursued and the amount which has been cost-avoided. The selected Offeror 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 selected Offeror will pay, and to require that its Subcontractors pay, all Clean Claims for EPSDT services to children, and services to children having medical coverage under a Title IV-D child support order to the extent the selected Offeror is notified by the Department of such support orders or to the extent they become aware of such orders, and then seek reimbursement from liable third parties. The selected Offeror shall communicate and encourage Providers to bill other primary insurance first, prior to submitting the claim to Medicaid. The selected Offeror recognizes that cost avoidance of these claims is prohibited.

   c. The selected Offeror may not deny authorization or delay approval of otherwise covered treatment or services based upon TPL considerations. The selected Offeror
may neither unreasonably delay payment nor deny payment of claims unless the probable existence of third party health-related insurance coverage is established at the time the claim is Adjudicated.

2. Post-Payment Recoveries

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

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

c. Due to potential time constraints involving cases subject to litigation, the Department must ensure that it identifies these cases and establishes its claim before resolution of the case. Should the Department fail to identify and establish a claim prior to case resolution due to the selected Offeror's untimely submission of notice of legal involvement where the selected Offeror has received such notice, the amount of the Department's actual loss of recovery shall be assessed against the selected Offeror. The Department's actual loss of recovery shall not include the attorney's fees or other costs, which would not have been retained by the Department.

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

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

f. Encounter data that is not submitted to the Department in accordance with the data requirements and/or timeframes identified in this document may result in a loss of revenue to the Department. Strict compliance with these requirements and timeframes shall therefore be enforced by the Department and may result in the assessment of liability against the selected Offeror.

g. As part of its authority under paragraph d. above, the selected Offeror is responsible for pursuing, collecting, and retaining recoveries of 1) a claim involving workers’ compensation, 2) health-related insurance resources where the liable party has improperly denied payment based upon either lack of a medically necessary determination or lack of coverage. The selected Offeror is encouraged to develop and implement cost-effective procedures to identify and pursue cases that are susceptible to collection through either legal action or traditional subrogation and collection procedures.

3) Health Insurance Premium Payment (HIPP) Program

The HIPP Program pays for employment-related health insurance for Members when it is determined to be cost effective. The cost effectiveness determination involves the review of group health insurance benefits offered by employers to their employees to determine if the anticipated expenditures in MA payments are likely to be greater than the cost of paying the premiums under a group plan for those services.

The Department shall not purchase Medigap policies for equally eligible Members in the HealthChoices Zone.

4) Requests for Additional Data

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

5) Accessibility to TPL Data

The Department shall provide the selected Offeror with accessibility to data maintained on the TPL file.

6) Third Party Resource Identification

a. Third party resources identified by the selected Offeror, which do not appear on the Department’s TPL database, must be supplied to the Department’s TPL Division by the selected Offeror. In addition to newly identified resources, coverage for other household members, addition of coverage types, changes to existing resources,
including termination of coverage and changes to coverage dates, must also be supplied to the Department’s TPL Division. The method of reporting shall be via electronic process or manual submission or by any alternative method approved by the Department. TPL resource information must be submitted within two (2) weeks of its receipt by the selected Offeror. A manual document is only to be submitted for “negated” TPL resources or to send resource referrals older than five (5) years from the Department’s processing date. For electronic submissions, the selected Offeror must follow the required report format, data elements, and specifications supplied by the Department. For manual submissions, the selected Offeror must use an exact replica of the TPL resource referral form supplied by the Department. As the office responsible for the maintenance and quality assurance of the records stored on the TPL database, the Department’s TPL Division will use these submissions for subsequent updates to the system.

b. The selected Offeror shall use the Department’s verification systems (i.e. POSNET and EVS) to assure detailed information is provided for insurance carriers when a resource is received that does not have a unique carrier code.

J. Estate Recovery

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

K. Performance Management Information System and Reporting

1) General

The requirement that the selected Offeror provide requested data is a result of the requirements established by CMS. CMS specified that the state define a minimum data set and require all MCOs to submit the data.

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

This data will include components specified by the Department and also problem areas targeted by the continuous quality improvement program, both of which may change from time to time.

The selected Offeror will manage the program in compliance with the Department's standards and requirements and will provide data reports to support this management.

The Primary Contractor must, at its expense, arrange for a background check for each of its employees, as well as for the employees of its Subcontractors, who will have access to Commonwealth Information Technology (IT) facilities, either through on site or remote
access. Background checks are to be conducted via the Request for Criminal Record Check. The background check must be conducted prior to initial access by an employee and annually thereafter.

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


The Department may request medical records directly from the selected Offeror and BH Services Providers for issues related to quality of care, behavioral health outcome measures, Third Party Liability (TPL), and fraud and abuse.

2) Management Information System

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

The selected Offeror's MIS must be compatible with the Department's Pennsylvania Open Systems Network (POSNet) and have FTP connection capability with DPW’s PROMISe contractor.

The selected Offeror must comply with the policy and procedures governing the operation of the Department's Pennsylvania Open Systems Network (POSNet), as defined in the document POSNet Interface Specifications contained in the HealthChoices Library.

The selected Offeror must comply with all changes made to the POSNet Interface Specifica-
tions by DPW, or modifications made to the specifications by the Office of Medical Assistance or the Office of Mental Health and Substance Abuse Services.

The selected Offeror is required to maintain an automated Provider directory and upon request, is required to provide this directory to the Department via POSNet or via CD-ROM.

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

3) Encounter and Alternative Payment Arrangements Data

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

The Department requires the selected Offeror submit a separate Alternative Payment Arrangement record for each advance payment made to a contractor or Provider responsible for all or part of a Member's behavioral health care. If the payment is an Alternative Payment Arrangement reimbursement, a separate record is required to report the amount paid on behalf of each Member. The Primary Contractor must take appropriate action to provide the Department with accurate and complete data for payments made by the selected Offeror to its contractors and Providers; the Department's point of contact for Alternative Payment Arrangement data will be the selected Offeror and not other Subcontractors or Providers.

The Department will validate the accuracy of data on the encounter and Alternative Payment Arrangement data files. Validation criteria are included for each data element in the Requirements and Specifications Manual for Encounter Data/Alternative Payment Arrangement Data and in the Denial Log and Complaint and Grievance reporting Manuals, both of which are found in the HealthChoices Library.

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

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

c. Data Format. The selected Offeror must submit Encounter and Alternative Payment Arrangement data electronically to the Department through PROMISe using the FTP. Data file content must conform to the requirements specified in the HIPAA Implementation Guides and PROMISe Companion Guides and the Denial Log and Complaint and Grievance Reporting Manuals.
d. Timing of Data Submittal.

An encounter must be submitted and pass PROMISe edits on or before the last calendar day of the third month after the selected Offeror paid/Adjudicated the encounter.

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

The selected Offeror must adhere to the file size specifications provided by the Department. A file submission schedule will be developed and provided to the selected Offeror.

e. Member Medical Information

When requested, the selected Offeror must provide a Member's medical records within fifteen (15) days of the Department's request.

f. Data Validation

The selected Offeror must assist the Department in its validation of utilization data by making available medical records and its claims data. The validation may be completed by Department staff and independent, external review organizations.

L. Audits

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

M. Restitution

The selected Offeror shall make full and prompt restitution to the Department, as directed by the Department, for any payments received in excess of amounts due under this Agreement whether such overpayment is discovered by the selected Offeror, the Department, or other third party.

N. Claims Processing and Management Information System (MIS)

The selected must have a comprehensive automated MIS that is capable of meeting the requirements listed below and throughout this document. The selected Offeror’s MIS must comply with the requirements listed in the latest version of the MIS and System Performance Review Standards. As a reference to assist in an internal systems review, a copy is available in the HealthChoices Library. The Department will provide data support for the selected Offeror as listed in Appendix O and described in the "Managed Care Data Support Overview for Behavioral Health" which can be referenced in the HealthChoices Library.
The Membership management system must have the capability to receive, update and maintain the Membership files consistent with information provided by the Department.

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

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

- The selected Offeror must have sufficient telecommunication, including electronic mail, capabilities to meet the requirements of this document.

- The selected Offeror must have the capability to electronically transfer data files with the Department.

- The selected Offeror must be compliant with the Health Insurance Portability and Accountability Act (HIPAA) of 1996 as amended, Administrative Simplification Rule for the eight electronic transactions and for the code sets used in these transactions.

- The selected Offeror must have a procedure for maintaining recipient enrollment and eligibility data, including a procedure for reconciliation of data discrepancies between its eligibility database and the Department’s EVS, CIS and daily monthly eligibility file transfers.

The selected Offeror's information system shall be subject to review and approval by the Department at any time.

O. Data Support

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

P. Federalizing General Assistance (GA) Data Reporting

The selected Offeror must submit a properly formatted monthly file to the Department regarding payments applicable to state-only general assistance (GA) Members. The file shall include data on hospital claims paid by the selected Offeror during the reporting month. The files shall include data for three (3) types of hospital services as listed below:

- Admissions to inpatient psychiatric hospitals
- Admissions to acute care hospitals
- Admissions to rehabilitation hospitals

The following types of information must be included in each record on the file.
- HMO code
- Provider
- Member
- Claim
- Additional data elements as required by Report #16 and Appendix P in the FRR.

Failure to comply with these requirements shall result in a penalty equal to three (3) times the amount that applies to other reporting requirements.

Q. CPP Reporting Requirements.

The approved hiring commitment will become a contractual obligation included in the contract. Hiring commitments shall be maintained throughout the term of the contract, including any renewal or extensions. In the event of a renewal or extension of the original contract term and upon request of CPP, the selected Contractor will submit an updated plan. Any proposed change must be submitted to the Contractor Partnership Program, which will make a recommendation to the Contracting Officer regarding course of action. Upon approval of the Department, this updated plan will become part of the contract. If a contract is assigned to another contractor, the new contractor must maintain the CPP recruiting and hiring plan of the original contract.

Upon award of the agreement, the selected Offeror is required to complete and submit the PA 1540 Quarterly Employment Report Form on a quarterly basis to document the number of TANF cash assistance recipients hired for that quarter. The form must be completed in its’ entirety and forwarded to the Contractor Partnership Program, with a copy sent to the DPW Contract Monitor, by the fifteenth day of the following month after the quarter ends. If the 15th falls on a weekend or state holiday, the report is due the next business day. The quarters are based on the Department of Public Welfare’s fiscal year and are as follows:

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<tr>
<th>Quarters</th>
<th>Begin Date</th>
<th>End Date</th>
<th>Reports Due</th>
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<tbody>
<tr>
<td>1 – First</td>
<td>July 1</td>
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<tr>
<td>4 – Fourth</td>
<td>April 1</td>
<td>June 30</td>
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The selected Offeror, regardless of its contract Effective Date, must submit the PA 1540 based on the schedule above. If a contract begins in the middle of a quarter, the information reported will be based on activity that occurred from the contract Effective Date through the end of the quarter. If no activity occurred, the form must be completed by stating “No Activity in this Quarter with the Contractor’s comments.” This report must be signed by the entity that holds the contract with the DPW; it may not be signed by a subcontractor.

The information submitted on this report will be audited for its accuracy and the findings will be utilized to determine if the selected Offeror is meeting its hiring requirements.

**Verification**

The Contractor Partnership Program will review the PA 1540 Form for accuracy and completeness. In addition, the individuals reported on the 1540 Form as TANF cash assistance recipients will be verified through DPW’s Client Information System (CIS). DPW will take a
statistical sample of all public assistance hires reported to determine if the selected Offeror will receive credit. The results of the sample will determine if additional verification measures are needed. If the selected Offeror is found to report inaccurate information on a consistent basis, it will be reported to the Contracting Officer for appropriate action.

*Please note that the PA 1540 Form will be mailed to the Contractor after their contract is executed.

R. Mentor Protégé Program (MPP) Reporting Requirements.

The approved MPP commitment will become a contractual obligation included in the contract. Mentor Protégé Plan commitment shall be maintained throughout the term of the contract, including any renewals or extension of the original contract term and upon request of DPW BEO – MPP, the selected Contractor will submit an updated plan. Any proposal change must be submitted to the Department of Public Welfare, Bureau of Equal Opportunity, Mentor Protégé Program, which will make a recommendation to the Contracting Officer regarding course of action. Upon approval of the Department, this updated plan will become part of the contract. If a contract is assigned to another contractor, the new contractor must maintain the Mentor Protégé Plan commitment. Upon request of DPW, BEO – MPP the Contractor will submit a revised plan. Upon approval, this plan will become part of the contract.

Upon award of the contract, the selected Offeror is required to provide a copy of the signed agreement between the Mentor and the Protégé. The Offeror is required to provide a written narrative to DPW BEO – MPP on a quarterly basis with an update of the Mentor Protégé Program Plan with a copy sent to the DPW Contract Monitor, by the fifteenth day of the following month after the quarter ends. If the 15th falls on a weekend or state holiday, the report is due the next business day. The quarters are based on the Department of Public Welfare’s fiscal year and are as follows:

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The selected Offeror, regardless of its contract Effective Date, must submit the written narrative based on the schedule above. If a contract begins in the middle of a quarter, the information reported will be based on activity that occurred from the contract Effective Date through the end of the quarter. If no activity occurred, the written narrative must provide an explanation. This written narrative must be signed by the entity that holds the contract with DPW; it MAY NOT be signed by the Protégé.

The information submitted on this report will be audited for its accuracy and the findings will be utilized to determine if the selected Offeror is meeting its Mentor Protégé Program Plan.

**Verification**

The Department of Public Welfare, Bureau of Equal Opportunity – Mentor Protégé Plan will review the written narrative to ensure it is consistent with the Mentor Protégé Program Plan.
addition, DPW BEO – MPP may contact the Protégé to ensure compliance with Mentor Protégé
Program Plan. The results will determine if additional verification measures are needed. If the
selected Offeror is found to report inaccurate information on a consistent basis, it will be reported
to the Contracting Officer for appropriate action.
PROPOSAL COVER SHEET
COMMONWEALTH OF PENNSYLVANIA
Office of Mental Health and Substance Abuse Services
RFP# 16-12

Enclosed in five separately sealed submittals is the proposal of the Offeror identified below for the above-referenced RFP:

### Offeror Information:

<table>
<thead>
<tr>
<th>Offeror Name</th>
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<tbody>
<tr>
<td>Offeror Mailing Address</td>
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<tr>
<td>Offeror Website</td>
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<tr>
<td>Offeror Contact Person</td>
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<td>Contact Person’s Phone Number</td>
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<td>Contact Person’s Facsimile Number</td>
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<tr>
<td>Contact Person’s E-Mail Address</td>
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<tr>
<td>Offeror Federal ID Number</td>
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</tbody>
</table>

### Submittals Enclosed and Separately Sealed:

- [ ] Technical Submittal
- [ ] Disadvantaged Business Submittal
- [ ] Contractor Partnership Program Submittal
- [ ] Mentor Protégé Program

### Signature

<table>
<thead>
<tr>
<th>Signature of an official authorized to bind the Offeror to the provisions contained in the Offeror’s proposal:</th>
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<tbody>
<tr>
<td>Printed Name</td>
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<tr>
<td>Title</td>
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</table>

FAILURE TO COMPLETE, SIGN AND RETURN THIS FORM WITH THE OFFEROR’S PROPOSAL MAY RESULT IN THE REJECTION OF THE OFFEROR’S PROPOSAL

Commonwealth of Pennsylvania
HealthChoices Behavioral Health
STANDARD GRANT TERMS AND CONDITIONS FOR SERVICES

1. TERM OF GRANT

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

2. INDEPENDENT GRANTEE

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

3. COMPLIANCE WITH LAW

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

4. ENVIRONMENTAL PROVISIONS

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

5. POST-CONSUMER RECYCLED CONTENT

Except as specifically waived by the Department of General Services in writing, any products which are provided to the Commonwealth as a part of the performance of the Grant must meet the minimum percentage levels for total recycled content as specified in Exhibits A-1 through A-8 to these Standard Grant Terms and Conditions.

6. COMPENSATION/EXPENSES

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

7. INVOICES

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

8. PAYMENT

a. The Commonwealth shall put forth reasonable efforts to make payment by the required payment date. The required payment date is: (a) the date on which payment is due under the terms of the Grant; (b) thirty (30) days after a proper invoice actually is received at the "Provide Service and Bill To" address if a date on which payment is due is not specified in the Grant (a "proper" invoice is not received until the Commonwealth accepts the service as satisfactorily performed); or (c) the payment date specified on the invoice if later than the dates established by (a) and (b) above. Payment may be delayed if the payment amount on an invoice is not based upon the price(s) as stated in the Grant. If any payment is not made within fifteen (15) days after the required payment date, the Commonwealth may pay interest as determined by the Secretary of Budget in accordance with Act No. 266 of 1982 and regulations promulgated pursuant thereto. Payment should not be construed by the Grantee as acceptance of the service performed by the Grantee. The Commonwealth reserves the right to conduct further testing and inspection after payment, but within a reasonable time after performance, and to reject the service if such post payment testing or inspection discloses a defect or a failure to meet specifications. The Grantee agrees that the Commonwealth may set off the amount of any state tax liability or other obligation of the Grantee or its subsidiaries to the Commonwealth against any payments due the Grantee under any Grant with the Commonwealth.

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

9. TAXES

The Commonwealth is exempt from all excise taxes imposed by the Internal Revenue Service and has accordingly registered with the Internal Revenue Service to make tax free purchases under Registration No. 23740001-K. With the exception of purchases of the following items, no exemption certificates are required and none will be issued: undyed diesel fuel, tires, trucks, gas guzzler emergency vehicles, and sports fishing equipment. The Commonwealth is also exempt from Commonwealth of Pennsylvania HealthChoices Behavioral Health
Pennsylvania state sales tax, local sales tax, public transportation assistance taxes and fees and vehicle rental tax. The Department of Revenue regulations provide that exemption certificates are not required for sales made to governmental entities and none will be issued. Nothing in this paragraph is meant to exempt a construction Grantee from the payment of any of these taxes or fees which are required to be paid with respect to the purchase, use, rental, or lease of tangible personal property or taxable services used or transferred in connection with the performance of a construction Grant.

10. WARRANTY

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

11. PATENT, COPYRIGHT, AND TRADEMARK INDEMNITY

The Grantee warrants that it is the sole owner or author of, or has entered into a suitable legal agreement concerning either: a) the design of any product or process provided or used in the performance of the Grant which is covered by a patent, copyright, or trademark registration or other right duly authorized by state or federal law or b) any copyrighted matter in any report document or other material provided to the commonwealth under the Grant. The Grantee shall defend any suit or proceeding brought against the Commonwealth on account of any alleged patent, copyright or trademark infringement in the United States of any of the products provided or used in the performance of the Grant. This is upon condition that the Commonwealth shall provide prompt notification in writing of such suit or proceeding; full right, authorization and opportunity to conduct the defense thereof; and full information and all reasonable cooperation for the defense of same. As principles of governmental or public law are involved, the Commonwealth may participate in or choose to conduct, in its sole discretion, the defense of any such action. If information and assistance are furnished by the Commonwealth at the Grantee's written request, it shall be at the Grantee's expense, but the responsibility for such expense shall be only that within the Grantee's written authorization. The Grantee shall indemnify and hold the Commonwealth harmless from all damages, costs, and expenses, including attorney's fees that the Grantee or the Commonwealth may pay or incur by reason of any infringement or violation of the rights occurring to any holder of copyright, trademark, or patent interests and rights in any products provided or used in the performance of the Grant. If any of the products provided by the Grantee in such suit or proceeding are held to constitute infringement and the use is enjoined, the Grantee shall, at its own expense and at its option, either procure the right to continue use of such infringement products, replace them with non-infringement equal performance products or modify them so that they are no longer infringing. If the Grantee is unable to do any of the preceding, the Grantee agrees to remove all the equipment or software which are obtained contemporaneously with the infringing product, or, at the option of the Commonwealth, only those items of equipment or software which are held to be infringing, and to pay the Commonwealth: 1) any amounts paid by the Commonwealth towards the purchase of the product, less straight line depreciation; 2) any license fee paid by the Commonwealth for the use of any software, less an amount for the period of usage; and 3) the pro rata portion of any maintenance fee representing the time remaining in any period of maintenance paid for. The obligations of the Grantee under this paragraph continue without time limit. No costs or expenses shall be incurred for the account of the Grantee without its written consent.

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12. OWNERSHIP RIGHTS

The Commonwealth shall have unrestricted authority to reproduce, distribute, and use any submitted report, data, or material, and any software or modifications and any associated documentation that is designed or developed and delivered to the Commonwealth as part of the performance of the Grant.

13. ASSIGNMENT OF ANTITRUST CLAIMS

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

14. HOLD HARMLESS PROVISION

The Grantee shall hold the Commonwealth harmless from and indemnify the Commonwealth against any and all claims, demands and actions based upon or arising out of any activities performed by the Grantee and its employees and agents under this Grant and shall, at the request of the Commonwealth, defend any and all actions brought against the Commonwealth based upon any such claims or demands.

15. AUDIT PROVISIONS

The Commonwealth shall have the right, at reasonable times and at a site designated by the Commonwealth, to audit the books, documents and records of the Grantee to the extent that the books, documents and records relate to costs or pricing data for the Grant. The Grantee agrees to maintain records which will support the prices charged and costs incurred for the Grant. The Grantee shall preserve books, documents, and records that relate to costs or pricing data for the Grant for a period of three (3) years from date of final payment. The Grantee shall give full and free access to all records to the Commonwealth and/or their authorized representatives.

16. DEFAULT

a. The Commonwealth may, subject to the provisions of Paragraph 17, Force Majeure, and in addition to its other rights under the Grant, declare the Grantee in default by written notice thereof to the Grantee, and terminate (as provided in Paragraph 18, Termination Provisions) the whole or any part of this Grant for any of the following reasons:

1) Failure to begin work within the time specified in the Grant or as otherwise specified;
2) Failure to perform the work with sufficient labor, equipment, or material to insure the completion of the specified work in accordance with the Grant terms;
3) Unsatisfactory performance of the work;
4) Failure or refusal to remove material, or remove and replace any work rejected as defective or unsatisfactory;
5) Discontinuance of work without approval;
6) Failure to resume work, which has been discontinued, within a reasonable time after notice to do so;

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7) Insolvency or bankruptcy;
8) Assignment made for the benefit of creditors;
9) Failure or refusal within 10 days after written notice by the Granting Officer, to make payment or show cause why payment should not be made, of any amounts due for materials furnished, labor supplied or performed, for equipment rentals, or for utility services rendered;
10) Failure to protect, to repair, or to make good any damage or injury to property; or
11) Breach of any provision of this Grant.

b. In the event that the Commonwealth terminates this Grant in whole or in part as provided in Subparagraph a. above, the Commonwealth may procure, upon such terms and in such manner as it determines, services similar or identical to those so terminated, and the Grantee shall be liable to the Commonwealth for any reasonable excess costs for such similar or identical services included within the terminated part of the Grant.

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

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

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

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

17. FORCE MAJEURE

Neither party will incur any liability to the other if its performance of any obligation under this Grant is prevented or delayed by causes beyond its control and without the fault or negligence of either party. Causes beyond a party’s control may include, but aren’t limited to, acts of God or war, changes in controlling law, regulations, orders or the requirements of any governmental entity, severe weather conditions, civil disorders, natural disasters, fire, epidemics and quarantines, general strikes throughout the trade, and freight embargoes.

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The Grantee shall notify the Commonwealth orally within five (5) days and in writing within ten (10) days of the date on which the Grantee becomes aware, or should have reasonably become aware, that such cause would prevent or delay its performance. Such notification shall (i) describe fully such cause(s) and its effect on performance, (ii) state whether performance under the Grant is prevented or delayed and (iii) if performance is delayed, state a reasonable estimate of the duration of the delay. The Grantee shall have the burden of proving that such cause(s) delayed or prevented its performance despite its diligent efforts to perform and shall produce such supporting documentation as the Commonwealth may reasonably request. After receipt of such notification, the Commonwealth may elect either to cancel the Grant or to extend the time for performance as reasonably necessary to compensate for the Grantee’s delay.

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

18. TERMINATION PROVISIONS

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

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

b. NON-APPROPRIATION: The Commonwealth’s obligation to make payments during any Commonwealth fiscal year succeeding the current fiscal year shall be subject to availability and appropriation of funds. When funds (state and/or federal) are not appropriated or otherwise made available to support continuation of performance in a subsequent fiscal year period, the Commonwealth shall have the right to terminate the Grant. The Grantee shall be reimbursed for the reasonable value of any nonrecurring costs incurred but not amortized in the price of the supplies or services delivered under this Grant. Such reimbursement shall not include loss of profit, loss of use of money, or administrative or overhead costs. The reimbursement amount may be paid for any appropriations available for that purpose.

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

19. GRANT CONTROVERSIES

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

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

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

20. ASSIGNABILITY AND SUBGRANTING

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

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

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

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

e. For the purposes of this Grant, the term "assign" shall include, but shall not be limited to, the sale, gift, assignment, pledge, or other transfer of any ownership interest in the Grantee provided, however, that the term shall not apply to the sale or other transfer of stock of a publicly traded company.

f. Any assignment consented to by the Granting Officer shall be evidenced by a written assignment agreement executed by the Grantee and its assignee in which the assignee agrees to be legally bound by all of the terms and conditions of the Grant and to assume the duties, obligations, and responsibilities being assigned.

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Appendix B

21. NONDISCRIMINATION/SEXUAL HARASSMENT CLAUSE

During the term of the Grant, the Grantee agrees as follows:

a. In the hiring of any employee(s) for the manufacture of supplies, performance of work, or any other activity required under the grant agreement or any subgrant agreement, contract, or subcontract, the Grantee, a subgrantee, a contractor, a subcontractor, or any person acting on behalf of the Grantee shall not, by reason of gender, race, creed, or color, discriminate against any citizen of this commonwealth who is qualified and available to perform the work to which the employment relates.

b. The Grantee, any subgrantee, contractor or any subcontractor or any person on their behalf shall not in any manner discriminate against or intimidate any of its employees on account of gender, race, creed, or color.

c. The Grantee, any subgrantee, contractor or any subcontractor shall establish and maintain a written sexual harassment policy and shall inform their employees of the policy. The policy must contain a notice that sexual harassment will not be tolerated and employees who practice it will be disciplined.

d. The Grantee, any subgrantee, contractor or any subcontractor shall not discriminate by reason of gender, race, creed, or color against any subgrantee, contractor, subcontractor or supplier who is qualified to perform the work to which the grant relates.

e. The Grantee, any subgrantee, any contractor or any subcontractor shall, within the time periods requested by the commonwealth, furnish all necessary employment documents and records and permit access to their books, records, and accounts by the granting agency and the Bureau of Small Business Opportunities (BSBO), for purpose of ascertaining compliance with provisions of this Nondiscrimination/Sexual Harassment Clause. Within thirty (30) days after award of any grant, the Grantee shall be required to complete, sign and submit Form STD-21, the “Initial Contract Compliance Data” form. Grantees who have fewer than five employees or whose employees are all from the same family or who have completed the STD-21 form within the past 12 months may, within the 30 days, request an exemption from the STD-21 form from the granting agency.

f. The Grantee, any subgrantee, contractor or any subcontractor shall include the provisions of this Nondiscrimination/Sexual Harassment Clause in every subgrant agreement, contract or subcontract so that those provisions applicable to sub-grantees, contractors or subcontractors will be binding upon each subgrantee, contractor or subcontractor.

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

It is essential that those who seek to Grant with the Commonwealth observe high standards of honesty and integrity. They must conduct themselves in a manner that fosters public confidence in the integrity of the Commonwealth procurement process. In furtherance of this policy, Grantee agrees to the following:

a. Grantee shall maintain the highest standards of honesty and integrity during the performance of this Grant and shall take no action in violation of state or federal laws or regulations or any other applicable laws or regulations, or other requirements applicable to Grantee or that govern Granting with the Commonwealth.

b. Grantee shall establish and implement a written business integrity policy, which includes, at a minimum, the requirements of these provisions as they relate to Grantee employee activity with the Commonwealth and Commonwealth employees, and which is distributed and made known to all Grantee employees.

c. Grantee, its affiliates, agents and employees shall not influence, or attempt to influence, any Commonwealth employee to breach the standards of ethical conduct for Commonwealth employees set forth in the Public Official and Employees Ethics Act, 65 Pa.C.S. §§1101 et seq.; the State Adverse Interest Act, 71 P.S. §776.1 et seq.; and the Governor’s Code of Conduct, Executive Order 1980-18, 4 Pa. Code §7.151 et seq., or to breach any other state or federal law or regulation.

d. Grantee, its affiliates, agents and employees shall not offer, give, or agree or promise to give any gratuity to a Commonwealth official or employee or to any other person at the direction or request of any Commonwealth official or employee.

e. Grantee, its affiliates, agents and employees shall not offer, give, or agree or promise to give any gratuity to a Commonwealth official or employee or to any other person, the acceptance of which would violate the Governor’s Code of Conduct, Executive Order 1980-18, 4 Pa. Code §7.151 et seq. or any statute, regulation, statement of policy, management directive or any other published standard of the Commonwealth.

f. Grantee, its affiliates, agents and employees shall not, directly or indirectly, offer, confer, or agree to confer any pecuniary benefit on anyone as consideration for the decision, opinion, recommendation, vote, other exercise of discretion, or violation of a known legal duty by any Commonwealth official or employee.

g. Grantee, its affiliates, agents, employees, or anyone in privity with him or her shall not accept or agree to accept from any person, any gratuity in connection with the performance of work under the Grant, except as provided in the Grant.

h. Grantee shall not have a financial interest in any other Grantee, subGrantee, or supplier providing services, labor, or material on this project, unless the financial interest is disclosed to the Commonwealth in writing and the Commonwealth consents to Grantee’s financial interest prior to Commonwealth execution of the Grant. Grantee shall disclose the financial interest to the Commonwealth at the time of bid or proposal submission, or if no bids or proposals are solicited, no later than Grantee’s submission of the Grant signed by Grantee.

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i. Grantee, its affiliates, agents and employees shall not disclose to others any information, documents, reports, data, or records provided to, or prepared by, Grantee under this Grant without the prior written approval of the Commonwealth, except as required by the Pennsylvania Right-to-Know Law, 65 P.S. §§ 67.101-3104, or other applicable law or as otherwise provided in this Grant. Any information, documents, reports, data, or records secured by Grantee from the Commonwealth or a third party in connection with the performance of this Grant shall be kept confidential unless disclosure of such information is:

1) Approved in writing by the Commonwealth prior to its disclosure; or

2) Directed by a court or other tribunal of competent jurisdiction unless the Grant requires prior Commonwealth approval; or

3) Required for compliance with federal or state securities laws or the requirements of national securities exchanges; or

4) Necessary for purposes of Grantee’s internal assessment and review; or

5) Deemed necessary by Grantee in any action to enforce the provisions of this Grant or to defend or prosecute claims by or against parties other than the Commonwealth; or

6) Permitted by the valid authorization of a third party to whom the information, documents, reports, data, or records pertain: or

7) Otherwise required by law.

j. Grantee certifies that neither it nor any of its officers, directors, associates, partners, limited partners or individual owners has been officially notified of, charged with, or convicted of any of the following and agrees to immediately notify the Commonwealth agency Granting officer in writing if and when it or any officer, director, associate, partner, limited partner or individual owner has been officially notified of, charged with, convicted of, or officially notified of a governmental determination of any of the following:

1) Commission of embezzlement, theft, forgery, bribery, falsification or destruction of records, making false statements or receiving stolen property.

2) Commission of fraud or a criminal offense or other improper conduct or knowledge of, approval of or acquiescence in such activities by Grantee or any affiliate, officer, director, associate, partner, limited partner, individual owner, or employee or other individual or entity associated with:

   a) obtaining;
   b) attempting to obtain; or
   c) performing a public Grant or subGrant.
Grantee’s acceptance of the benefits derived from the conduct shall be deemed evidence of such knowledge, approval or acquiescence.

3) Violation of federal or state antitrust statutes.

4) Violation of any federal or state law regulating campaign contributions.

5) Violation of any federal or state environmental law

6) Violation of any federal or state law regulating hours of labor, minimum wage standards or prevailing wage standards; discrimination in wages; or child labor violations.

7) Violation of the Act of June 2, 1915 (P.L.736, No. 338), known as the Workers’ Compensation Act, 77 P.S. 1 et seq.

8) Violation of any federal or state law prohibiting discrimination in employment.

9) Debarment by any agency or department of the federal government or by any other state.

10) Any other crime involving moral turpitude or business honesty or integrity.

Grantee acknowledges that the Commonwealth may, in its sole discretion, terminate the Grant for cause upon such notification or when the Commonwealth otherwise learns that Grantee has been officially notified, charged, or convicted.

k. If this Grant was awarded to Grantee on a non-bid basis, Grantee must, (as required by Section 1641 of the Pennsylvania Election Code) file a report of political contributions with the Secretary of the Commonwealth on or before February 15 of the next calendar year. The report must include an itemized list of all political contributions known to Grantee by virtue of the knowledge possessed by every officer, director, associate, partner, limited partner, or individual owner that has been made by:

1) Any officer, director, associate, partner, limited partner, individual owner or members of the immediate family when the contributions exceed an aggregate of one thousand dollars ($1,000) by any individual during the preceding year; or

2) Any employee or members of his immediate family whose political contribution exceeded one thousand dollars ($1,000) during the preceding year.

To obtain a copy of the reporting form, Grantee shall contact the Bureau of Commissions, Elections and Legislation, Division of Campaign Finance and Lobbying Disclosure, Room 210, North Office Building, Harrisburg, PA 17120.

l. Grantee shall comply with requirements of the Lobbying Disclosure Act, 65 Pa.C.S. § 13A01 et seq., and the regulations promulgated pursuant to that law. Grantee employee activities prior to or outside of formal Commonwealth procurement communication protocol are considered lobbying and subjects the Grantee employees to the registration

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and reporting requirements of the law. Actions by outside lobbyists on Grantee’s behalf, no matter the procurement stage, are not exempt and must be reported.

m. When Grantee has reason to believe that any breach of ethical standards as set forth in law, the Governor’s Code of Conduct, or in these provisions has occurred or may occur, including but not limited to contact by a Commonwealth officer or employee which, if acted upon, would violate such ethical standards, Grantee shall immediately notify the Commonwealth Granting officer or Commonwealth Inspector General in writing.

n. Grantee, by submission of its bid or proposal and/or execution of this Grant and by the submission of any bills, invoices or requests for payment pursuant to the Grant, certifies and represents that it has not violated any of these Grantee integrity provisions in connection with the submission of the bid or proposal, during any Grant negotiations or during the term of the Grant.

o. Grantee shall cooperate with the Office of Inspector General in its investigation of any alleged Commonwealth employee breach of ethical standards and any alleged Grantee non-compliance with these provisions. Grantee agrees to make identified Grantee employees available for interviews at reasonable times and places. Grantee, upon the inquiry or request of the Office of Inspector General, shall provide, or if appropriate, make promptly available for inspection or copying, any information of any type or form deemed relevant by the Inspector General to Grantee’s integrity and compliance with these provisions. Such information may include, but shall not be limited to, Grantee’s business or financial records, documents or files of any type or form that refers to or concern this Grant.

p. For violation of any of these Grantee Integrity Provisions, the Commonwealth may terminate this and any other Grant with Grantee, claim liquidated damages in an amount equal to the value of anything received in breach of these provisions, claim damages for all additional costs and expenses incurred in obtaining another Grantee to complete performance under this Grant, and debar and suspend Grantee from doing business with the Commonwealth. These rights and remedies are cumulative, and the use or non-use of any one shall not preclude the use of all or any other. These rights and remedies are in addition to those the Commonwealth may have under law, statute, regulation, or otherwise.

q. For purposes of these Grantee Integrity Provisions, the following terms shall have the meanings found in this Paragraph.

1) “Confidential information” means information that a) is not already in the public domain; b) is not available to the public upon request; c) is not or does not become generally known to Grantee from a third party without an obligation to maintain its confidentiality; d) has not become generally known to the public through a act or omission of Grantee; or e) has not been independently developed by Grantee without the use of confidential information of the Commonwealth.

2) “Consent” means written permission signed by a duly authorized officer or employee of the Commonwealth, provided that where the material facts have been disclosed, in writing, by pre-qualification, bid, proposal, or Grantual terms, the Commonwealth shall be deemed to have consented by virtue of execution of this Grant.
3) “Grantee” means the individual or entity that has entered into this Grant with the Commonwealth, including those directors, officers, partners, managers, and owners having more than a five percent interest in Grantee.

4) “Financial interest” means:
   (a) Ownership of more than a five percent interest in any business; or
   (b) Holding a position as an officer, director, trustee, partner, employee, or holding any position of management.

5) “Gratuity” means tendering, giving or providing anything of more than nominal monetary value including, but not limited to, cash, travel, entertainment, gifts, meals, lodging, loans, subscriptions, advances, deposits of money, services, employment, or Grants of any kind. The exceptions set forth in the Governor’s Code of Conduct, Executive Order 1980-18, the 4 Pa. Code §7.153(b), shall apply.

6) “Immediate family” means a spouse and any unemancipated child.

7) “Non-bid basis” means a Grant awarded or executed by the Commonwealth with Grantee without seeking bids or proposals from any other potential bidder or offeror.

8) “Political contribution” means any payment, gift, subscription, assessment, Grant, payment for services, dues, loan, forbearance, advance or deposit of money or any valuable thing, to a candidate for public office or to a political committee, including but not limited to a political action committee, made for the purpose of influencing any election in the Commonwealth of Pennsylvania or for paying debts incurred by or for a candidate or committee before or after any election.

23. GRANTEE RESPONSIBILITY PROVISIONS

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

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

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

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

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

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

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

24. AMERICANS WITH DISABILITIES ACT

a. Pursuant to federal regulations promulgated under the authority of The Americans With Disabilities Act, 28 C.F.R. § 35.101 et seq., the Grantee understands and agrees that it shall not cause any individual with a disability to be excluded from participation in this Grant or from activities provided for under this Grant on the basis of the disability. As a condition of accepting this Grant, the Grantee agrees to comply with the "General Prohibitions Against Discrimination," 28 C.F.R. § 35.130, and all other regulations promulgated under Title II of The Americans With Disabilities Act which are applicable to all benefits, services, programs, and activities provided by the Commonwealth of Pennsylvania through Grants with outside Grantees.

b. The Grantee shall be responsible for and agrees to indemnify and hold harmless the Commonwealth of Pennsylvania from all losses, damages, expenses, claims, demands, suits, and actions brought by any party against the Commonwealth of Pennsylvania as a result of the Grantee's failure to comply with the provisions of subparagraph a above.

25. HAZARDOUS SUBSTANCES

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

a. Labeling. The Grantee shall insure that each individual product (as well as the carton, container or package in which the product is shipped) of any of the following substances

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(as defined by the Act and the regulations) supplied by the Grantee is clearly labeled, tagged or marked with the information listed in Paragraph (1) through (4):

1) Hazardous substances:
   a) The chemical name or common name,
   b) A hazard warning, and
   c) The name, address, and telephone number of the manufacturer.

2) Hazardous mixtures:
   a) The common name, but if none exists, then the trade name,
   b) The chemical or common name of special hazardous substances comprising .01% or more of the mixture,
   c) The chemical or common name of hazardous substances consisting 1.0% or more of the mixture,
   d) A hazard warning, and
   e) The name, address, and telephone number of the manufacturer.

3) Single chemicals:
   a) The chemical name or the common name, a hazard warning, if appropriate, and
   b) The name, address, and telephone number of the manufacturer.

4) Chemical Mixtures:
   a) The common name, but if none exists, then the trade name,
   b) A hazard warning, if appropriate,
   c) The name, address, and telephone number of the manufacturer, and
   d) The chemical name or common name of either the top five substances by volume or those substances consisting of 5.0% or more of the mixture.

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

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

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

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

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

26. COVENANT AGAINST CONTINGENT FEES

The Grantee warrants that no person or selling agency has been employed or retained to solicit or secure the Grant upon an agreement or understanding for a commission, percentage, brokerage, or contingent fee, except bona fide employees or bona fide established commercial or selling agencies maintained by the Grantee for the purpose of securing business. For breach or violation of this warranty, the Commonwealth shall have the right to terminate the Grant without liability or in its discretion to deduct from the Grant price or consideration, or otherwise recover the full amount of such commission, percentage, brokerage, or contingent fee.

27. APPLICABLE LAW

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

28. INTEGRATION

The Grant, including all referenced documents, constitutes the entire agreement between the parties. No agent, representative, employee or officer of either the Commonwealth or the Grantee has authority to make, or has made, any statement, agreement or representation, oral or written, in connection with the Grant, which in any way can be deemed to modify, add to or detract from, or otherwise change or alter its terms and conditions. No negotiations between the parties, nor any custom or usage, shall be permitted to modify or contradict any of the terms and conditions of the Grant. No modifications, alterations, changes, or waiver to the Grant or any of its terms shall be valid or binding unless accomplished by a written amendment signed by both parties. All such amendments will be made using the appropriate Commonwealth form.

29. CHANGE ORDERS

The Commonwealth reserves the right to issue change orders at any time during the term of the Grant or any renewals or extensions thereof: 1) to increase or decrease the quantities resulting from Commonwealth of Pennsylvania

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variations between any estimated quantities in the Grant and actual quantities; 2) to make changes to the services within the scope of the Grant; 3) to notify the Grantee that the Commonwealth is exercising any Grant renewal or extension option; or 4) to modify the time of performance that does not alter the scope of the Grant to extend the completion date beyond the Expiration Date of the Grant or any renewals or extensions thereof. Any such change order shall be in writing signed by the Granting Officer. The change order shall be effective as of the date appearing on the change order, unless the change order specifies a later effective date. Such increases, decreases, changes, or modifications will not invalidate the Grant, nor, if performance security is being furnished in conjunction with the Grant, release the security obligation. The Grantee agrees to provide the service in accordance with the change order. Any dispute by the Grantee in regard to the performance required under any change order shall be handled through Paragraph 19, "Grant Controversies".

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

30. RIGHT TO KNOW LAW 8-K-1580

a. Grantee or Subgrantee understands that this Grant Agreement and records related to or arising out of the Grant Agreement are subject to requests made pursuant to the Pennsylvania Right-to-Know Law, 65 P.S. §§ 67.101-3104, ("RTKL"). For the purpose of these provisions, the term "the Commonwealth" shall refer to the granting Commonwealth agency.

b. If the Commonwealth needs the Grantee’s or Subgrantee’s assistance in any matter arising out of the RTKL related to this Grant Agreement, it shall notify the Grantee or Subgrantee using the legal contact information provided in the Grant Agreement. The Grantee or Subgrantee, at any time, may designate a different contact for such purpose upon reasonable prior written notice to the Commonwealth.

c. Upon written notification from the Commonwealth that it requires Grantee’s or Subgrantee’s assistance in responding to a request under the RTKL for information related to this Grant Agreement that may be in Grantee’s or Subgrantee’s possession, constituting, or alleged to constitute, a public record in accordance with the RTKL ("Requested Information"), Grantee or Subgrantee shall:

1. Provide the Commonwealth, within ten (10) calendar days after receipt of written notification, access to, and copies of, any document or information in Grantee’s or Subgrantee’s possession arising out of this Grant Agreement that the Commonwealth reasonably believes is Requested Information and may be a public record under the RTKL; and

2. Provide such other assistance as the Commonwealth may reasonably request, in order to comply with the RTKL with respect to this Grant Agreement.

d. If Grantee or Subgrantee considers the Requested Information to include a request for a Trade Secret or Confidential Proprietary Information, as those terms are defined by the RTKL, or other information that Grantee or Subgrantee considers exempt from production under the RTKL, Grantee or Subgrantee must notify the Commonwealth and provide, within seven (7) calendar days of receiving the written notification, a written statement

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sign by a representative of Grantee or Subgrantee explaining why the requested material is exempt from public disclosure under the RTKL.

e. The Commonwealth will rely upon the written statement from Grantee or Subgrantee in denying a RTKL request for the Requested Information unless the Commonwealth determines that the Requested Information is clearly not protected from disclosure under the RTKL. Should the Commonwealth determine that the Requested Information is clearly not exempt from disclosure, Grantee or Subgrantee shall provide the Requested Information within five (5) business days of receipt of written notification of the Commonwealth’s determination.

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

g. The Commonwealth will reimburse Grantee or Subgrantee for any costs associated with complying with these provisions only to the extent allowed under the fee schedule established by the Office of Open Records or as otherwise provided by the RTKL if the fee schedule is inapplicable.

h. Grantee or Subgrantee may file a legal challenge to any Commonwealth decision to release a record to the public with the Office of Open Records, or in the Pennsylvania Courts, however, Grantee or Subgrantee shall indemnify the Commonwealth for any legal expenses incurred by the Commonwealth as a result of such a challenge and shall hold the Commonwealth harmless for any damages, penalties, costs, detriment or harm that the Commonwealth may incur as a result of Grantee’s or Subgrantee’s failure, including any statutory damages assessed against the Commonwealth, regardless of the outcome of such legal challenge. As between the parties, Grantee or Subgrantee agrees to waive all rights or remedies that may be available to it as a result of the Commonwealth’s disclosure of Requested Information pursuant to the RTKL.

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

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

B. **CONFIDENTIALITY**

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

C. **INFORMATION**

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

D. **CERTIFICATION AND LICENSING**

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

E. **PROGRAM SERVICES**

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

F. **CHILD PROTECTIVE SERVICE LAWS**

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

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

The Contractor agrees to comply with the requirements of the Pro-Children Act of 1994; Public Law 103277, Part C-Environment Tobacco Smoke (also known as the Pro-Children Act of 1994) requires that smoking not be permitted in any portion of any indoor facility owned or leased or contracted by an entity and used routinely or regularly for the provision of health care services, day care and education to children under the age of 18, if the services are funded by Federal programs whether directly or through State and Local governments. Federal programs include grants, cooperative agreements, loans or loan guarantees and contracts. The law does not apply to children’s services provided in private residences, facilities funded solely by Medicare or Medicaid funds, and portions of facilities used for impatient drug and alcohol treatment.
H. MEDICARE/MEDICAID REIMBURSEMENT

1. To the extent that services are furnished by contractors, subcontractors, or organizations related to the contractor/subcontractor and such services may in whole or in part be claimed by the Commonwealth for Medicare/Medicaid reimbursements, contractor/subcontractor agrees to comply with 42 C.F.R., Part 420, including:

   a. Preservation of books, documents and records until the expiration of four (4) years after the services are furnished under the contract.
   b. Full and free access to (i) the Commonwealth, (ii) the U.S. Comptroller General, (iii) the U.S. Department of Health and Human Services, and their authorized representatives.

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

I. TRAVEL AND PER DIEM EXPENSES

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

J. INSURANCE

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

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

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

   b. Public liability and property damage insurance to protect the Commonwealth, the Contractor, and any and all subcontractors from claim for damages for personal injury (including bodily injury), sickness or disease, accidental death and damage to property, including loss of use resulting from any property damage, which may arise from the activities performed under this contract or the failure to perform under this contract whether such performance or nonperformance be by the contractor, by any subcontractor, or by anyone directly or indirectly employed by either. The limits of such insurance shall be in an amount not less than $500,000 each person and $2,000,000 each occurrence, personal injury and property damage combined. Such policies shall be occurrence rather than claims-made policies and shall name the Commonwealth of Pennsylvania as an additional insured. The insurance shall not contain any endorsements or any other form designated to limit or restrict any action by the Commonwealth, as an additional insured, against the insurance coverage in regard to work performed for the Commonwealth.
Prior to commencement of the work under the contract and during the term of the contract, the Contractor shall provide the Department with current certificates of insurance. These certificates shall contain a provision that the coverages afforded under the policies will not be cancelled or changed until at least thirty (30) days’ written notice has been given to the Department.

K. PROPERTY AND SUPPLIES

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

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

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

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

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

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

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

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

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

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

I. DISASTERS

If, during the terms of this contract, the Commonwealth’s premises are so damaged by flood, fire or other Acts of God as to render them unfit for use; then the Agency shall be under no liability or obligation to the contractor hereunder during the period of time there is no need for the services...
M. SUSPENSION OR DEBARMENT

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

N. COVENANT AGAINST CONTINGENT FEES

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

O. CONTRACTOR’S CONFLICT OF INTEREST

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

P. INTEREST OF THE COMMONWEALTH AND OTHERS

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

Q. CONTRACTOR RESPONSIBILITY TO EMPLOY WELFARE CLIENTS

(Applicable to contracts $25,000 or more)

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

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

3. The contractor, within 10 days of receiving the notice to proceed, must register in the Commonwealth Workforce Development System (CWDS). In order to register the selected

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contractor must provide business, location and contact details by creating an Employer Business Folder for review and approval, within CWDS at HTTPS://WWW.CWDS.State.PA.US. Upon CPP review and approval of Form PA-778 and the Employer Business Folder in CWDS, the Contractor will receive written notice (via the pink Contractor’s copy of Form PA-778) that the plan has been approved.

4. Hiring under the approved plan will be monitored and verified by Quarterly Employment Reports (Form PA-1540); submitted by the contractor to the Central Office of Employment and Training – CPP Division. A copy of the submitted Form PA-1540 must also be submitted (by the contractor) to the DPW Contract Monitor (i.e. Contract Officer). The reports must be submitted on the DPW Form PA1540. The form may not be revised, altered, or re-created.

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

R. TUBERCULOSIS CONTROL

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

S. ACT 13 APPLICATION TO CONTRACTOR

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

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

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

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

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

T. **LOBBYING CERTIFICATION AND DISCLOSURE** (applicable to contracts $100,000 or more)

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

U. **AUDIT CLAUSE** (applicable to contracts $100,000 or more)

This contract is subject to audit in accordance with the Audit Clause attached hereto and incorporated herein.
A. **Federal Audit Requirements – Local Governments and Nonprofit Organizations**

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

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

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

B. **Department of Public Welfare Audit Requirements** A local government or nonprofit provider must meet the DPW audit requirements.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Commonwealth of Pennsylvania
HealthChoices Behavioral Health
AUDIT CLAUSE A – SUBRECIPIENT
Local Governments and Nonprofit Organizations

SUBMISSION OF AUDIT REPORTS TO THE COMMONWEALTH

A. Federally Required Audit Reports

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

1. Auditor’s reports
   a. Independent auditor’s report on the financial statements, which expresses an opinion on whether the financial statements are presented fairly in all material respects in conformity with the stated accounting policies.
   b. Independent auditor’s report on the supplementary Schedule of Expenditures of Federal Awards (SEFA), which should determine and provide an opinion on whether the SEFA is presented fairly in all material respects in relation to the subrecipient’s financial statements taken as a whole. This report can be issued separately or combined with the independent auditor’s report on the financial statements.
   c. Report on internal control over financial reporting, compliance and other matters based on an audit of financial statements performed in accordance with Government Auditing Standards.
   d. Report on compliance with requirements applicable to each major program and report on internal control in accordance with the circular.
   e. Schedule of findings and questioned costs.

2. Financial statements and notes to the financial statements

3. SEFA and notes to the SEFA

4. Summary schedule of prior audit findings

5. Corrective action plan (if applicable)

6. Data collection form

7. Management letter (if applicable)

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

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

Steps for submission:

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

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

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

B. DPW Required Audit Reports and Additional Submission by Subrecipients

Submit three copies of the DPW required audit report package.

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

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

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

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

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

CORRECTIVE ACTION PLAN

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

REMEDIES FOR NONCOMPLIANCE

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

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

TECHNICAL ASSISTANCE

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

Department of Public Welfare
Bureau of Financial Operations
Division of Financial Policy and Operations
Audit Resolution Section
3rd Floor, Bertolino Building
P.O. Box 2675
Harrisburg, Pennsylvania 17105-2675
Phone: (717) 787-8890 FAX: (717) 772-2522
The Department of Public Welfare (DPW) requires an Independent Accountant’s Report on the Attestation to be in the format described by the American Institute of Certified Public Accountants (AICPA). The following is the form of report an Independent Accountant should use when expressing an opinion on an entity’s compliance with specified requirements during a period of time. For further guidance, refer to the AICPA guidelines.

**Independent Accountant’s Report [Introductory Paragraph]**

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

**[Scope Paragraph]**

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

**[Opinion Paragraph]**

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

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

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

### A. Federal Audit Requirements – For-Profit Organizations

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

SUBMISSION OF AUDIT REPORT TO THE COMMONWEALTH

A. Federally Required Audit Reports

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

1. Auditor’s reports
   a. Independent auditor’s report on the financial statements, which expresses an opinion on whether the financial statements are presented fairly in all material respects in conformity with the stated accounting policies.
   b. Independent auditor’s report on the supplementary Schedule of Expenditures of Federal Awards (SEFA), which should determine and provide an opinion on whether the SEFA is presented fairly in all material respects in relation to the subrecipient’s financial statements taken as a whole. This report can be issued separately or combined with the independent auditor’s report on the financial statements.
   c. Report on internal control over financial reporting, compliance and other matters based on an audit of financial statements performed in accordance with Government Auditing Standards.
   d. Report on compliance with requirements applicable to each major program and report on internal control in accordance with the circular.
   e. Schedule of findings and questioned costs.

2. Financial statements and notes to the financial statements

3. SEFA and notes to the SEFA

4. Summary schedule of prior audit findings

5. Corrective action plan (if applicable)

6. Data collection form

7. Management letter (if applicable)
SUBRECIPIENT AUDIT CLAUSE B
For-Profit Organization

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

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

Steps for submission:

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

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

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

B. DPW Required Audit Reports and Additional Submission by Subrecipients Submit three copies of the DPW required audit report package.

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

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

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

Commonwealth of Pennsylvania
HealthChoices Behavioral Health
PERIOD SUBJECT TO AUDIT

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

CORRECTIVE ACTION PLAN

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

REMEDIES FOR NONCOMPLIANCE

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

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

TECHNICAL ASSISTANCE

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

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

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

Independent Accountant’s Report [Introductory Paragraph]

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

[Scope Paragraph]

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

[Opinion Paragraph]

In our opinion, [name of entity] complied, in all material respects, with the aforementioned requirements for the year ended December 31, 20XX.
The Commonwealth of Pennsylvania, Department of Public Welfare (DPW), distributes federal and state funds to local governments, nonprofit, and for-profit organizations. Federal expenditures are subject to federal audit requirements, and federal funding and state funding passed through DPW are subject to DPW audit requirements. If any federal statute specifically prescribes policies or specific requirements that differ from the standards provided herein, the provisions of the subsequent statute shall govern.

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

**Department of Public Welfare Audit Requirements**

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

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

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

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

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

**DPW Required Audit Report Submission**

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

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

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

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

**REMEDIES FOR NONCOMPLIANCE**

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

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

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

Department of Public Welfare
Bureau of Financial Operations
Division of Financial Policy and Operations
Audit Resolution Section
3rd Floor, Bertolino Building
P.O. Box 2675
Harrisburg, Pennsylvania 17105-2675
Phone: (717) 787-8890 FAX: (717) 772-2522
The Department of Public Welfare (DPW) requires an Independent Accountant's Report on the Attestation to be in the format described by the American Institute of Certified Public Accountants (AICPA). The following is the form of report an Independent Accountant should use when expressing an opinion on an entity's compliance with specified requirements during a period of time. For further guidance, refer to the AICPA guidelines.

**Independent Accountant’s Report** [Introductory Paragraph]

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

[Scope Paragraph]

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

[Opinion Paragraph]

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

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

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

Department of Public Welfare Audit Requirement

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

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

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

Records that relate to litigation or the settlement of claims arising out of performance or expenditures under this contract to which exception has been taken by the auditors, shall be retained by the contractor or provided to the Commonwealth at the DPW’s option until such litigation, claim, or exceptions have reached final disposition.
Except for documentary evidence delivered pursuant to litigation or the settlement of claims arising out of the performance of this contract, the contractor may, in fulfillment of his obligation to retain records as required by this Audit Clause, substitute photographs, microphotographs, or other authentic reproductions of such records, after the expiration of two years following the last day of the month of reimbursement to the contractor of the invoice or voucher to which such records relate, unless a shorter period is authorized by the Commonwealth.

**DPW Required Audit Report Submission**

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

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

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

2. Submit the audit report directly to the program office. **REMEDIES FOR NONCOMPLIANCE** The provider’s failure to provide an acceptable audit, in accordance with the requirements of the Audit Clause & Requirements, may result in the PDPW’s not accepting the report and initiating sanctions against the contractor that may include the following:
   - Disallowing the cost of the audit.
   - Withholding a percentage of the contract funding pending compliance.
   - Suspending subsequent contract funding pending compliance.

**TECHNICAL ASSISTANCE**

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

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

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

[Scope Paragraph]

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

[Opinion Paragraph]

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

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

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

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

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

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

Issued May 2004

Commonwealth of Pennsylvania
HealthChoices Behavioral Health
LOBBYING CERTIFICATION AND DISCLOSURE
OF LOBBYING ACTIVITIES

Certification for Contracts, Grants, Loans, and Cooperative Agreements

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

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

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

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

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

SIGNATURE: ________________________________

TITLE: ________________________________

DATE: ________________________________
**INSTRUCTIONS FOR COMPLETION OF DISCLOSURE OF LOBBYING ACTIVITIES**

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

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

2. Identify the status of the covered federal action.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

<table>
<thead>
<tr>
<th>1. Type of Federal Action:</th>
<th>2. Status of Federal Action:</th>
<th>3. Report Type:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Contract</td>
<td>Bid/Offer Application</td>
<td>a. Initial Filing</td>
</tr>
<tr>
<td>a. Grant</td>
<td>a. Initial Award</td>
<td>b. Material Change</td>
</tr>
<tr>
<td>b. Cooperative Agreement</td>
<td>b. Post-Award</td>
<td>For Material Change:</td>
</tr>
<tr>
<td>c. Loan</td>
<td></td>
<td>Year _______ Quarter _______</td>
</tr>
<tr>
<td>d. Loan Guarantee</td>
<td></td>
<td>Date of last report _______</td>
</tr>
<tr>
<td>e. Loan Insurance</td>
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<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>4. Name and Address of Reporting Entity:</th>
<th>5. If Reporting Entity in No. 4 is Subawardee, Enter Name and Address of Prime:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Prime</td>
<td>Congressional District, if known</td>
</tr>
<tr>
<td>Subawardee</td>
<td></td>
</tr>
<tr>
<td>Tier ______ if known:</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>6. Federal Department/Agency:</th>
<th>7. Federal Program Name/Description:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>CFDA Number, if applicable:</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>8. Federal Action Number, if known:</th>
<th>9. Award Amount, if known:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>$</td>
</tr>
</tbody>
</table>

| 10. Name and Address of Lobbying Entity   | 11. Amount of Payment (check all that apply):                                  |
| (if individual, last name, first name, MI): | $_________________________ actual planned                                      |
|                                          | SF-LLL-A, if necessary                                                        |

<table>
<thead>
<tr>
<th>12. Form of Payment (check all that apply):</th>
<th>13. Type of Payment</th>
</tr>
</thead>
<tbody>
<tr>
<td>a. Cash</td>
<td>a. retainer</td>
</tr>
<tr>
<td>b. In-kind: Specify: Nature ________________</td>
<td>b. one-time fee</td>
</tr>
<tr>
<td></td>
<td>c. commission</td>
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<tr>
<td></td>
<td>d. contingent fee</td>
</tr>
<tr>
<td></td>
<td>e. deferred</td>
</tr>
<tr>
<td></td>
<td>f. other; specify: ____________________</td>
</tr>
</tbody>
</table>

| 14. Brief Description of Services Performed or to be Performed and Date(s) of Service, including officer(s), employe(s) or Member(s) contacted, for payment indicated in Item 11: | |
|                                                                 | (attach Continuation Sheet(s) SF-LLL-A, if necessary) |

<table>
<thead>
<tr>
<th>15. Continuation Sheet(s) SF-LLL-A attached:</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
</table>

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

Federal Use Only: Authorized for Local Reproduction Standard Form - LLL
| Reporting Entry: _______________________________ | Page _____ of ________ |
COMMONWEALTH OF PENNSYLVANIA
BUSINESS ASSOCIATE APPENDIX

WHEREAS, the Pennsylvania Department of Welfare (Covered Entity) and ______________________ (Business Associate) intend to protect the privacy and security of certain Protected Health Information (PHI) to which Business Associate may have access in order to provide goods or services to or on behalf of Covered Entity, in accordance with the Health Insurance Portability and Accountability Act of 1996, Public Law 104-191 (HIPAA), the Health Information Technology for Economic and Clinical Health (HITECH) Act, Title XIII of Division A and Title IV of Division B of the American Recovery and Reinvestment Act of 2009 (ARRA), Pub. L. No. 111-5 (Feb. 17, 2009) and related regulations, the HIPAA Privacy Rule (Privacy Rule), 45 C.F.R. Parts 160 and 164, as amended, the HIPAA Security Rule (Security Rule), 45 C.F.R. Parts 160, 162 and 164), as amended, 42 U.S.C. § 602(a)(1)(A)(iv), 42 U.S.C. § 1396a(a)(7), 35 P.S. § 7607, 50 Pa.C.S. § 7111, 71 P.S. § 1690.108(c), 62 P.S. § 404, 55 Pa. Code Chapter 105, 55 Pa. Code Chapter 5100, 42 C.F.R. §§ 431.301-431.302, 45 C.F.R. § 205.50, the Pennsylvania Breach of Personal Information Notification Act, 73 P.S. § 2301 et seq., and other relevant laws, including subsequently adopted provisions applicable to use and disclosure of confidential information, and applicable agency guidance.

WHEREAS, Business Associate may receive PHI from Covered Entity, or may create or obtain PHI from other parties for use on behalf of Covered Entity, which PHI must be used, handled and disclosed in accordance with this Appendix and the standards established by HIPAA, the HITECH Act and related regulations, and other applicable laws and agency guidance.

NOW, THEREFORE, Covered Entity and Business Associate agree as follows:

1. Definitions.
   a. “Business Associate” shall have the meaning given to such term under HIPAA, the HITECH Act, applicable regulations and agency guidance.
   b. “Covered Entity” shall have the meaning given to such term under HIPAA, the HITECH Act and applicable regulations and agency guidance.
   d. “HITECH Act” shall mean the Health Information Technology for Economic and Clinical Health (HITECH) Act, Title XIII of Division A and Title IV of Division B of the American Recovery and Reinvestment Act of 2009 (ARRA).
   e. “Privacy Rule” shall mean the standards for privacy of individually identifiable health information in 45 C.F.R. Parts 160 and 164, as amended, and related agency guidance.
   f. “Protected Health Information” or “PHI” means any information, transmitted or recorded in any form or medium; (i) that relates to the past, present or future physical or mental condition of an individual; the provision of health care to an individual; or the past, present or future payment for the provision of health care to an individual, and (ii) that identifies the individual or with respect to which there is a reasonable basis to believe the information can be used to identify the individual, and shall have the meaning given to such term under HIPAA, the HITECH Act and related regulations and agency guidance. PHI also includes any and all information that can be used to
identify a current or former applicant or recipient of benefits or services of Covered Entity or its contractors/ or business associates.

g. “Security Rule” shall mean the security standards in 45 C.F.R. Parts 160, 162 and 164, as amended, and related agency guidance.

h. “Unsecured PHI” shall mean PHI that is not secured through the use of a technology or methodology as specified in HITECH regulations and agency guidance or as otherwise defined in the HITECH Act.

2. **Stated Purposes For Which Business Associate May Use Or Disclose PHI.** The Parties hereby agree that Business Associate shall be permitted to use and/or disclose PHI provided by or obtained on behalf of Covered Entity for providing services under its agreement with the Covered Entity, except as otherwise stated in this Appendix.

**NO OTHER DISCLOSURES OF PHI OR OTHER INFORMATION ARE PERMITTED.**

3. **BUSINESS ASSOCIATE OBLIGATIONS:**

   a) **Limits On Use And Further Disclosure.** Business Associate shall not further use or disclose the PHI provided by, or created or obtained on behalf of Covered Entity other than as permitted or required by this Appendix or as required by law and agency guidance.

   b) **Appropriate Safeguards.** Business Associate shall establish and maintain appropriate safeguards to prevent any use or disclosure of PHI other than as provided for by this Appendix. Appropriate safeguards shall include implementing administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of the electronic PHI that is created, received, maintained, or transmitted on behalf of the Covered Entity and limiting use and disclosure to applicable minimum necessary requirements as set forth in applicable federal and state statutory and regulatory requirements and agency guidance.

   c) **Reports Of Improper Use Or Disclosure.** Business Associate hereby agrees that it shall report to Thomas Zarb, Chief, Security Architecture Section, Bureau of Information Systems at 717-772-7449, within two (2) days of discovery any use or disclosure of PHI not provided for or allowed by this Appendix.

   d) **Security Incidents.** In addition to following the breach notification requirements in section 13402 of HITECH Act and related regulations, agency guidance and other applicable federal and state laws, Business Associate shall report to Thomas Zarb at 717-772-7449, within two (2) days of discovery any security incident of which it becomes aware. At the sole expense of Business Associate, Business Associate shall comply with all applicable federal and state breach notification requirements. Business Associate shall indemnify the Covered Entity for costs associated with any incident involving the acquisition, access, use or disclosure of Unsecured PHI in a manner not permitted under federal or state law and agency guidance.

   e) **Subcontractors And Agents.** At any time PHI is provided or made available to any subcontractors or agents, Business Associate shall provide only the minimum necessary
Appendix E

PHI for the purpose of the covered transaction and shall first enter into a subcontract or contract with the subcontractor or agent that contains the same terms, conditions and restrictions on the use and disclosure of PHI as contained in this Appendix.

(f) Right Of Access To PHI. Business Associate will allow an individual who is the subject of PHI maintained in a designated record set, to have access to and copy that individual’s PHI within five (5) business days of receiving a written request from the Covered Entity. Business Associate shall provide PHI to the extent and in the manner required by 45 C.F.R. § 164.524 and other applicable federal and state law and agency guidance. If Business Associate maintains an electronic health record, Business Associate must provide the PHI in electronic format if requested. If any individual requests from Business Associate or its agents or subcontractors access to PHI, Business Associate shall notify Covered Entity of same within five (5) business days. Business Associate shall further conform with and meet all of the requirements of 45 C.F.R. § 164.524 and other applicable laws, including the HITECH Act and related regulations, and agency guidance.

(g) Amendment And Incorporation Of Amendments. Within five (5) business days of receiving a request from Covered Entity for an amendment of PHI maintained in a designated record set, Business Associate shall make the PHI available and incorporate the amendment to enable Covered Entity to comply with 45 C.F.R. §164.526, applicable federal and state law, including the HITECH Act and related regulations, and agency guidance. If any individual requests an amendment from Business Associate or its agents or subcontractors, Business Associate shall notify Covered Entity within five (5) business days.

(h) Provide Accounting Of Disclosures. Business Associate will maintain a record of all disclosures of PHI in accordance with 45 C.F.R. §164.528 and other applicable laws and agency guidance, including the HITECH Act and related regulations. Such records shall include, for each disclosure, the date of the disclosure, the name and address of the recipient of the PHI, a description of the PHI disclosed, the name of the individual who is the subject of the PHI disclosed, and the purpose of the disclosure. Business Associate shall make such record available to the individual or the Covered Entity within five (5) business days of a request for an accounting of disclosures.

(i) Requests for Restriction. Business Associate shall comply with requests for restrictions on disclosures of PHI about an individual if the disclosure is to a health plan for purposes of carrying out payment or health care operations (and is not for treatment purposes), and the PHI pertains solely to a health care item or service for which the service involved was paid in full out-of-pocket. For other requests for restriction, Business Associate shall otherwise comply with the Privacy Rule, as amended, and other applicable statutory and regulatory requirements and agency guidance.

(j) Access To Books And Records. Business Associate will make its internal practices, books, and records relating to the use or disclosure of PHI received from, or created or received by Business Associate on behalf of the Covered Entity, available to the Secretary of Health and Human Services or designee for purposes of determining compliance with applicable laws and agency guidance.
(k) **Return Or Destruction Of PHI.** At termination or expiration of its contract with Covered Entity, Business Associate will return or destroy all PHI provided by or obtained on behalf of Covered Entity. Business Associate will not retain any copies of the PHI after termination of this contract. If return or destruction of the PHI is not feasible, Business Associate extends the protections of this Appendix to limit any further use or disclosure until such time as the PHI may be returned or destroyed. If Business Associate elects to destroy the PHI, it shall certify to Covered Entity that the PHI has been destroyed.

(l) **Maintenance of PHI.** Notwithstanding Section 3(k) of this Agreement, Business Associate and its subcontractors or agents shall retain all PHI throughout the term of its contract and shall continue to maintain the information required under the various documentation requirements of this Appendix (such as those in §3(h)) for a period of six (6) years after termination of the contract, unless Covered Entity and Business Associate agree otherwise.

(m) **Mitigation Procedures.** Business Associate will establish and provide to Covered Entity upon request, procedures for mitigating, to the maximum extent practicable, any harmful effect from the use or disclosure of PHI in a manner contrary to this Appendix or the Privacy Rule, as amended. Business Associate will mitigate any harmful effect that is known to Business Associate of a use or disclosure of PHI by Business Associate in violation of this Appendix or applicable laws and agency guidance.

(n) **Sanction Procedures.** Business Associate shall develop and implement a system of sanctions for any employee, subcontractor or agent who violates this Appendix, applicable laws or agency guidance.

(o) **Grounds For Breach.** Non-compliance by Business Associate with this Appendix or the Privacy or Security Rules, as amended, is a breach of the contract, if Business Associate knew or reasonably should have known of such non-compliance and failed to immediately take reasonable steps to cure the non-compliance.

(p) **Termination by Commonwealth.** Business Associate authorizes termination of its contract for Medical Review Team services if the Covered Entity determines, in its sole discretion, that the Business Associate has violated a material term of this Agreement.

(q) **Failure to Perform Obligations.** In the event Business Associate fails to perform its obligations under this Appendix, Covered Entity may immediately discontinue providing PHI to Business Associate. Covered Entity may also, at its option, require Business Associate to submit to a plan of compliance, including monitoring by Covered Entity and reporting by Business Associate, as Covered Entity in its sole discretion determines to be necessary to maintain compliance with this Appendix and applicable laws and agency guidance.

(r) **Privacy Practices.** The Department will provide and Business Associate shall immediately begin using any applicable form, including but not limited to, any form used for Notice of Privacy Practices, Accounting for Disclosures, or Authorization,
upon the effective date designated by the Program or Department. The Department retains the right to change the applicable privacy practices, documents and forms. The Business Associate shall implement changes as soon as practicable, but not later than 45 days from the date of notice of the change.

4. **OBLIGATIONS OF COVERED ENTITY:**

   a) **Provision of Notice of Privacy Practices.** Covered Entity shall provide Business Associate with the notice of privacy practices that the Covered Entity produces in accordance with applicable law and agency guidance, as well as changes to such notice.

   b) **Permissions.** Covered Entity shall provide Business Associate with any changes in, or revocation of, permission by individual to use or disclose PHI of which Covered Entity is aware, if such changes affect Business Associate’s permitted or required uses and disclosures.

   c) **Restrictions.** Covered Entity shall notify Business Associate of any restriction to the use or disclosure of PHI that the Covered Entity has agreed to in accordance with 45 C.F.R. §164.522 and other applicable laws and applicable agency guidance, to the extent that such restriction may affect Business Associate’s use or disclosure of PHI.
Fraud and Abuse Program Requirements

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

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

1. Primary Contractor’s Responsibility for Fraud and Abuse Requirements of the HealthChoices Contract

The Primary Contractor shall develop or require the BHMCO to develop a written compliance plan that must contain the following elements:

• Written policies, procedures and standards of conduct that articulate the organization’s commitment to comply with all Federal and State standards related to Medicaid managed care organizations;
• The designation of a compliance officer and a compliance committee that is accountable to senior management;
• Effective training and education for the compliance officer and MCO employees;
• Effective lines of communication between the compliance officer and MCO employees;
• Enforcement of standards through well publicized disciplinary guidelines;
  • Provisions for internal monitoring and auditing; and
• Provisions for prompt response to detected offenses and the development of corrective action initiatives.

The Primary Contractor shall designate a Fraud and Abuse Coordinator who will be responsible for preventing, detecting, investigating, and referring suspected fraud and abuse in the HealthChoices behavioral health program to the Department. The Fraud and Abuse Coordinator will act as a direct contact with the Department in matters relating to fraud and abuse. The Primary Contractor shall submit the name, address, title, and contact information of the Coordinator to the Department.

The Primary Contractor may designate the BH-MCO to fulfill the function of managing the HealthChoices fraud and abuse requirements and, in this event, shall submit policies.
and procedures describing the measures taken to ensure that the BH-MCO complies with all requirements related to fraud and abuse. In this instance the Primary Contractor shall provide oversight of the BH-MCO and shall require the BH-MCO to report all cases of suspected fraud or abuse to the primary contractor and the Department.

2. **Fraud and Abuse Requirements for HealthChoices**

   a. **Corporate Integrity / Compliance / Fraud and Abuse Staff**
   The Primary Contractor or BH-MCO shall have experienced fraud and abuse staff that shall prevent, detect, investigate, and report suspected fraud and abuse that may be committed by network Providers, members, employees, and subcontracted parties.

   b. **Written Policies**
   The Primary Contractor or BH-MCO shall maintain and comply with written policies and procedures for the prevention, detection, and reporting of suspected fraud and abuse, which are subject to the approval of the Department’s Bureau of Program Integrity.

   The Department may require new or updated policies and procedures during the course of the contract period. The policies and procedures shall contain the following:
   - The name, title, and contact information of the Fraud and Abuse Coordinator and staff.
   - A description of specific controls in place for fraud and abuse detection, including an explanation of the technology used to identify aberrant billing patterns, procedures for claims edits and post processing review of claims, review of complaints and grievances, and other means of identifying fraud and abuse.
   - A description of the methodology and standard operating procedures used to investigate fraud and abuse, such as on-site visits and record reviews.
   - Explanation of the process for referring suspected fraud and abuse to the Department within thirty (30) business days of identification of the problem/issue. This explanation shall state that the MCO must gather and send to BPI any and all documentation supporting the referral. Such information will include, but will not be limited to, the items listed on the "Checklist of Supporting Documentation for Referrals" (Attachment 5).
   - Methodology for recovering overpayments or otherwise sanctioning Providers.
   - Process for reporting in writing any Providers who are suspended, resign, or voluntarily withdraw after initiation of fraud and abuse review.
   - A statement outlining an educational plan for staff relating to fraud and abuse.
   - Statement ensuring full cooperation with state and federal oversight agencies including, but not limited to, the Department’s Bureau of Program Integrity, the Office of Attorney General’s Medicaid Fraud Control Section, The Pennsylvania Office of the Inspector General, and the US Justice Department.
   - A statement that the Department’s Medicheck List and the Federal Office of Inspector General’s List of Excluded Individuals and Entities (LEIE) are used to verify that Providers sanctioned by the state or federal government are not participating in HealthChoices.
   - A method to verify whether services reimbursed by the Primary Contractor and/or its BH-MCO were actually furnished to recipients.
   - A certification that the policies and procedures were reviewed and approved by the Primary Contractor or BH-MCO.
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Commonwealth of Pennsylvania
HealthChoices Behavioral Health

c. **Duty to Report Suspected Fraud and Abuse to the Department**
   The Fraud and Abuse Coordinator shall be required to report all suspected fraud and abuse to the Department within thirty (30) business days of the identification of the problem/issue or pattern of abuse. The Fraud and Abuse Coordinator is responsible for assembling all documentation supporting the referral and sending it to BPI. "MCO Fraud and Abuse Reporting Requirements" (Attachment 1) provides examples of fraud and abuse, as well as reporting information to the Department. The "Checklist of Supporting Documentation for Referrals" (Attachment 2) includes examples of the information that the MCO must gather and send to BPI in order to support a referral. The Fraud and Abuse Coordinator should check the appropriate boxes on the "Checklist of Supporting Documentation for Referrals" form indicating the supporting documentation information that is sent with each referral. A copy of the completed checklist and all supporting documentation should accompany each referral. All suspected fraud and abuse shall be reported prior to any internal sanctioning, including corrective actions by the Primary Contractor or BH-MCO.

The Fraud and Abuse Coordinator shall submit to the Department quarterly statistical reports which detail its Fraud and Abuse detection and sanctioning activities regarding Providers.

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

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

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

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

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

The Primary Contractor and/or its BH-MCO must supply updated disclosure to the Department within fifteen (15) days upon request.

e. Fraud and Abuse Hotline

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

f. Precluded Providers

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

The Department shall notify Primary Contractors when actions are taken to terminate behavioral health Providers from participation in the Medicaid and Medicare Programs. The notification will not include the basis for the departmental action, due to confidentiality issues. Upon notification from the Department that a Provider is suspended or terminated from participation in the Medicaid or Medicare Programs, BH-MCO shall immediately act to terminate the Provider from participation. Terminations for loss of licensure and criminal convictions must coincide with the MA effective date of the action.
The Department recommends that the Primary Contractor / BH-MCO access the Office of Medical Assistance Program’s Medcheck List at http://www.dpw.state.pa.us/learnaboutdpw/fraudandabuse/medicheckprecludedproviderslist/S001152 for information on Providers who have been precluded from the MA Program. The Centers for Medicare and Medicaid Services (CMS) also recommend the Federal List of Excluded Individuals and Entities (LEIE) be checked monthly by accessing http://oig.hhs.gov/fraud/exclusions.asp and EPLS Excluded Parties list at www.epls.arnet.gov.

g. Duty to Notify Department
The Primary Contractor or BH-MCO must immediately notify the Department in writing if a Provider, Subcontractor, or employee resigns, is suspended, terminated, decredentialied or voluntarily withdraws from participation in the network as a result of suspected or confirmed fraud or abuse. The notification must contain the reason for the action.

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

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

i. Subcontracts
The Primary Contractor and BH-MCO agree to ensure that all Subcontractors comply with the fraud and abuse requirements listed in this Agreement. In addition, although all health care Providers with whom the Primary Contractor and BH-MCO Subcontracts are enrolled in the MA program and subject to MA regulations, the Primary Contractor and BH-MCO agrees to ensure, via contract, that such health care Providers comply with MA regulations, and understand and agree that they are subject to enforcement actions directly initiated by the Department under its regulations, including termination and restitution actions, among others.
MCO FRAUD AND ABUSE REPORTING REQUIREMENTS

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

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

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

Abuse of a Member
- Physical, mental, sexual
- Discrimination

Employee / Subcontractor Theft or Embezzlement

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

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

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

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

DPW Bureau of Program Integrity
Managed Care Unit
PO Box 2675
Harrisburg, PA 17105-2675
3. Reporting Suspected Member Fraud and Abuse and requesting recipient restriction (lock-in) action: Report to:

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

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

DPW Bureau of Program Integrity
Managed Care Unit
PO Box 2675
Harrisburg, PA 17105-2675
717-772-4655 (fax)
Appendix F
Attachment 2

Checklist of Supporting Documentation for Referrals

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

Example of materials for provider or staff person referrals –

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

Example of materials for pharmacy referrals–

- paid claims
- prescriptions
- signature logs
- encounter forms
- purchase invoices
- EOB’s
- delivery slips
- licensing information
- other: _____________________________________________________
Example of materials for RTF referrals-

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

Example of materials for behavioral health referrals-

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

Example of materials for DME referrals-

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

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Appendix F
Attachment 3

DPW’s Toll-Free Fraud and Abuse Hotline
Information for Inclusion in MCO Member and Provider Manuals

For Member Handbooks:

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

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

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

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

You can also report suspected fraud and abuse by using the website: 
http://www.dpw.state.pa.us/dpworganization/officeofmedicalassistanceprograms/index.htm or email omaptips@state.pa.us. This has been set up so you do not have to give your name also.

For Provider Handbooks:
The Department of Public Welfare has established a hotline to report suspected fraud and abuse committed by any entity providing services to Medical Assistance recipients.

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

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

Suspected fraud and abuse may also be reported via the website at: 
http://www.dpw.state.pa.us/dpworganization/officeofmedicalassistanceprograms/index.htm or emailed to omaptips@state.pa.us. Information reported via the website or email can also be done anonymously. The website contains additional information on reporting fraud and abuse.
HEALTHCHOICES ENROLLMENT PROGRAM

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

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

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

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

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

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

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

- To ensure that outreach efforts are specifically targeted to the various populations and needs of the Medicaid consumers in all HC-zones.
- To provide education and information to Medicaid consumers to enable them to make informed decisions on which physical health plans meet their needs in order to decrease plan transfers and encourage continuity of care.

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

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

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

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

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

Complaint, Grievance, and Fair Hearing Processes

A. General Requirements

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

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

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

4. The BH-MCO policies and procedures regarding member complaints and grievances must be provided to members in written form:
   a. Upon enrollment into the BH-MCO,
   b. Upon member request, and
   c. At least 30 days prior to implementation of procedural revisions.

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

6. The BH-MCO may not charge a member a fee for filing a complaint or grievance at any level of the process.

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

8. The BH-MCO must designate and train sufficient staff to be responsible for receiving, processing, and responding to member complaints and grievances in accordance with the requirements in this Appendix.
9. The BH-MCO must identify a lead person responsible for overall coordination of the complaint and grievance processes, including the provision of information and instructions to members.

10. Staff performing complaint and grievance reviews must have the necessary orientation, clinical training and experience to make an informed and impartial determination regarding issues assigned to them.

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

12. The BH-MCO must ensure that members have access to all relevant documentation pertaining to the subject of the complaint or grievance.

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

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

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

16. The BH-MCO must provide members with disabilities assistance in presenting their case at complaint or grievance reviews at no cost to the member. This includes:

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

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

18. The BH-MCO must offer members the assistance of a BH-MCO staff member throughout the complaint and grievance process. The BH-MCO staff member cannot have had previous involvement with the issue in dispute.

19. The BH-MCO must ensure that anyone who participates in making the decision on a complaint or grievance was not involved in any previous level of review or decision-making.

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

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

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

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

B. Complaint Requirements

Complaint: A complaint is a dispute or objection filed with the BH-MCO regarding a participating health care provider or the coverage, operations, or management policies of a BH-MCO, including but not limited to: 1) a denial because the requested service is not a covered benefit; 2) failure of the BH-MCO to meet the required timeframes for providing a service; 3) failure of the BH-MCO to decide a complaint or grievance within the specified timeframes; 4) a denial of payment after a service(s) has been delivered because the service(s) was provided
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without authorization by a provider not enrolled in the Pennsylvania Medical Assistance Program; 5) a denial of payment after a service(s) has been delivered because the service is not a covered benefit.

The term does not include a grievance.

1. First Level Complaint Process

   a. A BH-MCO must permit a member or member’s representative, which may include the member’s provider, with proof of the member’s written authorization for the representative to be involved and/or take action on the member’s behalf, to file a complaint either orally or in writing. An oral complaint filed about the following:

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

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

   b. If the complaint is about the following:

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

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

   c. If a member files a complaint to dispute a decision to discontinue, reduce, or change a service that the member has been receiving on the basis that the service is not a covered benefit, the member must continue to receive the disputed service at
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the previously authorized level pending resolution of the complaint, if the complaint is hand delivered or post-marked within ten days from the date on the written notice of decision.

d. Upon receipt of the complaint, the BH-MCO must send the member and member’s representative, if the member has designated one, an acknowledgment letter using the template supplied by the Department as Attachment 2a of this Appendix or, if the complaint is about the following:
  i. a denial because the requested service is not a covered benefit, or
  ii. the failure of the BH-MCO to meet the required timeframes for providing a service, or
  iii. the failure of the BH-MCO to decide a complaint or a grievance within the specified timeframes, or
  iv. a denial of payment after a service has been delivered because the service(s) was provided without authorization by a provider not enrolled in the Pennsylvania Medical Assistance Program, or
  v. a denial of payment after a service has been delivered because the service is not a covered benefit

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

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

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

g. If the complaint is about the following:
  i. a denial because the requested service is not a covered benefit, or
  ii. the failure of the BH-MCO to meet the required timeframes for providing a service, or
  iii. the failure of the BH-MCO to decide a complaint or a grievance within the specified timeframes, or
  iv. a denial of payment after a service has been delivered because the service(s) was provided without authorization by a provider not enrolled in the Pennsylvania Medical Assistance Program, or
  v. a denial of payment after a service has been delivered because the service is not a covered benefit
the member must be afforded a reasonable opportunity to present evidence, and allegations of fact or law, in person as well as in writing. The BH-MCO must be flexible when scheduling the review to facilitate the member’s attendance. If the member cannot appear in person at the review, an opportunity to communicate with the first level complaint review committee by telephone or videoconference must be provided. The member may elect not to attend the first level complaint meeting but the meeting must be conducted with the same protocols as if the member was present. The member and/or anyone the member chooses may present the member’s position to the first level complaint review committee.

h. The first level complaint review committee must complete its review of the complaint as expeditiously as the member’s health condition requires, but no more than 30 days from receipt of the complaint, which may be extended by 14 days at the request of the member.

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

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

i. a denial because the requested service is not a covered benefit, or
ii. the failure of the BH-MCO to meet the required timeframes for providing a service, or
iii. the failure of the BH-MCO to decide a complaint or a grievance within the specified timeframes, or
iv. a denial of payment after a service has been delivered because the service(s) was provided without authorization by a provider not enrolled in the Pennsylvania Medical Assistance Program, or
v. a denial of payment after a service has been delivered because the service is not a covered benefit using the template supplied by the Department as Attachment 3b of this Appendix.

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

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

2. Second Level Complaint Process

a. The member or the member’s representative, which may include the member’s provider, with proof of the member’s written authorization for the representative to be involved and/or take action on the member’s behalf, may file a request for a second level complaint review (“second level complaint”), within 45 days from the date the member receives written notice of the BH-MCO’s first level complaint decision.

b. Upon receipt of the second level complaint, the BH-MCO must send the member and member’s representative, if the member has designated one, an acknowledgment letter using the template supplied by the Department as Attachment 4 of this Appendix.

c. If a member files a second level complaint to dispute a decision to discontinue, reduce, or change a service that the member has been receiving on the basis that the service is not a covered benefit, the member must continue to receive the disputed service at the previously authorized level pending resolution of the second level complaint, if the second level complaint is hand delivered or post-marked within ten days from the date on the written notice of the BH-MCO’s first level complaint decision.

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

e. At least one third of the committee members must be enrolled in the BH-MCO

(1) If the complaint involves a service for an adult, the consumer member(s) on the second level complaint review committee must be an adult who has received or is currently receiving services (mental health services if the issue is a mental health complaint; substance abuse services if the issue is a substance abuse complaint) through the BH-MCO.

(2) If the complaint involves a service for a child or adolescent, the consumer member(s) on the second level complaint review committee must be a parent or guardian of a child or adolescent who has received or is currently receiving services (mental health services if the issue is a mental health complaint; substance abuse services if the issue is a substance abuse complaint) through the BH-MCO.
f. A committee member who does not personally attend the review meeting may not be part of the decision making process unless that person actively participates in the review by telephone or videoconference and has the opportunity to review any information introduced at the meeting.

g. The member must be provided the opportunity to appear before the second level complaint review committee. The BH-MCO must be flexible when scheduling the second level complaint review to facilitate the member’s attendance. The member must be given at least 15 days advance written notice of the review date. The review must be conducted at a time and place convenient to the member. If the member cannot appear in person at the second level complaint review, an opportunity to communicate with the second level complaint review committee by telephone or videoconference must be provided. The member may elect not to attend the second level complaint meeting but the meeting must be conducted with the same protocols as if the member was present. The member and/or anyone the member chooses may present the member’s position to the second level complaint review committee.

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

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

j. The second level complaint review committee must complete the second level complaint review within 30 days from the BH-MCO’s receipt of the member’s second level complaint.

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

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

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

l. If the complaint is about the following:
i. a denial because the requested service is not a covered benefit, or

ii. the failure of the BH-MCO to meet the required timeframes for providing a service, or

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

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

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

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

3. External Review of Second Level Complaint Review Decision

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

b. If a member files a request for an external review of a second level complaint decision to dispute a decision to discontinue, reduce, or change a service that the member has been receiving on the basis that the service is not a covered benefit, the member must continue to receive the disputed service at the previously authorized level pending resolution of the external review, if the request for external review is hand delivered or post-marked within ten days from the date on the written notice of the BH-MCO’s second level complaint decision.

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

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

4. Expedited Complaint Process

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

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

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

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

e. If a member files a request for expedited review of a complaint to dispute a decision to discontinue, reduce, or change a service that the member has been receiving on the basis that the service is not a covered benefit, the member must continue to receive the disputed service at the previously authorized level pending resolution of the complaint, if the request for expedited review is hand delivered or post-marked within ten days from the date on the written notice of decision.

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

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

h. A summary of the issues presented and decisions made must be maintained as part of the complaint record.
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i. The member or the member’s representative, with proof of the member’s written authorization for the representative to be involved and/or take action on the member’s behalf, may file a request for an expedited external complaint review with the BH-MCO within two business days from the date the member receives the written notice of the BH-MCO’s expedited complaint decision.

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

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

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

C. Grievance Requirements

Grievance: A grievance is a request to have a BH-MCO or utilization review entity reconsider a decision solely concerning the medical necessity and appropriateness of a health care service. A grievance may be filed regarding a BH-MCO decision to 1) deny, in whole or in part, payment for a service if based on lack of medical necessity; 2) deny or issue a limited authorization of a requested service, including the type or level of service; 3) reduce, suspend, or terminate a previously authorized service; 4) deny the requested service but approve an alternative service. The term does not include a complaint.

1. First Level Grievance Process

a. The BH-MCO must permit a member or the member’s representative, which may include the member’s provider, with proof of the member’s written authorization for the representative to be involved and/or take action on the member’s behalf, to file a grievance either orally or in writing. Oral requests must be committed to writing by the BH-MCO and must be provided to the member for signature. The member’s signature may be obtained at any point in the process, and failure to obtain a signed grievance may not delay the grievance process. The member will be given 45 days from the date the written notice was received to file a grievance.

b. In order for the provider to represent the member in the filing of a grievance, the provider must obtain the written consent of the member. A provider may obtain the member’s written permission at the time of treatment. A provider may NOT require a member to sign a document authorizing the provider to file a grievance as a condition of treatment. The written consent must include:
   (1) The name and address of the member, the member’s date of birth and identification number,
   (2) If the member is a minor, or is legally incompetent, the name, address and relationship to the member of the person who signed the consent,
   (3) The name, address and plan identification number of the provider to whom the member is providing consent,
   (4) The name and address of the plan to which the grievance will be submitted,
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(5) An explanation of the specific service for which coverage was provided or denied to the enrollee to which the consent will apply, and

(6) The following statement: “The member or the member’s representative may not submit a grievance concerning the services listed in this consent form unless the member or the member’s representative rescinds consent in writing. The member or member’s representative has the right to rescind consent at any time during the grievance process.”

c. A member who files a grievance to dispute a decision to discontinue, reduce or change a service that the member has been receiving must continue to receive the disputed service at the previously authorized level pending resolution of the grievance, if the grievance is hand delivered or post-marked within ten days from the date on the written notice of decision.

d. Upon receipt of the grievance, the BH-MCO must send the member and member’s representative, if the member has designated one, an acknowledgment letter using the template supplied by the Department as Attachment 7 of this Appendix.

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

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

g. The first level grievance review committee must complete its review of the grievance and make a decision as expeditiously as the member’s health condition requires, but no more than 30 days from receipt of the grievance, which may be extended by up to 14 days at the request of the member.

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

i. The BH-MCO must send a written notice of the first level grievance decision, using the template supplied by the Department as Attachment 8 of this Appendix, to the member, member’s representative, if the member has designated one, service provider and prescribing provider, if applicable, within five business days from the first level grievance review committee’s decision.
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j. The member may file a request for a fair hearing within 30 days from the date on the written notice of the BH-MCO’s first level grievance decision.

2. Second Level Grievance Process

a. The member or the member’s representative, which may include the member’s provider, with proof of the member’s written authorization for the representative to be involved and/or take action on the member’s behalf, may file a request for a second level grievance within 45 days from the date the member receives the written notice of the BH-MCO’s first level grievance decision.

b. Upon receipt of the second level grievance, the BH-MCO must send the member and the member’s representative, if the member has designated one, an acknowledgment letter using the template supplied by the Department as Attachment 9 of this Appendix.

c. A member who files a second level grievance to dispute a decision to discontinue, reduce, or change a service that the member has been receiving must continue to receive the disputed service at the previously authorized level pending resolution of the second level grievance, if the second level grievance is hand delivered or post-marked within ten days from the date on the written notice of the BH-MCO’s first level grievance decision.

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

e. At least one third of the committee members must be enrolled in the BH- MCO

1) If the grievance involves a service for an adult, the consumer member(s) on the second level grievance review committee must be an adult who has received or is currently receiving services (mental health services if the issue is a mental health grievance; substance abuse services if the issue is a substance abuse grievance) through the BH-MCO.

2) If the grievance involves a service for a child or adolescent, the consumer member(s) on the second level grievance review committee must be a parent or guardian of a child or adolescent who has received or is currently receiving services (mental health services if the issue is a mental health grievance; substance abuse services if the issue is a substance abuse grievance) through the BH-MCO.

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

g. The member must be provided the opportunity to appear before the second level grievance review committee. The BH-MCO must be flexible when scheduling the second level review to facilitate the member’s attendance. The committee meeting must be conducted at a time and place convenient to the member. The member
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must be given at least 15 days advance written notice of the review date. If the member cannot appear in person at the second level review, an opportunity to communicate with the second level grievance review committee by telephone or videoconference must be provided. The member may elect not to attend the second level grievance meeting but the meeting must be conducted with the same protocols as if the member was present. The member and/or anyone the member chooses may present the member’s position to the committee.

h. The BH-MCO will provide the member with a listing of advocate organizations available to assist the member.

i. The second level grievance review committee must complete the second level grievance review and reach a decision within 30 days from receipt of the member’s second level grievance.

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

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

l. The BH-MCO must send a written notice of its decision, using the template supplied by the Department as Attachment 10a of this Appendix, to the member, member’s representative, if the member has designated one, service provider and prescribing provider, if applicable, within five business days of the second level grievance review committee’s decision.

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

3. External Review of the Second Level Grievance Decision:

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

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

c. A member who files a request for external grievance review to dispute a decision to discontinue, reduce or change a service that the member has been receiving must continue to receive the disputed service at the previously authorized level pending resolution of the external grievance review. If the request for external grievance review is hand delivered or post-marked within ten days from the date on the written notice of the BH-MCO’s second level grievance decision.
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d. Within five business days of receipt of the request for an external grievance review, the BH-MCO must notify the member, the member’s representative, if the member has designated one, or the health care provider, and the Department of Health that the request for an external grievance review has been filed.
e. The external grievance review must be conducted by an independent utilization review entity not directly affiliated with the BH-MCO.
f. Within two business days from receipt of the request for external grievance review, the Department of Health will randomly assign a certified utilization review entity (CRE) to conduct the review. The BH-MCO and assigned CRE will be notified of this decision.
g. If the Department of Health fails to select a CRE within two business days of receipt of a request for an external grievance review, the BH-MCO may designate a CRE to conduct a review from the list of CREs approved by the Department of Health. The BH-MCO may not select a CRE that has a current contract or is negotiating a contract with the BH-MCO or its affiliates or is otherwise affiliated with the BH-MCO or its affiliates.
h. The BH-MCO must forward all documentation regarding the decision, including all supporting information, a summary of applicable issues, and the basis and clinical rationale for the decision, to the CRE conducting the external grievance review. This transmission of information must take place within 15 days from receipt of the request for an external grievance review.
i. The BH-MCO must inform the member that within 15 days from receipt of the request for an external grievance review by the BH-MCO, the member or the member’s representative, which may include the member’s provider, with proof of the member’s written authorization, may supply additional information to the CRE conducting the external review for consideration. Copies must also be provided at the same time to the BH-MCO so that the BH-MCO has an opportunity to consider the additional information.
j. Within 60 days from the filing of the request for the external grievance review, the CRE conducting the external grievance review must issue a written decision to the BH-MCO, the member, the member’s representative and the provider (if the provider filed the grievance with the member’s consent), that includes the basis and clinical rationale for the decision. The standard of review must be whether the service was medically necessary and appropriate under the terms of the BH-MCO contract.
k. The external grievance decision shall be subject to appeal to a court of competent jurisdiction within 60 days from the date the member receives notice of the external grievance decision.

4. Expedited Grievance Process

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

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

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

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

e. A member who files a request for expedited review of a grievance to dispute a
decision to discontinue, reduce or change a service that the member has been
receiving must continue to receive the disputed service at the previously
authorized level pending resolution of the grievance, if the request for expedited
review of a grievance is hand delivered or post-marked within ten days from the
date on the written notice of decision.

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

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

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

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

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

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

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

D. Department’s Fair Hearing Requirements

1. Department’s Fair Hearing Process

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

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

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

ii) the denial of a requested service on the basis that the service is not a covered benefit;

iii) the denial or issuance of a limited authorization of a requested service, including the type or level of service;

iv) the reduction, suspension, or termination or a previously authorized service;

v) the denial of a requested service but approval of an alternative service;

vi) the failure to provide services in a timely manner, as defined by the Department;

vii) the failure of the BH-MCO to decide a complaint or grievance within the timeframes specified in this Appendix;

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

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

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

Department of Public Welfare  
Office of Mental Health and Substance Abuse Services  
Division of Grievance and Appeals  
Beechmont Building # 32
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P.O. Box 2675
Harrisburg, PA 17105-2675

A member who files a request for a fair hearing to dispute a decision to discontinue, reduce or change a service that the member has been receiving must continue to receive the disputed service at the previously authorized level pending resolution of the fair hearing, if the request for a fair hearing is hand delivered or post-marked within ten days from the date on the written notice of decision.

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

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

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

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

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

2. Expedited Fair Hearing Process

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

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

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

d. A member who files a request for an expedited fair hearing to dispute a decision
to discontinue, reduce or change a service that the member has been receiving
must continue to receive the disputed service at the previously authorized level
pending resolution of the fair hearing, if the request for an expedited fair hearing
is hand delivered or post-marked within ten days from the date on the written
notice of decision.

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

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

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

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

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

E. Provision of and Payment for Services Following Decision

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

2. If the BH-MCO or the Bureau of Hearings and Appeals reverses a decision to deny
authorization of services, and the member received the disputed services during the
complaint, grievance or fair hearing process, the BH-MCO must pay for those services.
ATTACHMENT 1a

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

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

Member Name
Address
City, State Zip

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

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

Dear [Member Name]:

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

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

1)  **File a Complaint**

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

To file a complaint:

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

[MCO Address for filing complaint]

2)  **Request a Fair Hearing**
You may ask for a fair hearing from the Department of Public Welfare. Your request for a fair hearing must be in writing and must be postmarked within 30 days from the date on this notice. Your request should include the following information:

- Your (the member’s) name, social security number, and date of birth;
- A telephone number where you can be reached during the day;
- Whether you want to have a hearing in person or by telephone;
- The reason(s) you are asking for a fair hearing, or a copy of this notice.

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

Department of Public Welfare  
Office of Mental Health and Substance Abuse Services  
Division of Grievances and Appeals  
Beechmont Building #32  
P.O. Box 2675  
Harrisburg, PA 17105-2675

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

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

Sincerely,

[MCO Name]

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

[MCO, the following statement must appear in English, Russian, Cambodian, Vietnamese, Spanish, Chinese, and any other language as required by the contract:]

The information in this notice is about the [complaint][grievance] you filed with [MCO Name]. It is available in other languages and formats by calling [MCO Name] at [#].
ATTACHMENT 1b
Notice for Payment Denial Because the Service Was Provided Without Authorization by a Provider Not Enrolled in the Pennsylvania Medical Assistance Program

THIS IS NOT A BILL

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

Member Name
Address
City, State Zip

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

Dear [Member Name]:

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

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

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

1) File a Complaint

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

To file a complaint:

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

[MCO Address for filing complaint]

2) Request a Fair Hearing

You may ask for a fair hearing from the Department of Public Welfare. Your request for a fair hearing must be in writing and must be postmarked within 30 days from the date on this notice. Your request should include the following information:
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- Your (the member’s) name, social security number, and date of birth;
- A telephone number where you can be reached during the day;
- Whether you want to have a hearing in person or by telephone;
- The reason(s) you are asking for a fair hearing, or a copy of this notice.

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

Department of Public Welfare  
Office of Mental Health & Substance Abuse Services  
Division of Grievance & Appeals  
Beechmont Bldg. #32, Second floor  
P.O. Box 2675  
Harrisburg, Pennsylvania, 17105-2675

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

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

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

[Address for records information]

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

Sincerely,

[MCO Name]

cc: [Provider]

[MCO, the following statement must appear in English, Russian, Cambodian, Vietnamese, Spanish, Chinese, and any other language as required by the contract:]  

The information in this notice is about payment for medical services. It is available in other languages and formats by calling [MCO Name] at [#].
ATTACHMENT 1c
Notice for Payment Denial Because the Service Was Not a Covered Service for the Member

THIS IS NOT A BILL

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

Member Name
Address
City, State Zip

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

Dear [Member Name]:

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

________ It is not covered under the Medical Assistance Program; OR

________ It is not part of your benefit package; OR

________ [Provider’s name] is not in [MCO Name’s] provider network and provided this service without [MCO Name’s] authorization.

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

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

1) File a Complaint

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

To file a complaint:

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

  [MCO Address for filing complaint]

2) Request a Fair Hearing

You may ask for a fair hearing from the Department of Public Welfare. Your request for a fair hearing must be in writing and must be postmarked within 30 days from the date on this notice. Your request should include the following information:

- Your (the member’s) name, social security number, and date of birth;
- A telephone number where you can be reached during the day;
- Whether you want to have a hearing in person or by telephone;
- The reason(s) you are asking for a fair hearing, or a copy of this notice.

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

  Department of Public Welfare  
  Office of Mental Health & Substance Abuse Services  
  Division of Grievance & Appeals  
  Beechmont Bldg. #32, Second floor  
  P.O. Box 2675  
  Harrisburg, Pennsylvania, 17105-2675

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

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

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

  [Address for records information]

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

[MCO Name]

cc: [Provider]

[MCO, the following statement must appear in English, Russian, Cambodian, Vietnamese, Spanish, Chinese, and any other language as required by the contract:]

The information in this notice is about payment for medical services. It is available in other languages and formats by calling [MCO Name] at [#].
ATTACHMENT 1d

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

THIS IS NOT A BILL

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

Member Name
Address
City, State Zip

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

Dear [Member Name]:

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

The service you received was not medically necessary because:

[Explain in detail every reason for denial; in addition to explanation for decision, include specific references to approved criteria, rules or protocols on which decision is based; if denied because of insufficient information, identify all additional information needed to render decision].

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

Sincerely,

[MCO Name]

cc: [Provider]

[MCO, the following statement must appear in English, Russian, Cambodian, Vietnamese, Spanish, Chinese, and any other language as required by the contract:]

The information in this notice is about payment for medical services. It is available in other languages and formats by calling [MCO Name] at [#].

Commonwealth of Pennsylvania
HealthChoices Behavioral Health
ATTACHMENT 2a

First Level Complaint Acknowledgment Letter

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

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

[Date Letter Mailed]

Member Name
Address
City, State Zip

Member ID: ********

Subject: Your Complaint About [Complaint Issue].

Dear [Member Name]:

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

The First Level Complaint Process

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

At any time during the complaint process, you can have someone you know represent you or act on your behalf. This person will be “your representative.” If you decide to have someone represent you or act for you, tell [MCO Name], in writing, the name of that person and how we can reach him or her.
You or your representative may ask [MCO Name] to see all information relevant to your complaint. You may also send information that you have about your complaint to [MCO Name]:

[MCO Address]

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

Pennsylvania Department of Health
Bureau of Managed Care
Room 912 Health & Welfare Building
625 Forster Street
Harrisburg, PA  17108
Telephone: 1-888-466-2787; Fax: 1-717-705-0947
AT&T Relay: 1-800-654-5984   (for persons with hearing impairments)

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

To get help with your complaint

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

Sincerely,

[MCO Name]

cc: [Member Representative, if designated]

[MCO, the following statement must appear in English, Russian, Cambodian, Vietnamese, Spanish, Chinese, and any other language as required by the contract:]

The information in this letter is about the complaint you filed with [MCO Name]. It is available in other languages and formats by calling [MCO Name] at [#].
ATTACHMENT 2b
First Level Complaint Acknowledgment Letter

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

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

[Date Letter Mailed]

Member Name
Address
City, State Zip

Member ID: ********

Subject: Your Complaint About [Complaint Issue].

Dear [Member Name]:

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

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

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

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

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

_____ you disagree with the decision to deny payment to your provider because the service you received is not a covered benefit.
The First Level Complaint Process

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

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

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

[MCO Address]

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

Pennsylvania Department of Health
Bureau of Managed Care
Room 912, Health & Welfare Building
625 Forster Street
Harrisburg, PA  17108
Telephone:  1-888-466-2787; Fax:  1-717-705-0947
AT&T Relay: 1-800-654-5984  (for persons with hearing impairments)

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

To ask for an early decision

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

- Call [MCO Name] at [#];
- Your doctor or psychologist must fax a letter to [MCO fax #] explaining why taking [30, unless the MCO will be using a shorter time frame to decide first level complaints] days to decide your complaint could harm your health.
[MCO Name] will notify you of the decision within 48 hours from when we receive your doctor’s or psychologist’s letter, or within 3 business days from when we receive your request, whichever is sooner.

The Fair Hearing Process

At any point before [MCO Name] makes its decision, you may ask for a fair hearing from the Department of Public Welfare. Your request for a fair hearing must be in writing and must be postmarked within 30 days from the date on this letter. Your request should include the following information:

- Your (the member’s) name, social security number, and date of birth;
- A telephone number where you can be reached during the day;
- Whether you want to have a hearing in person or by telephone;
- The reason(s) you are asking for a fair hearing, or a copy of this letter;
- A copy of the original denial notice, if available. [MCO: Include this last item only for complaints challenging a denial because service is not a covered benefit or because the service was provided without authorization by a non-MA provider.]

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

Department of Public Welfare  
Office of Mental Health and Substance Abuse Services  
Division of Grievances and Appeals  
Beechmont Building # 32  
P.O. Box 2675  
Harrisburg, PA 17105-2675

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

To ask for an early decision

If your doctor or psychologist believes that the usual time frame for deciding a fair hearing could harm your health, you may ask that the fair hearing take place more quickly. To do this:

- Call the Department at 1-877-356-5355, or fax your request to 1-717-772-7827;
- Your doctor or psychologist must fax a letter to 1-717-772-7827 explaining why taking the usual amount of time to decide your request for a fair hearing could harm your health. If your doctor or psychologist does not send a letter, your doctor or psychologist must testify at the fair hearing to explain why taking the usual amount of time to decide your request for a fair hearing could harm your health.
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The Department will schedule a telephone hearing and notify you of its decision within 3 business days from when it receives your request.

To get help with your complaint or request for fair hearing

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

Sincerely,

[MCO Name]

cc: [Member Representative, if designated]

[MCO, the following statement must appear in English, Russian, Cambodian, Vietnamese, Spanish, Chinese, and any other language as required by the contract:]

The information in this letter is about the complaint you made with [MCO Name]. It is available in other languages and formats by calling [MCO Name] at [#].
MCO, Use this template for all complaints EXCEPT for those involving the following:

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

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

Member Name
Address
City, State Zip

Member ID: ********

Subject: Decision About Your Complaint

Dear [Member Name]:

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

Based on a review of all information provided, the first level complaint review committee has decided that [state decision in detail].

The reasons for this decision are:

[Explain in detail every reason for decision; in addition to explanation for decision, include specific references to approved criteria, rules or protocols on which decision is based; if unable to make a decision because of insufficient information, identify all additional information needed to render decision].
IF YOU DO NOT AGREE WITH THIS DECISION, YOU MAY DO ONE OR BOTH OF THE FOLLOWING:

1) Request Guidelines

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

[MCO Address]

2) File a Second Level Complaint

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

To file a second level complaint:

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

[MCO Address for filing complaint]

To get help with a complaint

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

Sincerely,

[MCO Name]

cc: [Member Representative, if designated]

[MCO, the following statement must appear in English, Russian, Cambodian, Vietnamese, Spanish, Chinese, and any other language as required by the contract:]

The information in this notice is about the complaint you filed with [MCO Name]. It is available in other languages and formats by calling [MCO Name] at [#].

ATTACHMENT 3b
First Level Complaint Decision Notice

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

Member Name
Address
City, State Zip

Member ID: *******

Subject: Decision About Your Complaint

Dear [Member Name]:

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

Based on a review of all information provided, the first level complaint review committee has decided that [state decision in detail].

The reasons for this decision are:

[Explain in detail every reason for decision; in addition to explanation for decision, include specific references to approved criteria, rules or protocols on which decision is based; if unable to make a decision because of insufficient information, identify all additional information needed to render decision].

[MCO: Include the following paragraph only if the complaint challenges a denial because the service is not a covered benefit.]
To continue getting services

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

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

1) Request Guidelines

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

[MCO Address]

2) File a Second Level Complaint

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

To file a second level complaint:

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

[MCO Address for filing complaint]

To ask for an early decision

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

- Call [MCO Name] at [#];
- Your doctor or psychologist must fax a letter to [MCO fax #] explaining why taking [30 unless the MCO will be using a shorter time frame to decide second level complaints] days to decide your complaint could harm your health.
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[MCO Name] will notify you of the decision within 48 hours from when we receive your doctor’s or psychologist’s letter or within 3 business days from when we receive your request, whichever is sooner.

3) Request a Fair Hearing

You may ask for a fair hearing from the Department of Public Welfare. Your request for a fair hearing must be in writing and must be postmarked **within 30 days from the date on this notice**. Your request should include the following information:

- Your (the member’s) name, social security number, and date of birth;
- A telephone number where you can be reached during the day;
- Whether you want to have a hearing in person or by telephone;
- The reason(s) you are asking for a fair hearing, or a copy of this notice;
- A copy of the original denial notice, if available.  **[MCO: Include this last item only for complaints challenging a denial because service is not a covered benefit or because the service was provided without authorization by a non-MA provider.]**

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

Department of Public Welfare  
Office of Mental Health and Substance Abuse Services  
Division of Grievances and Appeals  
Beechmont Building #32  
P.O. Box 2675  
Harrisburg, PA 17105-2675

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

**To ask for an early decision**

If your doctor or psychologist believes that the usual time frame for deciding a fair hearing could harm your health, you may ask that the fair hearing take place more quickly. To do this:

- Call the Department at 1-877-356-5355, or fax your request to 1-717-772-7827;
- Your doctor or psychologist must fax a letter to 1-717-772-7827 explaining why taking the usual amount of time to decide your request for a fair hearing could harm your health. If your doctor or psychologist does not send a letter, your doctor or psychologist must testify at the fair hearing to explain why taking the usual amount of time to decide your request for a fair hearing could harm your health.
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The Department will schedule a telephone hearing and notify you of its decision within 3 business days from when it receives your request.

To get help with a complaint or request for fair hearing

- If you need help filing a second level complaint, call us at [MCO Phone #] and [MCO Name] will assign someone who has not been involved in the complaint issue to help you.

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

Sincerely,

[MCO Name]

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

[MCO, the following statement must appear in English, Russian, Cambodian, Vietnamese, Spanish, Chinese, and any other language as required by the contract:]

The information in this notice is about the complaint you filed with [MCO Name]. It is available in other languages and formats by calling [MCO Name] at [#].
ATTACHMENT 4

Second Level Complaint Acknowledgment Letter

[Date Letter Mailed]

Member Name
Address
City, State Zip

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

Subject: Your Second Level Complaint About [Complaint Issue]

Dear [Member Name]:

[MCO Name] received your second level complaint about [identify subject of complaint] on [date of receipt].

The Second Level Complaint Process

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

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

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

[MCO Address]

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

To get help with your complaint

Commonwealth of Pennsylvania
HealthChoices Behavioral Health
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- If you need help with your complaint, call us at [MCO Phone #] and [MCO Name] will assign someone who has not been involved in the complaint issue to help you.
- If you have any other questions, you may call us at [MCO Phone #], the legal aid office at 1-800-322-7572 (www.palegalservices.org), or the Pennsylvania Health Law Project at 1-800-274-3258 (www.phlp.org).

Sincerely,

[MCO Name]

cc: [Member Representative, if designated]

[MCO, the following statement must appear in English, Russian, Cambodian, Vietnamese, Spanish, Chinese, and any other language as required by the contract:]

The information in this letter is about the complaint you filed with [MCO Name]. It is available in other languages and formats by calling [MCO Name] at [#].
ATTACHMENT 5a

Second Level Complaint Decision Notice

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

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

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

Member Name
Address
City, State Zip

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

Subject: Decision About Your Second Level Complaint

Dear [Member Name]:

[MCO Name] has reviewed your second level complaint about [issue], received on [date].

Based on a review of all information provided, the second level complaint review committee has decided that [state decision in detail].

The reasons for this decision are:

[Explain in detail every reason for decision; in addition to explanation for decision, include specific references to approved criteria, rules or protocols on which decision is based; if unable to make a decision because of insufficient information, identify all additional information needed to render decision].

IF YOU DO NOT AGREE WITH THIS DECISION, YOU MAY DO ONE OR BOTH OF THE FOLLOWING:
1) **Request Guidelines**

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

[MCO Address]

2) **Request an External Review**

You may ask for an “external review” of the second level complaint decision from the Pennsylvania Department of Health or the Pennsylvania Insurance Department within **15 days from the date you get this notice**.

Send your request to one of the following addresses:

Pennsylvania Department of Health  
Bureau of Managed Care  
Room 912 Health & Welfare Building  
625 Forster Street  
Harrisburg, PA 17108  
Telephone: 1-888-466-2787  
Fax: 1-717-705-0947  
AT&T Relay: 1-800-654-5984 (for persons with hearing impairments)

Pennsylvania Insurance Department  
Bureau of Customer Service  
1321 Strawberry Square  
Harrisburg, PA 17120  
Telephone: 1-877-881-6388

Your request for external review by either Department must include the following information:

- Your (the member’s) name, address, and daytime telephone number;
- Your (the member’s) [MCO Name] identification number;
- [MCO Name]’s name;
- A brief description of the issue;
- A copy of this notice.

If you send your request for external review to the wrong Department, that Department will send it to the other Department.

**To get help with a request for external review**

Commonwealth of Pennsylvania  
HealthChoices Behavioral Health
- If you need help filing a request for an external review, call us at [MCO Phone #] and [MCO Name] will assign someone who has not been involved in the complaint issue to help you.
- If you have any other questions, you may call us at [MCO Phone #], the legal aid office at 1-800-322-7572 (www.palegalservices.org), or the Pennsylvania Health Law Project at 1-800-274-3258 (www.phlp.org).

Sincerely,

[MCO Name]

cc: [Member Representative, if designated]

[MCO, the following statement must appear in English, Russian, Cambodian, Vietnamese, Spanish, Chinese, and any other language as required by the contract:]

The information in this notice is about the complaint you filed with [MCO Name]. It is available in other languages and formats by calling [MCO Name] at [#].
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ATTACHMENT 5b

Second Level Complaint Decision Notice

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

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

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

Member Name
Address
City, State Zip
Member ID: *********

Subject: Decision About Your Second Level Complaint

Dear [Member Name]:

[MCO Name] has reviewed your second level complaint about [issue], received on [date].

Based on a review of all information provided, the second level complaint review committee has decided that [state decision in detail].

The reasons for this decision are:

[Explain in detail every reason for decision; in addition to explanation for decision, include specific references to approved criteria, rules or protocols on which decision is based; if unable to make a decision because of insufficient information, identify all additional information needed to render decision].

[MCO: Include the following paragraph only if the complaint challenges a denial because the service is not a covered benefit.]
To continue getting services

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

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

1) Request Guidelines

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

[MCO Address]

2) Request an External Review

You may ask for an “external review” of the second level complaint decision from the Pennsylvania Department of Health or the Pennsylvania Insurance Department within 15 days from the date you get this notice.

Send your request to one of the following addresses:

Pennsylvania Department of Health
Bureau of Managed Care
Room 912 Health & Welfare Building
625 Forster Street
Harrisburg, PA 17108
Telephone: 1-888-466-2787
Fax: 1-717-705-0947
AT&T Relay: 1-800-654-5984 (for persons with hearing impairments)

Pennsylvania Insurance Department
Bureau of Customer Service
1321 Strawberry Square
Harrisburg, PA 17120
Telephone: 1-877-881-6388
Your request for external review by either Department must include the following information:

- Your (the member’s) name, address, and daytime telephone number;
- Your (the member’s) [MCO Name] identification number;
- [MCO Name]’s name;
- A brief description of the issue;
- A copy of this notice.

If you send your request for external review to the wrong Department, that Department will send it to the other Department.

3) **Request a Fair Hearing**

You may ask for a fair hearing from the Department of Public Welfare. Your request for a fair hearing must be in writing and must be postmarked **within 30 days from the date on this notice**. Your request should include the following information:

- Your (the member’s) name, social security number, and date of birth;
- A telephone number where you can be reached during the day;
- Whether you want to have a hearing in person or by telephone;
- The reason(s) you are asking for a fair hearing, or a copy of this notice;
- A copy of the original denial notice, if available. **[MCO: Include this last item only for complaints challenging a denial because service is not a covered benefit or because the service was provided without authorization by a non-MA provider.]**

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

Department of Public Welfare  
Office of Mental Health and Substance Abuse Services  
Division of Grievances and Appeals  
Beechmont Building #32  
P.O. Box 2675  
Harrisburg, PA 17105-2675

The Department will issue a decision within 90 days from when it receives your request.

**To ask for an early decision**

If your doctor or psychologist believes that the usual time frame for deciding a fair hearing could harm your health, you may ask that the fair hearing take place more quickly. To do this:

- Call the Department at 1-877-356-5355, or fax your request to 1-717-772-7827;
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- Your doctor or psychologist must fax a letter to 1-717-772-7827 explaining why taking the usual amount of time to decide your request for a fair hearing could harm your health. If your doctor or psychologist does not send a letter, your doctor or psychologist must testify at the fair hearing to explain why taking the usual amount of time to decide your request for a fair hearing could harm your health.

The Department will schedule a telephone hearing and notify you of its decision within 3 business days from when it receives your request.

To get help with a request for external review or fair hearing

- If you need help filing a request for an external review, call us at [MCO Phone #] and [MCO Name] will assign someone who has not been involved in the complaint issue to help you.
- If you have any other questions, or need help filing a request for a fair hearing, you may call us at [MCO Phone #], the legal aid office at 1-800-322-7572 (www.palegalservices.org), or the Pennsylvania Health Law Project at 1-800-274-3258 (www.phlp.org).

Sincerely,

[MCO Name]

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

[MCO, the following statement must appear in English, Russian, Cambodian, Vietnamese, Spanish, Chinese, and any other language as required by the contract:]

The information in this notice is about the complaint you filed with [MCO Name]. It is available in other languages and formats by calling [MCO Name] at [#].
ATTACHMENT 5c

Notice of Failure to Receive Provider Certification for an Expedited Complaint

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

Member Name
Address
City, State Zip

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

Subject: Request for “Expedited” Complaint

Dear [Member Name]:

[MCO Name] received your complaint about [identify subject of complaint], on [date] and your request to have the complaint decided more quickly than the usual [30, unless the MCO will be using a shorter time frame to decide first level complaints] - day time frame. As we told you when you filed your complaint, in order for your complaint to be decided more quickly, your [doctor][psychologist] needed to send us a written statement that taking the usual amount of time to decide the complaint could harm your health. [MCO Name] also asked your [doctor][psychologist] for this statement.

We have not received your [doctor’s][psychologist’s] statement, so your complaint will be decided within the usual time frame of [30, unless the MCO will be using a shorter time frame to decide first level complaints] days from when we first got your complaint.

The First Level Complaint Process

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

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

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

Commonwealth of Pennsylvania
HealthChoices Behavioral Health
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[MCO Address]

[MCO: Include the following paragraphs on the complaint review, Fair Hearings, and Expedited Fair Hearings only if the complaint is about one of the following: Failure to provide services in a timely manner; failure to decide a complaint or grievance within 30 days; denial of service as not a covered benefit (whether prior authorization or payment denial); or denial because the service was provided without authorization by a non-MA provider.]

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

The Fair Hearing Process

You may also ask for a fair hearing from the Department of Public Welfare. Your request for a fair hearing must be in writing and must be postmarked within 30 days from the date on this notice. Your request should include the following information:

- Your (the member’s) name, social security number, and date of birth;
- A telephone number where you can be reached during the day;
- Whether you want to have a hearing in person or by telephone;
- The reason(s) you are asking for a fair hearing, or a copy of this notice;
- A copy of the original denial notice, if available [MCO: Include this last item for complaints challenging a denial because service is not a covered benefit or because the service was provided without authorization by a non-MA provider.]

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

Department of Public Welfare
Office of Mental Health and Substance Abuse Services
Division of Grievances and Appeals
Beechmont Building #32
P.O. Box 2675
Harrisburg, PA 17105-2675

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

To ask for an early decision

If your doctor or psychologist believes that the usual time frame for deciding a fair hearing could harm your health, you may ask that the fair hearing take place more quickly. To do this:
Call the Department at 1-877-356-5355, or fax your request to 1-717-772-7827;

Your doctor or psychologist must fax a letter to 1-717-772-7827 explaining why taking the usual amount of time to decide your request for a fair hearing could harm your health. If your doctor or psychologist does not send a letter, your doctor or psychologist must testify at the fair hearing to explain why taking the usual amount of time to decide your request for a fair hearing could harm your health.

The Department will schedule a telephone hearing and notify you of its decision within 3 business days from when it receives your request.

To get help with your complaint or request for fair hearing

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

Sincerely,

[MCO Name]

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

[MCO, the following statement must appear in English, Russian, Cambodian, Vietnamese, Spanish, Chinese, and any other language as required by the contract:]

The information in this notice is about the complaint you filed with [MCO Name]. It is available in other languages and formats by calling [MCO Name] at [#].

ATTACHMENT 6

Expedited Complaint Decision Notice

[Date Notice Mailed (no more than 2 days after the date of the decision)]

Member Name
Address
City, State Zip

Member ID: **********
Subject: “Expedited” Decision About Your Complaint

Dear [Member Name]:

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

Based on a review of all information provided, the review committee has decided that [state decision in detail].

The reasons for this decision are:

[Explain in detail every reason for decision; in addition to explanation for decision, include specific references to approved criteria, rules or protocols on which decision is based; if unable to make a decision because of insufficient information, identify all additional information needed to render decision].

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

To continue getting services

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

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

1) Request Guidelines

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

[MCO Address]

2) Request an Expedited External Review

You may ask for an “expedited external review” of the complaint decision from the Pennsylvania Department of Health. You may ask for the external review within two business days from the date you get this notice. A decision will be issued within five business days from when we receive your request.
To file an expedited external review:

- Call [MCO Name] at [MCO Phone #]; or
- Fax [MCO Name] at [MCO Fax #]; or
- Send your request to [MCO Name] at the following address:

  [MCO Address for requesting external review]

3) **Request a Fair Hearing**

   **To ask for an early decision**

   You may ask for a fair hearing from the Department of Public Welfare. If your doctor or psychologist still believes that the usual time frame for deciding a fair hearing (between 60 and 90 days) could harm your health, you may ask that the fair hearing take place more quickly. To do this:

   - Call the Department at 1-877-356-5355, or fax your request to 1-717-772-7827;
   - Your doctor or psychologist must fax a letter to 1-717-772-7827 explaining why taking the usual amount of time to decide your request for a fair hearing could harm your health. If your doctor or psychologist does not send a letter, your doctor or psychologist must testify at the fair hearing to explain why taking the usual amount of time to decide your request for a fair hearing could harm your health.

   The Department will schedule a telephone hearing and notify you of its decision within 3 business days from when it receives your request.

Even if you no longer need an early decision, you may ask for a fair hearing from the Department of Public Welfare. Your request for a fair hearing must be in writing and must be postmarked **within 30 days from the date on this notice**.

Your request should include the following information:

- Your (the member’s) name, social security number, and date of birth;
- A telephone number where you can be reached during the day;
- Whether you want to have a hearing in person or by telephone;
- The reason(s) you are asking for a fair hearing, or a copy of this notice;
- A copy of the original denial notice, if available. **[MCO: Include this last item only for complaints challenging a denial because the service is not a covered benefit.]**

Your request for a fair hearing must be sent to the following address:
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Department of Public Welfare
Office of Mental Health and Substance Abuse Services
Division of Grievances and Appeals
Beechmont Building #32
P.O. Box 2675
Harrisburg, PA 17105-2675

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

To get help with a request for external review or fair hearing

- If you need help filing a request for an external review, call us at [MCO Phone #] and [MCO Name] will assign someone who has not been involved in the complaint issue to help you.
- If you have any other questions, or need help filing a request for a fair hearing, you may call us at [MCO Phone #], the legal aid office at 1-800-322-7572 (www.palegalservices.org), or the Pennsylvania Health Law Project at 1-800-274-3258 (www.phlp.org).

Sincerely,

[MCO Name]

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

[MCO, the following statement must appear in English, Russian, Cambodian, Vietnamese, Spanish, Chinese, and any other language as required by the contract;]

The information in this notice is about the complaint you filed with [MCO Name]. It is available in other languages and formats by calling [MCO Name] at [#].
ATTACHMENT 7

First Level Grievance Acknowledgment Letter

[Date Letter Mailed]

Member Name
Address
City, State Zip

Member ID: ********

Subject: Your Grievance About [Grievance Issue]

Dear [Member Name]:

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

The First Level Grievance Process

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

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

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

[MCO Address]

You and your representative may appear at the grievance review in person, by phone or by videoconference, if available, by calling us at [MCO Phone #] within ten days from the date on this letter. You may also bring a family member, friend, lawyer or other person to help you. If you decide that you do not want to attend, that will not affect the decision of the committee.

If you think your issue is really a complaint and should not be treated as a grievance, you may call or write to the Pennsylvania Department of Health:
If you need more information on what a complaint is, you can read your member handbook or call us at [MCO Phone #].

**To get help with your grievance**

- If you need help with your grievance, call us at [MCO Phone #] and [MCO Name] will assign someone who has not been involved in the grievance issue to help you.
- If you have any other questions, you may call us at [MCO Phone #], the legal aid office at 1-800-322-7572 (www.palegalservices.org), or the Pennsylvania Health Law Project at 1-800-274-3258 (www.phlp.org).

Sincerely,

[MCO Name]

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

[MCO, the following statement must appear in English, Russian, Cambodian, Vietnamese, Spanish, Chinese, and any other language as required by the contract:]

The information in this letter is about the grievance you filed with [MCO Name]. It is available in other languages and formats by calling [MCO Name] at [#].
ATTACHMENT 8

First Level Grievance Decision Notice

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

Member Name
Address
City, State Zip

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

Subject: Decision About Your Grievance

Dear [Member Name]:

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

Based on a review of all information provided, the first level grievance review committee has decided that [state decision in detail].

The reasons for this decision are:

[Explain in detail every reason for decision; in addition to explanation for decision, include specific references to approved criteria, rules or protocols on which decision is based; if denied because of insufficient information, identify all additional information needed to render decision].

To continue getting services

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

IF YOU DO NOT AGREE WITH THIS DECISION, YOU MAY DO ONE OR ALL OF THE FOLLOWING:
1) Request Criteria

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

[MCO Address]

2) File a Second Level Grievance

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

To file a second level grievance:

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

[MCO Address for filing grievance]

**To ask for an early decision**

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

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

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

3) Request a Fair Hearing

You may ask for a fair hearing from the Department of Public Welfare. Your request for a fair hearing must be in writing and must be postmarked **within 30 days from the date on this notice**. Your request should include the following information:

- Your (the member’s) name, social security number, and date of birth;
- A telephone number where you can be reached during the day;
- Whether you want to have a hearing in person or by telephone;
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- The reason(s) you are asking for a fair hearing, or a copy of this notice;
- A copy of the original denial notice, if available.

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

Department of Public Welfare
Office of Mental Health and Substance Abuse Services
Division of Grievances and Appeals
Beechmont Building #32
P.O. Box 2675
Harrisburg, PA 17105-2675

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

**To ask for an early decision**

If your doctor or psychologist believes that the usual time frame for deciding a fair hearing could harm your health, you may ask that the fair hearing take place more quickly. To do this:

- Call the Department at 1-877-356-5355, or fax your request to 1-717-772-7827;
- Your doctor or psychologist must fax a letter to 1-717-772-7827 explaining why taking the usual amount of time to decide your request for a fair hearing could harm your health. If your doctor or psychologist does not send a letter, your doctor or psychologist must testify at the fair hearing to explain why taking the usual amount of time to decide your request for a fair hearing could harm your health.

The Department will schedule a telephone hearing and notify you of its decision within three business days from when it receives your request.

**To get help with a grievance or request for fair hearing**

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

Sincerely,
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[MCO Name]

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

[MCO, the following statement must appear in English, Russian, Cambodian, Vietnamese, Spanish, Chinese, and any other language as required by the contract:]

The information in this notice is about the grievance you filed with [MCO Name]. It is available in other languages and formats by calling [MCO Name] at [#].
ATTACHMENT 9

Second Level Grievance Acknowledgment Letter

[Date Letter Mailed]

Member Name  
Address  
City, State Zip

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

Subject:  Your Second Level Grievance About [Grievance Issue]

Dear [Member Name]:

[MCO Name] received your second level grievance about [identify subject of grievance] on [date of receipt].

The Second Level Grievance Process

A committee of three or more people, which includes a licensed doctor or licensed psychologist, and at least one [MCO Name] member, will review your grievance. This is called the “grievance review.” No one on the committee will have been involved in the grievance issue. A decision will be made by [date that is no more than 30 days from receipt of the grievance]. A letter will be mailed to you within five business days after the decision is made, telling you each reason for the decision.

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

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

[MCO Address]

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

- If you need help with your grievance, call us at [MCO Phone #] and [MCO Name] will assign someone who has not been involved in the grievance issue to help you.
- If you have any other questions, you may call us at [MCO Phone #], the legal aid office at 1-800-322-7572 (www.palegalservices.org), or the Pennsylvania Health Law Project at 1-800-274-3258 (www.phlp.org).

Sincerely,

[MCO Name]

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

[MCO, the following statement must appear in English, Russian, Cambodian, Vietnamese, Spanish, Chinese, and any other language as required by the contract:]

The information in this letter is about the grievance you filed with [MCO Name]. It is available in other languages and formats by calling [MCO Name] at [#].
Second Level Grievance Decision Notice

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

Member Name
Address
City, State Zip

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

Subject: Decision About Your Second Level Grievance

Dear [Member Name]:

[MCO Name] has reviewed your second level grievance about [issue], received on [date].

Based on a review of all information provided, the second level grievance review committee has decided that [state decision in detail].

The reasons for this decision are:

[Explain in detail every reason for decision; in addition to explanation for decision, include specific references to approved criteria, rules or protocols on which decision is based; if denied because of insufficient information, identify all additional information needed to render decision].

To continue getting services

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

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

1) Request Criteria
Appendix H

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

[MCO Address]

2) Request an External Review

You may ask for an “external review” of the second level grievance decision within 15 days from the date on this notice. An external review is a review by a licensed doctor who does not work for [MCO Name].

Your request for an external review must be sent to the following address:

[MCO Address for requesting external review]

A decision will be issued within 60 days from when we receive your request.

3) Request a Fair Hearing

You may ask for a fair hearing from the Department of Public Welfare. Your request for a fair hearing must be in writing and must be postmarked within 30 days from the date on this notice. Your request should include the following information:

• Your (the member’s) name, social security number, and date of birth;
• A telephone number where you can be reached during the day;
• Whether you want to have a hearing in person or by telephone;
• The reason(s) you are asking for a fair hearing, or a copy of this notice;
• A copy of the original denial notice, if available.

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

Department of Public Welfare
Office of Mental Health and Substance Abuse Services
Division of Grievances and Appeals
Beechmont Building #32
P.O. Box 2675
Harrisburg, PA 17105-2675

The Department will issue a decision within 90 days from when it receives your request.

To ask for an early decision
If your doctor or psychologist believes that the usual time frame for deciding a fair hearing could harm your health, you may ask that the fair hearing take place more quickly. To do this:

- Call the Department at 1-877-356-5355, or fax your request to 1-717-772-7827;
- Your doctor or psychologist must fax a letter to 1-717-772-7827 explaining why taking the usual amount of time to decide your request for a fair hearing could harm your health. If your doctor or psychologist does not send a letter, your doctor or psychologist must testify at the fair hearing to explain why taking the usual amount of time to decide your request for a fair hearing could harm your health.

The Department will schedule a telephone hearing and notify you of its decision within 3 business days from when it receives your request.

To get help with a request for external review or fair hearing

- If you need help filing a request for an external review, call us at [MCO Phone #] and [MCO Name] will assign someone who has not been involved in the grievance issue to help you.
- If you have any other questions, or need help filing a request for a fair hearing, you may call us at [MCO Phone #], the legal aid office at 1-800-322-7572 (www.palegalservices.org), or the Pennsylvania Health Law Project at 1-800-274-3258 (www.phlp.org).

Sincerely,

[MCO Name]

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

[MCO, the following statement must appear in English, Russian, Cambodian, Vietnamese, Spanish, Chinese, and any other language as required by the contract:]

The information in this notice is about the grievance you filed with [MCO Name]. It is available in other languages and formats by calling [MCO Name] at [#].
ATTACHMENT 10b

Notice of Failure to Receive Provider Certification for an Expedited Grievance

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

Member Name
Address
City, State Zip

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

Subject: Request for “Expedited” Grievance

Dear [Member Name]:

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

We have not received your [doctor’s][psychologist’s] statement, so your grievance will be decided within the usual time frame of [30, unless the MCO will be using a shorter time frame to decide first level grievances] days from when we first got your grievance.

The First Level Grievance Process

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

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

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

[MCO Address]

You and your representative may appear at the grievance review in person, by phone or by videoconference, if available, by calling us at [MCO Phone #] within ten days from the date on this notice. You may also bring a family member, friend, lawyer or other person to help you. If you decide that you do not want to attend, that will not affect the decision of the committee.

The Fair Hearing Process

You may also ask for a fair hearing from the Department of Public Welfare. Your request for a fair hearing must be in writing and must be postmarked within 30 days from the date on this notice. Your request should include the following information:

- Your (the member’s) name, social security number, and date of birth;
- A telephone number where you can be reached during the day;
- Whether you want to have a hearing in person or by telephone;
- The reason(s) you are asking for a fair hearing, or a copy of this notice;
- A copy of the original denial notice, if available.

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

Department of Public Welfare  
Office of Mental Health and Substance Abuse Services  
Division of Grievances and Appeals  
Beechmont Building #32  
P.O. Box 2675  
Harrisburg, PA 17105-2675

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

To ask for an early decision

If your doctor or psychologist believes that the usual time frame for deciding a fair hearing could harm your health, you may ask that the fair hearing take place more quickly. To do this:
Appendix H

- Call the Department at 1-877-356-5355, or fax your request to 1-717-772-7827;
- Your doctor or psychologist must fax a letter to 1-717-772-7827 explaining why taking the usual amount of time to decide your request for a fair hearing could harm your health. If your doctor or psychologist does not send a letter, your doctor or psychologist must testify at the fair hearing to explain why taking the usual amount of time to decide your request for a fair hearing could harm your health.

The Department will schedule a telephone hearing and notify you of its decision within 3 business days from when it receives your request.

To get help with your grievance or request for fair hearing

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

Sincerely,

[MCO Name]

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

[MCO, the following statement must appear in English, Russian, Cambodian, Vietnamese, Spanish, Chinese, and any other language as required by the contract:]

The information in this notice is about the grievance you filed with [MCO Name]. It is available in other languages and formats by calling [MCO Name] at [#].
ATTACHMENT 11

Expedited Grievance Decision Notice

[Date Notice Mailed (no more than 2 days after the date of the decision)]

Member Name
Address
City, State Zip

Member ID: ********

Subject: “Expedited” Decision About Your Grievance

Dear [Member Name]:

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

Based on a review of all information provided, the review committee has decided that [state decision in detail].

The reasons for this decision are:

[Explain in detail every reason for decision; in addition to explanation for decision, include specific references to approved criteria, rules or protocols on which decision is based; if denied because of insufficient information, identify all additional information needed to render decision].

To continue getting services

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

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

1) Request Criteria

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

[MCO Address]

2) Request an Expedited External Review

You may ask for an “expedited” external review of the grievance decision. An external review is a review by a licensed doctor who does not work for [MCO Name]. You must ask for the “external review” within two business days from the date you get this notice. A decision will be issued within five business days from when we receive your request.

To ask for an external review:

- Call [MCO Name] at [MCO Phone #]; or
- Fax [MCO Name] at [MCO Fax #]; or
- Send your request to [MCO Name] at the following address:

[MCO Address for requesting external review]

3) Request a Fair Hearing

To ask for an early decision

You may ask for a fair hearing from the Department of Public Welfare. If your doctor or psychologist still believes that the usual time frame for deciding a fair hearing (between 60 and 90 days) could harm your health, you may ask that the fair hearing take place more quickly. To do this:

- Call the Department at 1-877-356-5355, or fax your request to 1-717-772-7827;
- Your doctor or psychologist must fax a letter to 1-717-772-7827 explaining why taking the usual amount of time to decide your request for a fair hearing could harm your health. If your doctor or psychologist does not send a letter, your doctor or psychologist must testify at the fair hearing to explain why taking the usual amount of time to decide your request for a fair hearing could harm your health.

The Department will schedule a telephone hearing and notify you of its decision within three business days from when it receives your request.

Even if you no longer need an early decision, you may ask for a fair hearing from the Department of Public Welfare. The request for a fair hearing must be in writing and must be
postmarked **within 30 days from the date on this notice.** Your request should include the following information:

- Your (the member’s) name, social security number, and date of birth;
- A telephone number where you can be reached during the day;
- Whether you want to have a hearing in person or by telephone;
- The reason(s) you are asking for a fair hearing, or a copy of this notice;
- A copy of the original denial notice, if available.

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

Department of Public Welfare  
Office of Mental Health and Substance Abuse Services  
Division of Grievances and Appeals  
Beechmont Building #32  
P.O. Box 2675  
Harrisburg, PA 17105-2675

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

**To get help with a request for external review or fair hearing**

- If you need help filing a request for an external review, call us at [MCO Phone #] and [MCO Name] will assign someone who has not been involved in the grievance issue to help you.
- If you have any other questions, or need help filing a request for a fair hearing, you may call us at [MCO Phone #], the legal aid office at 1-800-322-7572 (www.palegalservices.org), or the Pennsylvania Health Law Project at 1-800-274-3258 (www.phlp.org).

Sincerely,

[MCO Name]

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

[MCO, the following statement must appear in English, Russian, Cambodian, Vietnamese, Spanish, Chinese, and any other language as required by the contract:]  
The information in this notice is about the grievance you filed with [MCO Name]. It is available in other languages and formats by calling [MCO Name] at [#]
COMMONWEALTH OF PENNSYLVANIA
DEPARTMENT OF PUBLIC WELFARE
OFFICE OF MENTAL HEALTH AND SUBSTANCE ABUSE SERVICES

Indicators of the Application of CASSP Principles
For County Mental Health Programs

Instructions: The Local CASSP Advisory Committee should receive a copy of the Indicators of the Application of the CASSP Principles Checklist from the County Administrator for completion. In the event that there is no functioning local CASSP Advisory Committee, a committee composed of equal representation of family members, consumers, and professionals should be convened for this purpose. The CASSP Advisory Committee shall then forward the completed document to the MH/MR Administrator’s Office for inclusion in the County Plan for submission to OMHSAS.

Please complete the following checklist by denoting the presence of CASSP indicators in the county programs.

1. The first set of indicators address the county programs on a whole. Please indicate a “yes” or “no” response.

2. The second set is applicable to individual agencies. (They can also be found in the HealthChoices Southwest RFP, Appendix I). Please indicate the responses, “All”, “Most”, “Some”, and “Few”, that best describe the presence of the agency indicators in the county programs.

3. In addition to checking a response, please provide: a) any necessary explanation in the margins, especially for “no responses, b) any additional county program indicators that were not included in the checklist, and c) a one paragraph narrative summarizing how the principle will be strengthened in plan year 2001-2002.

I. Child-centered

The Principle:

Services are planned to meet the individual needs of the child, rather than to fit the child into an existing service. Services consider the child’s family and community contexts, are developmentally appropriate and child-specific, and also build on the strengths of the child and family to meet the mental health, social and physical needs of the child.
The Indicators for County Mental Health Program:

**YES**  **NO**

[ ] [ ] Office staff are courteous, respectful, and willing to assist parents either in person or on the telephone.

[ ] [ ] CASSP Coordinator position is filled.

[ ] [ ] CASSP Coordinator has a Master’s Degree or a minimum of 5 years experience with children’s services.

[ ] [ ] CASSP Coordinator is a discrete position located in an administrative office, has administrative responsibility for children’s services and provides no direct services.

[ ] [ ] Credentialing criteria for staff overseeing children’s programs reflect personnel qualifications indicative of expertise in child and adolescent growth and development and therapeutic interventions, and experience in child-serving systems.

[ ] [ ] Orientation to CASSP values has become an integrated component for new staff in administrative, supervisory, and direct service positions.

[ ] [ ] A service plan format for CASSP meetings with a reading level understandable to a child or adolescent is used and is signed by the child or adolescent.

[ ] [ ] Adolescents are included in CASSP meetings.

[ ] [ ] The county has a Consumer Satisfaction Team and/or Family Satisfaction Team and an adolescent satisfaction survey is included in consumer/family satisfaction protocols.

[ ] [ ] When conducting program evaluations, data elements collected include child and adolescent factors identified in the performance outcome measures (POMS).

[ ] [ ] CASSP Coordinator is provided with opportunity for training in child/adolescent issues.

**Other county level indicators:**

[ ] [ ] County staff are familiar with and utilize special communication tools such as qualified interpreters, TTY, large print, Braille, readers, etc. in assisting children and adolescents with special needs from initial intake, through assessment planning, intervention and after care services, and the communication tool of the child/adolescent’s choice is utilized.

**All**  **Most**  **Some**  **Few**

[ ] [ ] [ ] [ ] county funded agencies demonstrate [ ] [ ] [ ] [ ] of the following:
The Indicators for Agencies:

- Toys, children’s literature, furniture for small children, and adolescent literature are available in the waiting rooms and offices.
- Credentialing criteria reflect personnel qualifications indicative of expertise in child and adolescent growth and development and therapeutic interventions, and experience in child-serving systems.
- Assessments include the use of tools that are age- and/or developmentally-appropriate.
- The strengths, interests and resources of the child are identified in assessments, treatment plans and progress notes.
- An individualized treatment plan format with a reading level understandable to a child or adolescent is used and is signed by the child or adolescent.
- An adolescent satisfaction survey is included in consumer satisfaction protocols.
- Adolescents are included in interagency team meetings.
- Data elements collected include child and adolescent factors identified in the performance outcome measures (POMS).
- Financial support is given to the training of staff in child and adolescent clinical specialty areas.

Narrative summarizing how the “child-centered” principle will be strengthened in plan year 2001-2002:

II. Family-focused

The Principle: Services recognize that the family is the primary support system for the child. The family participates as full partner in all stages of the decision-making and treatment planning process, including implementation, monitoring and evaluation. A family may include biological, adoptive and foster parents, siblings, grandparents and other relatives, and other adults who are committed to the child. The development of mental health policy at state and local levels includes family representation.

The Indicators for County Mental Health Programs:

YES NO

[ ] [ ] Information for families, including local family support/advocacy organizations, is available in the office; for example, the PIN newsletter, Sharing, Right to Education, etc.

[ ] [ ] Parents/guardians participate as team members in CASSP meetings, or records include documentation of efforts to include them.

[ ] [ ] Parents/guardians sign the CASSP service plan after they have been fully involved in the development of it.

[ ] [ ] Personnel work to ensure that office hours and CASSP meetings are available in the evenings and on weekends and at times convenient for the family.
The county has a Family Satisfaction Team and the satisfaction protocols include items specific for families of children and adolescents, such as whether parents perceive themselves to be respected as the primary caretakers for their children, are treated as resources, and are included in decision-making about their child.

A CASSP Advisory/Management Committee meets at least quarterly and includes families of children and/or adolescents.

A parent/professional co-chair model for the Advisory/Steering Committee has been adopted.

Families are included on the county MH Committee.

Parents have input into county plans.

Parent-led support group(s) meet regularly.

Parent leaders routinely participate on child-serving system planning meetings.

Parents provide training to professionals on the parent’s perspective as a routine segment of orientation and agency training events.

Parents are invited to attend provider and administrative training on children’s issues.

Parents are supported in becoming leaders through scholarships to attend state and national conferences.

When parents act as trainers for professionals, they are paid the same honorarium as professional trainers.

The county funds a family advocate position.

Proposals submitted to state offices for new service initiatives include support letters from parents.

Parent leaders or groups agree that the local CASSP project has addressed their concerns.

Parents are included in program reviews

The county reimburses families for transportation and child-care costs related to participation in county CASSP activities.

**Other county level indicators:**

County staff are familiar with and will provide for and utilize special communication tools such as qualified interpreters, TTY, large print, Braille, readers, etc. in involving families/caregivers with special needs to participate in all phases of planning and treatment for their special needs family member. The communication tool of family’s/caregiver’s choice is utilized.
### All  Most  Some  Few  |  All  Most  Some  Few
---|---
[ ]   [ ]   [ ]   [ ]  |  [ ]   [ ]   [ ]   [ ]

County funded agencies demonstrate [ ] [ ] [ ] [ ] of the following:

#### The Indicators for Agencies:

- Information for families, including local family support/advocacy organizations, is in the waiting room; for example, the PIN newsletter, *Sharing*; CHADD; Right to Education, etc.
- Parents/guardians participate as team members on treatment teams or any interagency meetings, or records include documentation of efforts to include them.
- Parents/guardians sign the treatment plan after they have been fully involved in the development of it.
- Personnel work to ensure that appointments are available in the evenings and on weekends and at times convenient for the family.
- An agency handbook, which includes a grievance and appeals procedure, is written in clear and understandable language.
- Personnel ensure that families get copies of the agency handbook and understand who to call for help with questions.
- Consumer satisfaction protocols include items specific for families of children and adolescents.
- Families of children and/or adolescents are involved on the agency/management board or a family/community advisory committee to the agency.
- The agency handbook indicates that child and adolescent specialists can be requested by the family to provide treatment services for their child.
- The agency handbook contains information for families regarding the availability of training and education to assist them in supporting their child through the treatment process.

#### Narrative summarizing how the “family-focused” principle will be strengthened in plan year 2001-2002:

**III. Community-based**

**The Principle:** *Whenever possible, services are delivered in the child’s home community, drawing on formal and informal resources to promote the child’s successful participation in the community. Community resources include not only mental health professionals and provider agencies, but also social, religious and cultural organizations and other natural community support networks.*

**The Indicators for County Mental Health Programs:**

**YES  NO**

[ ]   [ ]  County office maintains a list of resources within the zip code or within 10 miles.

[ ]   [ ]  Local resource pamphlets - such as (but not limited to) the local library, the YMCA or YWCA, Boys and Girls Clubs - are available in the office.
Natural and community resources are used in the CASSP service plan, such as family, neighbors, school, work, leisure and church activities.

Orientation to and support for public transportation are available to families.

The data system tracks the use of local/community resources.

The county funds outreach programs.

The staff training schedule includes topics on community resources and understanding the community in which the staff works.

The county has identified gaps in the service system and has developed a plan to address them.

The county maintains records of community involvement and participation in activities including public meetings, hearings, and discussions.

Other county level indicators:

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<th>All</th>
<th>Most</th>
<th>Some</th>
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</table>

County funded agencies demonstrate [ ] [ ] [ ] [ ] of the following:

The Indicators for Agencies:

- Resources within the zip code or within 10 miles are used.
- Local resource pamphlets - such as (but not limited to) the local library, the YMCA or YWCA, Boys and Girls Clubs - are available in service management offices.
- Natural resources are used in each treatment plan, such as family, neighbors, school, work, leisure and church activities.
- Orientation to and support for public transportation are available to families.
- The data system tracks the use of local/community resources.
- There is a policy/procedure to reach out to families and their children when needed.
- The staff training schedule includes topics on community resources and understanding the community in which the staff works.
- If community-based resources are not available for a family, there is an administrative/financial plan to address the service gap.
- Records of community involvement and participation are maintained.

Narrative summarizing how the “community-based” principle will be implemented in plan year 2001-2002:
IV. Multi-system

The Principle: Services are planned in collaboration with all the child-serving systems involved in the child’s life. Representatives from all these systems and the family collaborate to define the goals for the child, develop a service plan, develop the necessary resources to implement the plan, provide appropriate support to the child and family, and evaluate progress.

The Indicators for County Mental Health Programs:

YES   NO
[   ]   [   ] A CASSP Advisory/Management Committee meets at least quarterly and includes representatives of each of the child-serving systems.
[   ]   [   ] Directors of MH/MR, Drug & Alcohol, Children and Youth, Special Education, Juvenile Probation, meet at least quarterly to discuss children’s issues.
[   ]   [   ] The CASSP Coordinator is responsible for assuring coordination among MH providers and child-serving systems in the county.
[   ]   [   ] Intersystem children’s needs assessment occurs on an annual basis with input from all CASSP participants.
[   ]   [   ] Intersystem professionals have input into county plans.
[   ]   [   ] CASSP projects provide input for annual plans which address local children’s service gaps and priorities for agencies including Children and Youth, Education/Special Education, Drug & Alcohol, Juvenile Probation, Mental Health, and Mental Retardation.
[   ]   [   ] Cross-system training occurs routinely, and/or agencies routinely invite other system staff to scheduled training.
[   ]   [   ] An intersystem conflict resolution process is established and reviewed/revised as needed.
[   ]   [   ] An intersystem release of information procedure is established and integrated into staff orientations.
[   ]   [   ] An intersystem forum to develop/review treatment/service plans for children needing multi system support meets regularly with all major child-serving systems participating.
[   ]   [   ] Child-serving system directors have formal or informal input into the CASSP Coordinator’s performance evaluation.
[   ]   [   ] Fiscal procedures to implement shared funding of children’s services are developed.
[   ]   [   ] The local ideal system of care for children has been described.
Proposals for new children’s services to state offices routinely include support letters from each of the child-serving systems.

Procedures to coordinate discharge planning for children and adolescents returning from community inpatient units, residential treatment centers, mental retardation centers, youth development centers and forestry camps and/or other out-of-county group care settings are established with mechanisms to ensure continuity for the child, aftercare, and establishment of “lead” or joint case management.

A local Student Assistance Program coordinating mechanism is in place.

Each of the major child-serving systems agrees that the local CASSP project has addressed intersystem issues which affect their own target populations.

Shared funding of children’s services based on an individualized service plan occurs routinely for children/adolescents requiring multi-system support.

Early Intervention issues and coordination have been addressed by the system directors.

**Other county level indicators:**

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<th>Most</th>
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</table>

County funded agencies demonstrate [   ] [   ] [   ] [   ] of the following:

**The Indicators for Agencies:**

- Families and, if they choose, an advocate/support person participate in the interagency meeting as members of the team.
- Interagency team meetings are held in a convenient and comfortable room with access to blackboard/newsprint, etc.
- At a minimum, mental health and education personnel are involved in interagency team meetings for children and adolescents who are of school age.
- Child-serving systems and other persons/informal support systems involved with the child are included in the treatment process as documented in telephone calls, conferences and interagency meetings.
- Letters of agreement with each child-serving system are current (for each fiscal year) and include a conflict resolution protocol.
- Procedures are written for convening the interagency team, including when meetings are called, who calls them and who leads them.
- Each child’s service plan reflects the contribution of each involved service system.
- The data system reports cross-system outcome measures.
- Individual practitioners/agency/MCO staff are knowledgeable and participate in the county child-serving system’s collaborative structure.
- Progress notes reflect a summary of interagency team meetings and attendees, and are distributed to the team.
Narrative summarizing how the “multi-system” principle will be strengthened in plan year 2001-2002:

V. Culturally competent

The Principle: Culture determines our world view and provides a general design for living and patterns for interpreting reality that are reflected in our behavior. Therefore, services that are culturally competent are provided by individuals who have the skills to recognize and respect the behavior, ideas, attitudes, values, beliefs, custom, language, rituals, ceremonies and practices characteristic of a particular group of people.

Note: Pennsylvania’s cultural competence initiative has focused specifically on African Americans, Latinos, Asian Americans and Native Americans who have historically not received culturally appropriate services.

The Indicators for County Mental Health Programs:

YES    NO

[ ] [ ] A CASSP Advisory/Management Committee meets at least quarterly and includes persons representing the cultural diversity of the county.

[ ] [ ] The county office has resources and materials that reflect the cultural diversity of the county.

[ ] [ ] Persons of various cultural backgrounds representative of the county have input into county plans.

[ ] [ ] Cross-system training includes a component on cultural competence for administrators, supervisors, and direct service staff.

[ ] [ ] Orientation procedures to county staff include cultural competence values and issues.

[ ] [ ] Persons of color, ethnic and religious groups are provided the opportunity to comment on the cultural appropriateness of the service they or their child received.

[ ] [ ] Assessment of the cultural diversity and competencies of local staff and clients has promoted the development of strategies to move toward a culturally competent system of care.

[ ] [ ] Local CASSP network mailing list includes ministers, churches, cultural centers, and community leaders who represent/service African, Latino, Asian, or Native American cultures.

[ ] [ ] County administrative and direct care staff represent the cultural diversity of the county.
Consumer and family satisfaction protocols include questions tailored to ethnic communities.

Other county level indicators:

County staff are trained in Deaf Culture and other cultures, communication skills and the distinction related to language, syntax, and expression of feelings in the culture.

County staff are trained in the protocol and use of interpreters.

All  Most  Some  Few  All  Most  Some  Few

County funded agencies demonstrate  of the following:

The Indicators for Agencies:

- Staff resources, consisting of literature (books, magazines and brochures), video and/or audio tapes, reflect the cultural diversity of the people served by the agency.
- Waiting rooms and offices have literature reflecting the ethnic groups in the community.
- The schedule of regular staff training includes cultural competence development, and related topics.
- Introductory cultural competency trainings for staff incorporate the following elements:
  - overview of cultural competence including specifics on local cultural diversity
  - the principles of cultural competency development
  - conducting psychiatric and psychological assessments applicable to the individual’s cultural context
  - treatment planning appropriate to the individual, family, and cultural context
  - integrating community supports and resources
  - considering and using non-traditional methods and services
  - direct service provision and effectively engaging minorities in treatment
  - more advanced trainings involve issues and related topics
- Service delivery reflects:
  - psychiatric assessments which incorporate an appreciation of the child’s or adolescent’s culture and level of acculturation
  - treatment plans/consultations which involve or reflect the family’s cultural perspective
  - up to date information on medications through current literature/studies on psychotropic medications and how they relate to minority populations
  - recognition of the importance of religion, religious expression and religious institutions
  - services available from clinical staff who speak the language understood by children and families or who use interpreters
  - interagency meetings which welcome extended family members
  - recognition of culturally relevant holidays and traditions
  - tracking of completion rates for appointments by ethnicity, age, and gender
- Administrative and treatment staff represent the cultural diversity of the community the agency serves.
- Minority members participate at the policy-making and administrative/monitoring levels.
- Advisory boards include minority membership.
- Consumer satisfaction protocols include questions tailored to ethnic communities.

Narrative summarizing how the “culturally competent” principle will be strengthened in plan year 2002-2002:

**VI. Least restrictive/least intrusive**

**The Principle:** Services take place in settings that are the most appropriate and natural for the child and family and are the least restrictive and intrusive available to meet the needs of the child and family.

**The Indicators for County Mental Health Programs:**

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**Other county level indicators:**

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of the following:
The Indicators for Agencies:

- Family-friendly consolidation in the scheduling of appointments is apparent so that it is efficient for the family both in time and location.
- The community integration questionnaire is used to ensure the use of least restrictive services.
- In-home, in-school and in-community resources are safely used first before out-of-home placement is considered or as part of a discharge plan when returning from placement.
- Justification for each service or placement considered is documented.
- The family has a voice in the process of identifying appropriate providers and staff for various in-home services.

Narrative summarizing how the “least restrictive/least intrusive” principle will be strengthened in plan year 2001-2002:
Appendix I
Attachment 2

COMMONWEALTH OF PENNSYLVANIA
DEPARTMENT OF PUBLIC WELFARE
OFFICE OF MENTAL HEALTH AND SUBSTANCE ABUSE SERVICES
Indicators of the Application of CSP Principles
For County Mental Health Programs

Instructions: The Local CSP Advisory Committee should receive a copy of the Indicators of the Application of the CSP Principles Checklist from the County Administrator for completion. In the event that there is no functioning local CSP Advisory Committee, a committee composed of equal representation of family members, consumers, and professionals should be convened for this purpose. The CSP Advisory Committee shall then forward the completed document to the MH/MR Administrator’s Office for inclusion in the County Plan for submission to OMHSAS.

Please complete the following checklist by denoting the presence of CSP indicators in the county programs.

1. The first set of indicators address the county programs on a whole. Please indicate a “yes” or “no” response.
2. The second set is applicable to individual agencies. Please indicate the responses “All”, “Most”, and “Some”, or “Few”, that best describe the presence of the agency indicators in the county program.
3. In addition to checking a response, please provide: a) any necessary explanation in the margins, especially for “no” responses, b) any additional county program indicators that were not included in the checklist, and c) a one paragraph narrative summarizing how the principle will be strengthened.

I. Consumer-center/Consumer-empowered
The Principle:
Services are organized to meet the needs of each consumer, rather than the needs of the managed care program or needs of service providers. Services incorporate consumer self-help approaches and are provided in a manner that allows persons to retain the greatest possible control over their own lives.

The Indicators for County Mental Health Programs:

YES NO
[ ] [ ] County office staff are courteous, respectful, and willing to assist consumers and family members either in person or on the telephone.
[ ] [ ] There is a county staff person designated as the CSP Liaison.
[ ] [ ] County staff overseeing adult mental health services reflect appropriate qualifications, including orientation to and training in CSP principles.
[ ] [ ] The county has integrated orientation to CSP values for all has become an integrated new county administrative, supervisory, and direct service staff.
[ ] [ ] County staff, including case managers, consider consumer choice and preference...
in the selection of services and treatment.

[ ] [ ] Consumers are included in CSP meetings.

[ ] [ ] Data elements collected by the county during program evaluations include factors identified in the state Performance Outcome Management System (POMS) and reflects outcomes important to consumers (e.g., employment, housing, transportation, and social supports).

[ ] [ ] The CSP Liaison is provided opportunity for training in adult mental health issues.

[ ] [ ] County staff encourage family members to participate in service and treatment decisions.

[ ] [ ] Consumers are integrally involved in planning, developing, and implementing new services and in the evaluation of services.

[ ] [ ] Consumers and families are involved in the county plan development.

[ ] [ ] Consumer and families participate in the budget meetings with county and state mental health staff.

[ ] [ ] The county program promotes and funds consumer self-help and consumer-run alternatives.

[ ] [ ] County personnel policies and practice encourage the hiring of consumers as staff, consultants, and trainers.

[ ] [ ] The county program uses people first language in all written materials (e.g., people with schizophrenia, not schizophrenics).

[ ] [ ] The county program makes information available to consumers on the self-help philosophy and statewide and local consumer organizations.

[ ] [ ] Notice of public/special hearings is widespread throughout the mental health community as well as in newspapers at least two weeks prior to the event.

[ ] [ ] Public/special hearings are held in locations accessible to public transportation, or transportation is arranged where no public transportation exists.

[ ] [ ] County staff are trained on consumer self-help approaches and the concept of recovery from mental illness.

[ ] [ ] Consumers are involved in all service and treatment decisions affecting their lives and given choice and preference in accessing/utilizing services.

**Other county level indicators:**

[ ] [ ] Consumers with special needs, including but not limited to persons who are deaf, hard of hearing, deafblind, elderly, etc and their families, are involved in county plan development, program assessment of need, implementation and evaluation of services, and participate in budget meetings with county and state mental health staff.

[ ] [ ] County staff are familiar with and utilize special communication tools such as qualified interpreters, TTY, large print, braille, readers, etc. in assisting consumers with special needs from initial intake, through assessment, planning, intervention and after care services, and that the communication tool of the consumer's choice is utilized.
The Indicators for Agencies:

- Consumers are integrally involved in designing and evaluating services.
- Consumer preferences are honored whenever possible (e.g., therapist/case manager, decor, living arrangements, programming, food selection, etc.).
- Consumer self-help and consumer-run alternatives are promoted and funded.
- Individual strengths, interests and resources are identified in assessments, treatment plans and progress notes.
- Treatment/service plans reflect consumer involvement in goal setting and decisions regarding services. Consumers' signatures appear on all treatment/service plans, or an explanation of why the consumer has not signed is noted.
- Personnel policies encourage the hiring of consumers as staff, consultants, trainers.
- Consumer confidentiality is honored.
- People First language is used in all written materials (e.g., people with schizophrenia not schizophrenics).

Information is available to consumers on self-help philosophy and statewide and local consumer organizations.

YES   NO

- Data collection reflects outcomes important to consumers (e.g., employment, housing, social supports).
- Provider staff are trained on the concept of recovery from mental illness and promote recovery concepts to consumers

Narrative summarizing how the "consumer-centered/consumer-empowered" principle will be strengthened:

II. Culturally Competent

The Principle:
Culture determines our world view and provides a general design for living and patterns for interpreting reality that are reflected in our behavior. Therefore, services that are culturally competent are designed and delivered to recognize and respect the behavior, ideas, attitudes, values, beliefs, customs, language, rituals, ceremonies and practices of an individual or a particular group of people.

The Indicators for County Mental Health Programs:

YES   NO
A County CSP Committee meets regularly and includes persons reflective of the county cultural/ethnic groups.

The county office has resources and materials that reflect the cultural diversity of the county.

Persons from minority cultures have input into county plans.

Training includes a component on cultural competence for administrators, supervisors, and direct service staff.

Training teams represent the ethnic groupings of the county.

Orientation procedures to county staff include cultural competence values and issues along with other CSP values.

Consumer satisfaction surveys include a request for persons of cultural minorities to comment on the cultural appropriateness of the service they received.

Assessment of the cultural diversity and competencies of local staff and clients are used in the development of strategies to move toward a culturally competent system of care.

Local CSP network mailing list includes ministers, churches, cultural centers, and community leaders who represent/serve African, Latino, Asian, Native American, or other local cultural groups.

Administrative staff represent the cultural diversity of the county.

Consumer and family satisfaction protocols include questions tailored to ethnic communities.

Other county level indicators:

County staff are trained in Deaf Culture and other cultures, communication skills and the nuances related to language, syntax, and expression of feelings in the culture.

County staff are trained in the protocol and use of interpreters.

The Indicators for Agencies:

- Staff resources, consisting of literature (books, magazines and brochures), video and/or audio tapes, reflect the diversity of the population the agency serves.
- Waiting room and offices have literature reflecting the ethnic groups in the community.
- The schedule of regular staff training includes cultural competency development, and related topics.
- Introductory cultural competency trainings for staff incorporate the following elements:
  - overview of cultural diversity
  - the principles of cultural competency development
- conducting psychiatric and psychological assessments applicable to the individual's cultural context
- treatment planning appropriate to the individual, family, and cultural context
- integrating community supports and resources
- considering and using non-traditional methods and services
- direct service provision and effectively engaging minorities in treatment

Service delivery reflects:
- psychiatric assessments which incorporate an appreciation of the consumer's culture and level of acculturation
- treatment plans/consultations which involve or reflect the family's cultural perspective
- up to date information on medications through current literature/studies on psychotropic medications and how they relate to minority populations
- recognition of the importance of religion, religious expression and religious institutions
- services available from clinical staff who speak the language understood by the consumer or who use interpreters
- interagency meetings which welcome extended family members
- recognition of culturally relevant holidays
- tracking of completion rate for appointments by ethnicity, age and gender

- Administrative and treatment staff represent the cultural diversity of the community the agency serves.
- Minority members participate at the policy-making and administrative/monitoring levels.
- Advisory boards include minority membership.
- Consumer satisfaction protocols include questions tailored to ethnic communities.

Narrative summarizing how the "culturally competent" principle will be strengthened:

III. Flexible

The Principle: The development and delivery of services and supports are flexible as possible in order to meet the needs of a wide diversity of persons in the geographic area. Flexibility includes having a wide variety of services, of variable intensity available at a wide range of times, and delivered in a wide range of environments.

The Indicators for County Mental Health Programs:

YES  NO

[ ]  [ ] The county, through its provider system, delivers a full array of services and treatment.

[ ]  [ ] The county ensures consumer choice in treatment plans and support services.
County staff are accessible and available during non-business hours.

County staff credentialing standards support the provision of rehabilitative, self-help, and alternative treatment services, as well as traditional mental health approaches.

The county has an outreach team to identify people in need of mental health services.

Other county level indicators:

The county has an outreach team to identify elderly people and other people with special needs who are in need of mental health services.

All  Most  Some  Few  
[ ] [ ] [ ] [ ]

County funded agencies demonstrate [ ] [ ] [ ] [ ] of the following:

The Indicators for Agencies:

- A full array of treatment, rehabilitation and support services are available in accessible locations.
- Day, evening and weekend hours are available.
- Services are delivered at a variety of locations, including the consumer's home or community as appropriate.
- Type and duration of service is based on consumer need.
- Staff credentialing standards recognize expertise in rehabilitative, self-help and alternative treatment approaches.

Narrative summarizing how the "flexible" principle will be strengthened:

**IV. Meet Special Needs**

The Principle:

*Services are adapted to meet the special needs of people with mental illness who are affected by one or more of such factors as old age, substance abuse, physical disability, loss of sight/hearing, mental retardation, homelessness, HIV/AIDS, and involvement in the criminal justice system.*

The Indicators for County Mental Health Programs:

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The county program actively collaborates with other human service agencies to meet the needs of consumers with special needs.

The county program supports creative inter-agency agreements, collaborative funding, and cross-system training of staff.

The county program tracks and/or coordinates outreach to special needs populations.

The county solicits input from other service agencies when planning, developing, or expanding services.

County staff training includes modules on special populations.

The county program has designated staff specialists for special populations.

Other county level indicators:

The county program actively seeks and utilizes input from persons with special needs, their family members and advocates, in the development of county plans.

The county program provides the necessary communication tools/qualified interpreters/large print materials/assistive hearing devices, etc. to enable persons with special needs to participate in the county plan development.

The county program ensures that a discharge plan for those being discharged from the criminal justice system involves networking with the criminal justice system and all systems which will enable a successful transition.

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All Most Some Few

of the following:

The Indicators for Agencies:

- Representatives from other service systems are involved in developing/implementing the treatment/service plan of persons with special needs.
- Staff specialists are available/trained to meet the diverse needs of consumers, as outlined above.
- Timely mobile outreach is provided to specialty populations including persons who are elderly, homeless and involved in the criminal justice system.
- Data systems track service utilization and outcomes specific to special populations.
- TDD telephone access, sign language interpreters, Braille materials and other assistive devices are available, as needed.
- Creative interagency agreements and funding focus on the total needs of the individual (cross-training of staff, co-location of staff, etc.).

Narrative summarizing how the "meet special needs" principle will be strengthened:

V. Accountable
The Principle:

Service providers are accountable to the users of the services. Consumers and their families are involved in planning, implementing, monitoring and evaluating services.

The Indicators for County Mental Health Programs:

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Other county level indicators:

| [ ] | [ ] | Consumer satisfaction data indicates that input has been sought from consumers with special needs, such as persons who are deaf, hard of hearing, deafblind, elderly, having HIV/AIDS, etc. and that the data indicates that consumers with special needs are treated with respect, dignity, and that they understand service options, and how to access services. |
| [ ] | [ ] | The county has open/closed captioned videos, large print materials, assistive hearing devices and other communication tools available to help consumers with special needs understand their rights, service options and how to access services. |

All  Most  Some  Few  All  Most  Some  Few
[ ] [ ] [ ] [ ] county funded agencies demonstrate [ ] [ ] [ ] [ ] of the following:

The Indicators for Agencies:

- Consumers and families are integrally involved in the design, development and evaluation of services. This includes:
• Consumer satisfaction teams.
• Consumer/family membership on governing/advisory boards.
• Information on services, diagnoses, medications, etc. is available and written in consumer friendly language.
• The member handbook/policies and procedures, which includes grievance and appeal procedures, is written in clear and understandable language.
• Personnel ensure that consumers receive copies of the member handbook/policies and procedures and understand who to call for help with questions.
• The agency has positive outcome measures aimed towards stabilization/growth in functioning, increased consumer satisfaction, etc.
• The agency has a balanced focus on cost, quality, outcome and access, when evaluating program success.
• Data and standards related to demographics, budgets/expenditures, criteria for service authorizations, complaints/appeals, outcomes, etc. are provided to consumers/families and advocates for review.

Narrative summarizing how the "consumer-centered/consumer-empowered" principle will be strengthened:

VI. Strengths-Based

The Principle:
Services build upon the assets and strengths of consumers to promote growth and movement toward independence.

The Indicators for County Mental Health Programs:

YES  NO

[ ] [ ] The county program promotes recovery from mental illness.
[ ] [ ] The county program facilitates opportunities for consumer growth and independence.
[ ] [ ] The county program assures that assessments, treatment/service plans, and progress notes highlight and capitalize on each individual's strengths, assets, skills and talents.
[ ] [ ] The county program assures that written materials support People First language and the role of the consumer as a key partner in the recovery process.
[ ] [ ] The county maintains a continuum of services allowing individuals to maintain the highest level of independence possible.
[ ] [ ] Self-help and consumer run services are funded and available.

Other county level indicators:
The county continuum of services allows individuals who have special needs to maintain the highest level of independence possible and the county networks with advocacy groups for persons with special needs to identify all resources available for the consumer to maintain the highest level of independence possible.

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County funded agencies demonstrate [ ] [ ] [ ] [ ] of the following:

**The Indicators for Agencies:**

- Service interventions promote a wellness, not illness, focus.
- Assessments, treatment/service plans and progress notes highlight and capitalize on each individual's strengths, assets, skills and talents.
- Written materials support People First language and the role of consumer as a key partner in the recovery process.
- Staff are trained in the concept of recovery from mental illness.
- The concept of recovery is promoted by providers.

Narrative summarizing how the "strengths-based" principle will be strengthened:

**VII. Community-Based/Natural Supports**

**The Principle:**

*Services are offered in the least coercive manner and most natural setting possible. Consumers are encouraged to use the natural supports in the community and to integrate into the living, working, learning, and leisure activities of the community.*

**The Indicators for County Mental Health Programs:**

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County office maintains a list of resources within the zip code or within 10 miles.

Local resource pamphlets describing natural community supports are available in the county office.

Natural and community resources are used in service plans, such as family, neighbors, work, leisure and church activities, and service and community organizations.

Orientation to and support for public transportation are available to families.

The data system tracks the use of local/community resources.

The county funds outreach programs.

The staff training schedule includes topics on community resources and understanding the community in which the staff works.

The county has identified gaps in the service system and has developed a plan to address them.
The county maintains records of community involvement and participation in activities including public meetings, hearings, and discussions.

Other county level indicators:

The county office insures that its staff and the contract provider staff are knowledgeable of and utilize natural and community supports which benefit consumers with special needs. Staff training includes presentations from consumers with special needs, as well as their family members and advocates.

All  Most  Some  Few
[ ] [ ] [ ] [ ] county funded agencies demonstrate [ ] [ ] [ ] [ ] of the following:

The Indicators for Agencies:

- Community based resources/services within the zip code or within 10 miles are used.
- Pamphlets/information on local resources and services are made available through administrative entities and provider agencies.
- Training and support in finding and using transportation is available to consumers.
- Natural resources are used in each treatment plan, such as housing, work, leisure and church activities.
- Consumers are encouraged to develop advance directives in preparation for crises for staff/family to follow.
- Individuals identified by the consumer as supports should be incorporated into the treatment/service plan.
- The data system tracks the use of local/community resources.
- There is a policy/procedure to reach out to consumers and their families when needed.
- The staff training schedule includes topics on community resources and understanding the community in which the staff works.

Narrative summarizing how the "community-based/natural supports" principle will be strengthened:

VIII. Coordinated

The Principle:

Services and supports are coordinated on both the local system level and on an individual consumer basis in order to reduce fragmentation and to improve efficiency and effectiveness with service delivery. Agencies must work in collaboration to meet the variety of needs that people with psychiatric disabilities have.
The Indicators for County Mental Health Programs:

County staff orientation and training includes an overview of various human services agencies.

YES  NO

[ ] [ ] County program staff are designated as liaisons with other human service systems.
[ ] [ ] County staff are available to provide orientation to other agencies regarding mental health services.
[ ] [ ] The county program ensures that written agreements/plans for coordination are in place with providers and agencies including: state-hospitals, medical services providers, social services agencies, and police and corrections offices.

Other county level indicators:

[ ] [ ] The county staff and contracted provider staff receive and provide orientation to agencies serving persons who have special needs. These agencies include but are not limited to the Office for the Deaf and Hard of Hearing, The Department of Aging and the Area Agencies on Aging, the Coalition for the Homeless, etc.

All  Most  Some  Few
[ ] [ ] [ ] [ ] county funded agencies demonstrate [ ] [ ] [ ] [ ] of the following:

The Indicators for Agencies:

- Written agreements/plans for coordination are in place with the following:
  - State hospitals.
  - Medical services providers/insurers. (This should include a good baseline medical work-up, coordination in monitoring physical and neurobiological services, etc.)
  - Social service agencies (Offices of aging, vocational rehabilitation, housing authorities, drug and alcohol programs, homeless shelters, legal services, etc.)
  - Police departments, district justices, jails and prisons, etc.
- Staff are designated as liaisons to other service agencies in order to plan and facilitate services.
- Staff development/training involves overview of service agencies in area (e.g., policies, procedures, mission statement, regulations, etc.).

Narrative summarizing how the "coordinated" principle will be strengthened:
DEPARTMENT OF DRUG AND ALCOHOL PROGRAMS  
Principles of Effective Treatment

Background

Alcohol and other drug abuse and dependency treatment services must be provided by facilities licensed by the Department of Drug and Alcohol Program Licensure, to ensure that minimum standards are being maintained to protect the health, safety and welfare of the individual.

Philosophy

Substance abuse and dependence are primary diseases, not symptoms of other underlying conditions. Substance use disorders can be diagnosed, are responsive to treatment and are complex behavioral disabilities usually having chronic medical, social and psychological components, which result in multiple negative consequences. Substance abuse and dependence related problems affect not only the dependent individual, but other family members, particularly children. Denial is a central characteristic or symptom of substance abuse and dependence that complicates an individual’s ability to acknowledge a problem.

Principles

- **Treatment needs to be readily available.** Because individuals diagnosed with a substance use disorder may be uncertain about entering treatment, taking advantage of opportunities when they are ready for treatment is crucial. Potential treatment applicants can be lost if treatment is not immediately available or is not readily accessible.

- **No single treatment is appropriate for all individuals.** Matching treatment settings, interventions, and services to each individual's particular problems and needs is critical to his or her ultimate success in returning to productive functioning in the family, workplace, and society.

- **Effective treatment attends to multiple needs of the individual, not just his or her substance use.** To be effective, treatment must not only address the individual's substance use but any associated medical, psychological, social, vocational, and legal problems.

- **Individuals diagnosed with a substance use disorder and with a coexisting mental disorders should have both disorder treated in an integrated way.** Because addictive disorders and mental disorders often occur in the same individual, persons presenting for either condition should be assessed and treated for the co-occurrence of the other type of disorder. Both disorders are considered primary.
- **Treatment should be person specific** and guided by an individualized treatment plan based upon a face to face comprehensive biopsychosocial evaluation of the person and when possible, a comprehensive evaluation of the family as well.

- **Counseling (individual and group) and other behavioral therapies are critical components of effective treatment for substance use disorder.** In therapy, the person addresses issues of motivation, build skills to resist substance use, replace substance-using activities with constructive and rewarding nonsubstance-using activities, and improve problem-solving abilities. Behavioral therapy also facilitates interpersonal relationships and the individual's ability to function in the family and community.

- **Self-help groups such as Alcoholics Anonymous, Narcotics Anonymous and Double Trouble are essential adjuncts to the treatment process.** Attendance should be encouraged when appropriate.

- **Medications are an important element of treatment for many individuals,** especially when combined with counseling and other behavioral therapies. Methadone and buprenorphine are very effective in helping individuals dependent upon opiates stabilize their lives and reduce their illicit drug use. Naltrexone is also an effective medication for some individuals diagnosed with opiate dependency as well as a co-occurring alcohol dependence. For persons dependent upon nicotine, a nicotine replacement product (such as patches or gum) or an oral medication (such as bupropion) can be an effective component of treatment. For individuals diagnosed with mental disorders, both behavioral treatments and medications can be critically important.

- **Treatment programs should provide assessment for HIV/AIDS, Hepatitis B and C, Tuberculosis and other infectious diseases,** and counseling to help individuals modify or change behaviors that place themselves or others at risk of infection. Counseling can help individuals avoid high-risk behavior. Counseling also can help people who are already infected manage their illness.

- **Remaining in treatment for an adequate period of time is critical for treatment effectiveness.** The appropriate duration for an individual depends on his or her problems and needs. Research indicates that for most people, the threshold of significant improvement is reached at about 3 months in treatment. Treatment may include Residential care followed by Intensive Outpatient care or Partial treatment followed by Outpatient care, or any movement through the level of care continuum. After this threshold is reached, additional treatment can produce further progress toward recovery. Because people often leave treatment prematurely, programs should include strategies to engage and keep people in treatment.

- **Recovery from substance use disorders can be a long-term process and frequently requires multiple episodes of treatment.** As with other chronic illnesses, relapses to substance use can occur during or after successful treatment episodes. Individuals diagnosed with a substance use disorder may require prolonged treatment and multiple episodes of treatment to achieve long-term abstinence and fully restored functioning.
Participation in self-help support programs during and following treatment often is helpful in maintaining long-term abstinence.

- **Treatment does not need to be voluntary to be effective.** Strong motivation can facilitate the treatment process. Sanctions or enticements in the family, employment setting, or criminal justice system can increase significantly both treatment entry and retention rates and the success of substance use treatment interventions.

- **Persons recovering from substance use disorders are viewed as important resources in the statewide service system.** As representatives of the recovering community, persons in recovery serve as an inspiration to the individuals struggling with a substance use disorder. As a practicing professional they provide an empathetic and knowledgeable approach to treatment philosophy, offer valuable input into the recovering community network, and serve as a voice for advocacy.

- **The majority of the above Principles are adapted from the National Institute of Drug Abuse (NIDA).**
BEHAVIORAL HEALTH MANAGED CARE ORGANIZATIONS (BH-MCOs)
PERFORMANCE/OUTCOME MANAGEMENT SYSTEM (POMS)

OVERVIEW

The POMS consists of a database that is updated on a periodic basis through batch data file extracts that are obtained from a variety of data sources (see attached table of outcome measures and data sources). The database, which is maintained and managed by the Department of Public Welfare, contains an extensive array of raw data concerning enrollees in the BH-MCOs. The primary purpose of the database is to serve as the basis for producing a set of performance measures/indicators. The Department will utilize the performance measures/indicators as its primary tool for continuously evaluating the effectiveness of the BH-MCO contractors in achieving a variety of systems level outcomes.

The POMS serves the following primary functions:

1. Provides accountability for public funds expended through the Department’s capitation payments to the BH-MCO contractors.
2. Provides a fair and objective evaluation of the BH-MCOs that the Department can use for implementing outcome oriented incentives and sanctions.
3. Supports the Department and the BH-MCO contractors to implement a collaborative continuous Quality Improvement process.

B. DATA COLLECTION PROCESSES

Raw data concerning BH-MCO enrollees, obtained from a variety of sources, will be transmitted via batch file extracts to the POMS central database (see attached flow chart). The data will be linked and integrated for each BH-MCO enrollee based on unique identifiers. The integrated database will provide the basis for DPW to derive quantitative performance indicators/measures that reflect systems level outcomes achieved by each BH-MCO primary contractor. The primary data sources and data collection processes are as follows:

1. BH-MCO Encounter Data - BH-MCOs, through a process similar to what DPW required for the HealthChoices PH-MCOs, will submit data files on a regular schedule to DPW. The data will be edited and then loaded into DPW’s Enterprise Data Warehouse. The Office of Mental Health and Substance Abuse Services (OMHSAS) will, on a regular schedule, receive a file of all DPW accepted encounter records and will perform additional edits before loading to the POMS central database.
2. **Enrollee Eligibility and Demographic Data** - DPW will on a regular schedule move enrollee eligibility and demographic data from its Client Information System (CIS) into the Enterprise Data Warehouse. OMHSAS will subsequently pull a subset of eligibility and demographic data elements via data file extracts into the POMS central database.

3. **Secondary Data** - OMHSAS will develop data exchange agreements with other state agencies, as feasible, to obtain regularly scheduled data file extracts that will be loaded into the POMS central database. Data exchanges with state agencies such as the Department of Corrections, State Police and the Department of Education are under development.

4. **Consumer/Family Satisfaction Reports** - There will be standardized measures administered by the BH-MCO. A Co-occurring Disorder (COD) question must be included on the survey and a sampling of COD consumers must be surveyed. The BH-MCO will submit reports of findings to the DPW. A survey will be conducted annually.

5. **BH-MCO Consumer Registry File** - BH-MCOs will maintain a computerized registry of their enrollees who have accessed behavioral health services. The registry is comprised of a minimum data set including clinical descriptions such as priority population and critical dates during the episode of care such as date of first service request, registration date and termination date. These data will be submitted by the BH-MCOs to the POMS central database.

6. **BH-MCO Quarterly Status File** - BH-MCOs will maintain a computerized file concerning the status of priority populations. The file will be updated on a calendar quarter basis for each enrollee in the priority population. The quarterly status file is comprised of a minimum data set including outcome measures such as vocational/educational status and independence of living arrangement. These data will be submitted by the BH-MCOs to the POMS central database on a regular schedule.

7. **Performance Indicator Reports** - On a regular schedule, DPW will produce from the POMS central database a set of performance indicators that measure the performance of each BH-MCO consistent with the outcome dimensions outlined in the attached table of outcome measures. The performance indicator reports will be issued by DPW on a regular schedule to all relevant DPW monitoring staff, the BH-MCOs and other stakeholder groups.

C. **CONTINUOUS QUALITY IMPROVEMENT (CQI) PROCESS**

The Department encourages the BH-MCOs to implement a Continuous Quality Improvement (CQI) process based upon Deming’s 14-point program for managed adapted to the health care industry, and Joint Commission on Accreditation of Health Care Organization (JCAHO) guidelines. The overall process should include:

- Delineating the scope of the services to be monitored and improved.
Identifying the important aspects of the services whose quality should be examined and improved.

Identifying indicators (including but not limited to the performance indicators established by DPW) that will be used to monitor the quality, accessibility and appropriateness of the important aspects of services.

Establishing thresholds (including but not limited to the thresholds established by DPW) for the review of indicators that become “flags” signaling the need for further analysis of the causes for the data reported to DPW.

Collecting data pertaining to each indicator and comparing the aggregate level of performance with the threshold for analysis. If the threshold is not reached, further analysis may not be necessary.

Initiating analyses of other important aspects of services when thresholds have been reached.

Taking actions to improve the aspects of services.

Reporting the findings to the organizations involved, including a report of findings to DPW on a regular schedule. Monitoring and analysis are continued in order to identify any future deficiencies in services and to improve quality.

DPW monitoring staff will review the CQI reports of findings submitted by the BH-MCOs. DPW monitoring staff will provide feedback to BH-MCOs indicating:

1. Concurrence with the BH-MCOs explanation/cause of the performance indicator findings and actions proposed by the BH-MCOs to improve performance (and/or correct deficiencies); or
2. Offer alternative explanations/causes for the performance indicator findings and/or recommended alternative actions to improve performance (and/or correct deficiencies).
BEHAVIORAL HEALTH MANAGED CARE ORGANIZATIONS
PERFORMANCE/OUTCOME MANAGEMENT SYSTEM

<table>
<thead>
<tr>
<th>OUTCOME DIMENSIONS</th>
<th>DATA SOURCE(S)</th>
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</thead>
<tbody>
<tr>
<td>1. <em>Increase Community Tenure and Less Restrictive Services</em></td>
<td></td>
</tr>
<tr>
<td>▪ Increase the appropriate use of behavioral health inpatient days.</td>
<td></td>
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<tr>
<td>▪ Decrease criminal incarcerations.</td>
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<tr>
<td>▪ Increase the appropriate use of MH residential care.</td>
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<tr>
<td>▪ Decrease out-of-home placements.</td>
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<tr>
<td>▪ Decrease homelessness.</td>
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<tr>
<td>▪ Increase residential stability.</td>
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<tr>
<td>▪ Decrease patient days in state mental hospitals.</td>
<td></td>
</tr>
<tr>
<td>*To be reported/compiled only for priority group consumers by age group (under age 21, 21-64 and age 65+).</td>
<td></td>
</tr>
<tr>
<td>1. Quarterly Status File (QSF)¹</td>
<td></td>
</tr>
<tr>
<td>2. Criminal incarceration data sets from state correctional institutions, county jails and juvenile court records.</td>
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<tr>
<td>3. BH encounter data and SMH data set (PCIS).</td>
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<p>| 2. <em>Increase Vocational and Educational Status</em>  |
| ▪ Increase school attendance (full time regular classroom)  |
| ▪ Increase school retention.  |
| ▪ Increase school performance.  |
| ▪ Improve school behavior.  |
| ▪ Increase vocational status for adults.  |
| *To be reported/compiled only for priority group consumers by age group.  |
| 1. Quarterly Status File (QSF)¹  |
| 2. Employment tax records.  |</p>
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<tr>
<th>OUTCOME DIMENSIONS</th>
<th>DATA SOURCE(S)</th>
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<tbody>
<tr>
<td><strong>3. Reduce Criminal/Delinquent Activity</strong>*</td>
<td>1. Quarterly Status File (QSF)¹</td>
</tr>
<tr>
<td>- Reduce number of arrests.</td>
<td>2. Arrest records (state police)</td>
</tr>
<tr>
<td>- Reduce positive drug screens.</td>
<td>3. Probation and Parole records</td>
</tr>
<tr>
<td>- Improve probation/parole status.</td>
<td>4. Automated Health Systems</td>
</tr>
<tr>
<td>- Reduce status offenses. (focus on truancy)</td>
<td>5. AOPC records</td>
</tr>
<tr>
<td>*To be reported/compiled only for priority group consumers by age group.</td>
<td></td>
</tr>
<tr>
<td><strong>4. Improve Health Care</strong>*</td>
<td>1. Encounter data from physical health HMOs.</td>
</tr>
<tr>
<td>- Meet or exceed DPW’s EPSDT screening targets.</td>
<td>2. 837I HIPAA Compliant Transaction Institutional.</td>
</tr>
<tr>
<td>- Increase % of consumers with annual physical exams.</td>
<td>3. 837P HIPAA Compliant Transaction Professional.</td>
</tr>
<tr>
<td>- Reduce hospital medical ER use.</td>
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<tr>
<td>*To be compiled only for priority group consumers by age group.</td>
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<tr>
<td><strong>5. Increase “Penetration Rates”</strong></td>
<td>1. Consumer Registry File (CRF)²</td>
</tr>
<tr>
<td>(i.e., percent of enrollees who received behavioral health treatment through the behavioral health contractor)</td>
<td>2. 837I HIPAA Compliant Transaction Institutional.</td>
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<tr>
<td>- Increase appropriate utilization by priority group and type of service.</td>
<td>3. 837P HIPAA Compliant Transaction Professional.</td>
</tr>
<tr>
<td>- Increase appropriate utilization by age and type of service.</td>
<td>4. Automated Health Systems</td>
</tr>
<tr>
<td><strong>6. Increase Consumer/Family Satisfaction</strong>*</td>
<td>1. Consumer Registry File (CRF)¹</td>
</tr>
<tr>
<td>*To be reported/compiled only for priority group consumers.</td>
<td>2. Consumer/Family Satisfaction Measurement Instruments</td>
</tr>
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### OUTCOME DIMENSIONS

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<tr>
<th>DATA SOURCE(S)</th>
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<tr>
<td>7. <strong>Implement Continuous Quality Improvement (CQI) Actions</strong>&lt;br&gt;1. CQI Periodic Reports – Behavioral health contractor must submit to DPW periodic narrative reports detailing its CQI activities, delineating deficiencies and areas for improvement, actions taken to improve performance (or remedy deficiencies) and the effectiveness/outcome of actions taken. CQI reports must address performance indicator reports issued by OMH.</td>
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<th>DATA SOURCE(S)</th>
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<tr>
<td>8. <strong>Increase Range of Services and Improve Utilization Patterns</strong>&lt;br&gt;1. 837I HIPAA Compliant Transaction Institutional.&lt;br&gt;2. 837P HIPAA Compliant Transaction Professional.&lt;br&gt;3. Encounter data from physical MCOs.</td>
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<th>DATA SOURCE(S)</th>
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<tr>
<td>9. <strong>Implement co-occurring disorder (COD) Performance Indicator or QA measure</strong>&lt;br&gt;1. BH-MCO self reporting</td>
</tr>
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1 Reporting requirements and Data elements for QSF are in the Proposers’ Library.<br>2 Reporting Requirements and Data elements for CRF are in the Proposers’ Library.<br><br>** HIPAA Implementation Guides and Addenda for the various types of transactions are available, free of charge, from the Washing Publishing Company at www.wpc-edi.com/hipaa/. These documents constitute the official HIPAA reporting standards as defined by the Accredited Standards Committee (ASC) X12.<br><br>*** Pennsylvania PROMISe Companion Guides for each of the types of transactions may be obtained, free of charge, by contacting OMHSAS directly. The Companion Guides provide detailed information specific to the submittal of claims and encounter transactions to Pennsylvania’s PROMISe system.
HealthChoices COD Performance Indicators/QA Measures

Please use the following operational definitions and reporting specifications for required DPW COD performance indicators/QA measures referenced in Appendix K.2

Operational definitions:

Co-occurring disorder: Individuals with a co-occurring disorder have one or more mental disorders as well as one or more disorders relating to the use of alcohol and/or other drugs.

Screening: A formal process that is typically brief and occurs soon after the individual presents for services. The purpose of the screening process is to determine the likelihood that a person has a co-occurring disorder, not to establish the presence or specific type of disorder, but to determine the need for an assessment. (No mandated instrument)

Assessment: A formal process of gathering information and engaging with the individual that enables the provider to establish the presence or absence of a co-occurring disorder that may involve clinical interviews, administration of standardized instruments, and/or review of existing information. The purpose of the assessment is to establish the existence of a clinical disorder or service need and to work with the individual to develop a treatment plan. (No mandated instrument)

Specific reporting criteria:
(unduplicated count, quarterly review and annual report)

1. Increase the percentage of network providers that routinely screen and assess for co-occurring mental health and substance use disorders:

   Total number of network providers: ______
   Number of network providers that have a written policy/procedure requiring individuals to be screened and assessed for co-occurring disorders: ______
   Total number of individuals screened and/or assessed for a co-occurring disorder: ______

2. Increase identification of co-occurring recipients (prevalence):
   Per Network provider:

   Total number of individuals admitted to the program: ______
   Total number of individuals determined to have a co-occurring disorder that have been admitted to the program: ______
   Total number of individuals determined to have a co-occurring disorder referred to another treatment provider: ______

   Commonwealth of Pennsylvania
   HealthChoices Behavioral Health

   Appendix K
   1/1/08
GUIDELINES FOR CONSUMER/FAMILY SATISFACTION TEAMS AND MEMBER SATISFACTION SURVEYS

The Department of Public Welfare (DPW) values and encourages the input of consumers and families in all aspects of the HealthChoices Program and expects that such input will be incorporated in quality improvement. In addition the Office of Mental Health and Substance Abuse Services (OMHSAS) encourages input from consumers, persons in recovery, and families regarding the services and supports received in the mental health and drug and alcohol service system. Consumer and family feedback helps inform Providers, counties and Behavioral Health Managed Care Organizations (BH-MCO) about how services can support recovery for adults, resilience in children and adolescents and be more effective. Consumers and families have specialized knowledge and sensitivity about how respect, dignity and responsiveness of services can affect the process of recovery and preserve resilience. Members are more likely to feel safe in describing their experience with someone who is not their service Provider. Soliciting feedback on satisfaction with services empowers consumers and families and allows them to have a greater role in determining the quality of behavioral health care and recommending system improvements DPW therefore requires Primary Contractors to implement a comprehensive approach for the measurement of consumer/family satisfaction, including but not limited to:

- A Consumer/Family Satisfaction Team (C/FST) Program
- An Annual Mailed/Telephonic Survey of Member Satisfaction

A. CONSUMER and FAMILY SATISFACTION TEAM PROGRAM

1. Purpose

The purpose of the C/FST Program is to determine whether adult behavioral health service recipients and children and adolescents with serious emotional disturbance and/or substance abuse disorders and their families are satisfied with services and to help ensure that problems related to service access, delivery and outcome are identified and resolved in a timely manner. Surveys should identify consumer and family member satisfaction with the services of a specific Provider as well as the level of satisfaction with the behavioral health system and all of the treatment, services and supports each consumer is receiving. This is primarily accomplished by gathering information through face-to-face discussions with Recipients of behavioral health services and the families of child and adolescent service Recipients, with follow-up reports, dialogue, and problem resolution feedback with the Primary Contractor.

It is the responsibility of the Primary Contractor (the Primary Contractor refers to the responsible party that holds the HealthChoices contract or agreement with DPW) to provide the support, encouragement, and resources necessary to build a strong, independent, conflict free C/FST Program. In a recovery oriented service system support and encouragement would be evidenced by a Primary Contractor that:
• Communicates the importance of listening to and acting upon the results of satisfaction feedback from C/FSTs;
• Supports and encourages C/FSTs so that they are considered a respected and valuable service;
• Requires timely Provider action in response to survey results;
• Has a Provider network that works in partnership with C/FSTs to continuously improve service responsiveness using survey results in their internal quality management program;
• Identifies system improvement needed based on survey results;
• Actively provides direction and feedback to C/FSTs about how to improve their program and acquire the skills needed to move toward the independent operation of a satisfaction survey program; and
• Provides the resources necessary to accomplish the requirements outlined in this document.

2. Organizational Requirements of Consumer/Family Satisfaction Team Programs

In order to determine whether or not behavioral health services are meeting the needs and expectations of adults, young adults, children and adolescents and their family members, the Primary Contractor shall ensure that the C/FST Program is organized and operates in compliance with the following:

The Primary Contractor either directly, or via a BH-MCO or other sub-contractor, must have systems and procedures to routinely assess service Recipient satisfaction. The C/FST Program may be either a single or a multi-county program based upon the nature of the contract between DPW and the Primary Contractors. The family satisfaction component may be accomplished either as a separate administrative entity or as a component of the C/FST Program that is specifically responsible for family satisfaction activities.

(a) The Primary Contractor for HealthChoices and/or the BH-MCO must have a contract or a written and signed agreement with each C/FST Program and fiduciary, if applicable, that delineates roles and responsibilities of all parties. Designation of who holds the responsibility for advocacy and follow-up on behalf of Members should also be included.

(b) Under the contract or written agreement, and consistent with the requirements of the Mental Health Procedures Act (Chapter 5100), the C/FST members will act as agents of the Primary Contractor, and are, therefore, to have the same access to consumers and family members as the Primary Contractor and service Providers, insofar as it is necessary to perform their responsibilities.

(c) Each C/FST Program must have a Director who may be full or part time depending upon the size of the program. The Director must be a person who self-identifies as a consumer, person in recovery, or family member as stated in 3(a) and (b) as of January 1, 2005. If the current Director hired prior to January 1, 2005 does not meet this requirement, he or she may continue to serve until such time as the position is vacant and a new Director is hired.
(d) C/FST members must be paid at least as much as other persons in the general workforce doing similar work in the same community.

(e) C/FSTs must be independent from any Provider of behavioral health services or any other agency that might create a conflict of interest. C/FSTs that do not have accounting capabilities may contract with a provider as its fiduciary provided the contract safeguards the independence of the C/FST for program direction including budget priorities, satisfaction surveys, findings and recommendations.

(f) The Primary Contractor shall work with the C/FST to establish an annual plan for conducting face-to-face interviews. The plan will include goals such as: the number of interviews to be completed, the levels of care to be surveyed and special focus surveys to address specifically identified special populations. If the C/FST Program identifies barriers to accessing Members to be surveyed, the Primary Contractor will assist to resolve the issue. Priority populations should be given priority for face-to-face interviews.

(g) The Primary Contractor will ensure that the C/FST Program has adequate financial resources, training, support, and necessary equipment for the program to produce high quality quarterly reports.

3. Consumer and Family Satisfaction Team Minimum Requirements

(a) Persons performing adult satisfaction activities must be, or have been, consumers of behavioral health services, persons in recovery, or family members.

(b) Persons performing family satisfaction activities must include family members of children and adolescents with serious emotional disturbance and/or substance abuse disorders who are receiving or have received behavioral health services in the publicly funded system, and may also include older adolescents and/or young adults who are receiving or have received behavioral health services as a child or adolescent in the publicly funded system.

(c) Family satisfaction team members must have child abuse and criminal history clearances in accordance with the Child Protective Services Law, Chapter 63, Sections 6303 and 6344, and are mandated reporters for child abuse.

(d) The family satisfaction component may be a separate and distinct administrative entity, or may be at least one team of a C/FST Program or one member of a team dedicated to family satisfaction activities.

(e) Young adults (18-22) may be interviewed by either consumer or family satisfaction team members, as appropriate, depending on the services being received.

4. Conducting Satisfaction Surveys

Consumer and family satisfaction interviews serve as a means for early identification and resolution of problems related to service access, and timeliness of service delivery,
appropriateness of services and recovery and resilience outcomes. Face-to-face interviews afford Members the opportunity to communicate openly with peers on an ongoing basis. Additionally, satisfaction surveys assist in determining the level of satisfaction with respect, dignity and hopefulness as integral components of the entire service delivery system. These activities also provide a further check to ensure that the service system is consistent with the principles of recovery in adults, resilience in children and adolescents, of the Community Support Program (CSP), the Child and Adolescent Service System Program (CASSP), cultural competence, and Drug and Alcohol (D&A) Treatment Principles. The Primary Contractor shall ensure:

(a) Consumer/family satisfaction should be assessed through face-to-face interviews with adult behavioral health service Recipients; children and adolescents with serious emotional disturbance and/or substance abuse disorders and their families. Interviews should be face-to-face whenever possible however, telephone or mailed surveys may be used if preferred by the Member.

(b) The Primary Contractor shall establish mechanisms in their contract or written agreement to inform the C/FST Program of newly enrolled Members receiving behavioral health services and on-going Members who may wish to participate in satisfaction interviews. The first mechanism below is to be used when member names, addresses and telephone numbers are provided to the C/FST. The second mechanism describes the process if the Primary Contractor does not wish Member names to be provided to the C/FST without Member consent. It is the Primary Contractors responsibility to select the mechanisms for notifying Members about the C/FST Program as follows:

i) The Primary Contractor periodically provides the names and addresses of Members newly enrolled in mental health services to the C/FST and at least annually updates the list for Members who continue to remain enrolled, and notifies Members receiving drug and alcohol services as stated in 4 (b) ii below; or

ii) The Primary Contractor informs all newly enrolled Members receiving mental health and/or drug and alcohol services about the C/FST Program. The names of members receiving mental health services who wish to be interviewed can be provided to the C/FST without a release of information. Members receiving drug and/or alcohol services must sign a release of information in order for their name, address and telephone number to be provided to the C/FST. A mechanism must be established to provide an opportunity to be interviewed at least annually for Members that remain enrolled in mental health and drug and alcohol services.

(c) Service Providers must provide C/FSTs with comfortable private space for interviews to ensure an environment in which behavioral health consumers and children and adolescents with serious emotional disturbance and/or substance abuse disorders and their families feel free to express any concerns they may have.

(d) C/FSTs solicit input from Recipients of behavioral health services and the families of children and adolescents receiving behavioral health services in order that
satisfaction and areas of concern can be identified and recommendations for systems improvement can be developed. This can be accomplished through individual and/or group discussions, upon discharge from a service, and as focus groups with behavioral health consumers, persons in recovery, children and adolescents with serious emotional disturbance and/or substance abuse disorders and their families, including visits to programs where members receive their services or to their homes. Family members may be more easily accessed when interviews are conducted by telephone. Information about the C/FST Program is best shared in face-to-face presentation with individuals or groups, however, such methods as videotapes, telephone or written material may also be used.

(e) Some of the C/FST survey questions should address satisfaction with the Provider(s) and the mental health and drug and alcohol service(s) the consumer is receiving. The findings of the C/FST shall be organized to identify the Provider, or special population in the case of a focused survey for three purposes: 1) to allow the managed care organization to include C/FST information in Provider profiling, 2) to provide feedback to the individual Provider about their program, and 3) to allow the Primary Contractor (County and/or Managed Care Organization) to direct the Provider to take corrective action to address a Member concern or concerns about the Provider operation or program. The face-to-face surveys and monthly problem solving process ensure action is taken on an on-going basis and resolution for the Member is timely and responsive. Both the on-going surveys and the annual survey described in Section B can be used to identify trends that may require system improvement.

(f) The Primary Contractor will identify and request the C/FST to conduct outreach efforts to under-served or un-served groups of consumers and families in order to conduct satisfaction surveys and identify system improvements that will increase the access, engagement and retention of these individuals in needed behavioral health services.

5. Areas for Consumer and Family Satisfaction Team Observation and Discussion with Recipients of Behavioral Health Services and the Families of Child and Adolescent Service Recipients

Consumers, persons in recovery, and families of children and adolescents shall have input into the questions asked in satisfaction surveys. The survey tool should allow identification of the Provider(s) and the service(s) provided as well as general satisfaction with the service system. Satisfaction surveys shall include but not be limited to the following areas:

**BH-MCO Related Issues:**
- Knowledge of and satisfaction with member services
- Knowledge of benefits and treatment options
- Awareness of complaint and grievance process (and satisfaction with outcome if process was used)
- Satisfaction with level of dignity and respect conveyed to Members by the BH-MCO staff
Service Delivery:
- Interagency Team Process for children and adolescents and their families
- Choice of Providers
- Satisfaction with timeliness and convenience of the service delivery system
- Perception of accessibility and acceptability of services (i.e., denial of preferred services, geographic, language/culture, problems resulting in discontinuation of services by Recipient)

Treatment:
- Service Recipient involvement in treatment planning and decisions
- Child or adolescent and their family members involvement in treatment planning and decisions
- Interagency Team Process for children and adolescents and their families
- Perception of effectiveness/outcomes of treatment
- Perception of changes in quality of life as a result of treatment
- Satisfaction with dignity, respect and hopefulness offered during treatment
- Satisfaction with physical health care

Overall Satisfaction:
- Degree to which services were consistent with CSP, CASSP and D&A principles, and facilitate recovery and resilience
- Freedom from sense of coercion or fear of retribution for Recipients of mental health services
- Satisfaction and comfort level with physical environment of facility or site where services were provided.
- Satisfaction with dignity, respect and hopefulness offered by all levels of the service system.

DPW may from time to time require specific questions to be added to C/FST satisfaction surveys in order to conduct statewide quality assurance activities.

6. Confidentiality

All employees of C/FST Programs must comply with applicable state and federal laws, regulations, and rules regarding the confidentiality of mental health consumers and recipients of drug and alcohol treatment services. The contract or written agreement will address confidentiality requirements including the following:

(a) All C/FST members must receive training in confidentiality regulations for mental health and substance abuse services. All family satisfaction team members must also receive training in confidentiality issues relevant to the child and adolescent population in both mental health and substance abuse services.

(b) All C/FST members must sign a confidentiality agreement, and personnel policies must address disciplinary procedures relevant to violation of the signed confidentiality agreement.
(c) Mental Health Confidentiality: For purposes of the HealthChoices program, C/FSTs are agents of the Primary Contractor, and have the delegated authority to collect and disseminate the needed information. C/FST members must be considered as equal to all other mental health professionals with regard to access to mental health consumers, children and adolescents with serious emotional disturbance and their families. There should be no special written permission required to engage consumers and families receiving mental health, whether in state hospitals or community programs.

(d) Mental Health Confidentiality: If the Recipient of mental health services is a child (up to 14 years of age), he or she may be interviewed but only in the presence of a responsible family member or authorized caregiver, and the family member or caregiver must also be interviewed. If the Recipient of mental health services is an adolescent (14 to 18 years of age), the adolescent should be interviewed independently and responsible family members or an authorized caregiver could also be offered the opportunity to be interviewed. It is preferable but not necessary to receive the adolescent’s consent before interviewing family members or caregivers.

(e) Drug and Alcohol Confidentiality: A service agreement between the C/FST Program and each Drug and Alcohol Provider outlining Drug and Alcohol confidentiality rules, rights, regulations and laws that govern Drug and Alcohol Providers in Pennsylvania is also required. This is consistent with the current practice of Drug and Alcohol Providers to require such an agreement be signed by representatives of the Departments of Health and Public Welfare, Joint Commission on Accreditation of Healthcare Organizations, and Single County Authorities for Drug and Alcohol services.

(f) Drug and Alcohol Confidentiality: Prior to a drug and alcohol service Provider contacting a C/FST Program to provide the name of a person who wishes to be surveyed, a consent to release information form must be signed by the Member requesting their name, address and telephone number be provided to the C/FST Program. A copy of the signed consent to release information form must be retained in the Member’s treatment file and a copy given to the Member and the C/FST. Consent to release information forms for Members receiving drug and alcohol treatment services are not required when the C/FST conducts surveys without receiving the persons name and reports data in the aggregate.

(g) Drug and Alcohol Confidentiality: Recipients of drug and alcohol treatment services, regardless of age, must give their written consent for a parent or other family member to be interviewed, or to be present while the Recipient of services is being interviewed.

(h) C/FSTs must be afforded the opportunity to meet with mental health consumers and Recipients of substance abuse services and the family members of child and adolescent service Recipients to describe and explain the purpose and function of C/FSTs.
7. Problem Identification and Recommendations for Action

C/FSTs must provide feedback to the Primary Contractor through written quarterly reports and monthly problem resolution meetings that allow for dialogue and review of findings. The Primary Contractor is responsible for timely reports back to the C/FST on specific actions and problem resolution resulting from identified issues, concerns and problems. The contract or written agreement shall identify the process the Primary Contractor will use to resolve problems and address suggestions identified by the C/FST including the following:

(a) Process for problem identification and resolution that includes the C/FST Program, consumers, persons in recovery, parents, adolescents, children, designated county staff, staff of the managed care organization, and advocates as appropriate to the problem identified.

(b) The problem resolution process must include how often problem resolution meetings will occur, with whom, and the responsibilities of all parties (County, C/FST, managed care organization, and Providers). This process will identify actions to be taken by the Primary Contactor if resolution is not reached. There must also be a process in place for responding to urgent matters identified by Members.

(c) The Managed Care Organization sub-contracts with Providers of behavioral health services in their network shall include the timeframe in which the Provider must respond to the recommendations made by the C/FST as directed by the County, Managed Care Organization or the C/FST. Providers of behavioral health services should be required to use C/FST feedback in their quality management program.

(d) The Primary Contractor must provide a timely response to the C/FST on actions taken in response to reported problems and concerns resulting from service Recipient interviews for inclusion in the next quarterly report.

(e) Mechanisms must be in place to address identified trends or system changes that may require the Primary Contractor to study in more depth to understand the issue and resolve. This may include focus meetings on specific topics or collaboration with other involved service systems. The results of these focus studies will be provided to the C/FST for inclusion in their reports.

8. Knowledge, Training and Orientation of Consumer and Family Satisfaction Teams

The Primary Contractor will ensure that C/FST members have both an initial orientation to and on-going training in the following areas:

(a) C/FST members must have basic knowledge of mental illness and addictive diseases and an understanding of the concept of recovery and resilience in relation to both for adults and children and adolescents. Persons performing Family Satisfaction activities must also have an understanding of serious emotional disturbance and substance abuse disorders in children and adolescents.
(b) Training for C/FST members must include confidentiality regulations for mental health and substance abuse services. Family satisfaction team members must also receive training in confidentiality issues relevant to the child and adolescent population in both mental health and substance abuse services. Training must include an understanding of responsibilities, as applicable, under the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

(c) C/FST members must also have an understanding of the cultural diversity of the individual and community being served in order to ensure culturally sensitive interactions. Training shall include the basic concepts of recovery and resilience.

(d) Family satisfaction team members must have training in the responsibilities of being mandated reporters for child abuse.

(e) The Primary Contractor shall arrange a minimum of two (2) hours orientation/training on the BH-MCO operations, policies and procedures for satisfaction team members.

9. **Quarterly Reports**

The Primary Contractor shall provide the Department with the C/FST Program’s quarterly report summarizing consumer and family satisfaction findings, as well as improvement actions and system changes implemented by the Primary Contractor in response to those findings. The Primary Contractor shall provide support and direction to the C/FST to ensure the report contains not only the numeric results of surveys conducted but also information about the actions taken in the previous quarter by the Primary Contractor or behavioral health service Provider, trends observed, and other relevant information that can be used by Providers and others about ways to improve treatment and supports.

10. **DPW Annual Review of Consumer/Family Satisfaction Team Programs**

DPW will conduct an annual review of the C/FST program that will include a review of the following:

(a) Results of satisfaction surveys;

(b) Actions taken to resolve identified issues and system changes;

(c) Role and effectiveness of the Primary Contractor in problem resolution and direction to the C/FST program;

(d) Adequacy of the budget, staff, and training opportunities to carry out the requirements of the program;

(e) Role of the fiduciary, if applicable, in supporting the program and financial priorities established by the C/FST program; and
B. **ANNUAL MEMBER SATISFACTION SURVEYS**

1. **Consumer and Family Satisfaction Annual Mailed/Telephonic Survey**

   The Primary Contractor is responsible for ensuring that an annual satisfaction survey of a representative sample of persons served by the behavioral health program is conducted by mail or telephonically. The purpose of the Annual Mailed/Telephonic Consumer and Family Member Satisfaction Survey is to determine the extent to which the BH-MCO adult Members and family members of children and adolescents are satisfied with overall BH-MCO operations and services, and to identify areas which need improvement. Surveys are developed and used by the BH-MCO to gather information to determine whether the BH-MCO adult Members and family members of children and adolescents are knowledgeable about and satisfied with the behavioral health program including core functions such as member services as well as to assess whether service availability, service access, and services provision and effectiveness are meeting the Member’s needs and expectations.

   (a) Surveys of Recipients of substance abuse services, regardless of age, must be distributed by Providers at service delivery sites in order to protect the confidentiality of persons being surveyed.

   (b) A separate survey instrument must be developed for children and adolescent service Recipients and their families.

   (c) Findings and resulting recommendations from the survey and consumer/family satisfaction activities are to be incorporated into the Primary Contractor’s ongoing quality management and improvement program.

   (d) The County may directly conduct the annual survey or direct the managed care organization, C/FST Program, or another entity that would be conflict free, to conduct the annual survey.

2. **Areas Covered by the Consumer and Family Satisfaction Survey**

   Consumers, persons in recovery, and families of children and adolescents shall have input into the questions asked in satisfaction surveys. Satisfaction surveys shall include but not be limited to the following areas:

   **BH-MCO Related Issues:**
   - Knowledge of and satisfaction with member services
   - Knowledge of benefits and treatment options
   - Awareness of complaint and grievance process (and satisfaction with outcome if process was used)
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➢ Satisfaction with level of dignity and respect conveyed to Members by the BH-MCO staff

Service Delivery:
➢ Interagency Team Process for children and adolescents and their families
➢ Choice of Providers
➢ Satisfaction with timeliness and convenience of the service delivery system
➢ Perception of accessibility and acceptability of services (i.e., denial of preferred services, geographic, language/culture, problems resulting in discontinuation of services by Recipient)

Treatment:
➢ Service Recipient involvement in treatment planning and decisions
➢ Child or adolescent and their family Members involvement in treatment planning and decisions
➢ Interagency Team Process for children and adolescents and their families
➢ Perception of effectiveness/outcomes of treatment
➢ Perception of changes in quality of life as a result of treatment
➢ Satisfaction with dignity, respect and hopefulness offered during treatment
➢ Satisfaction with physical health care

Overall Satisfaction:
➢ Degree to which services were consistent with CSP, CASSP and D&A principles, and facilitate recovery and resilience
➢ Freedom from sense of coercion or fear of retribution for Recipients of mental health services
➢ Satisfaction and comfort level with physical environment of facility or site where services were provided.
➢ Satisfaction with dignity, respect and hopefulness offered by all levels of the service system.

Miscellaneous:
➢ Items required by the Department as a result of the Department’s ongoing monitoring and program evaluation.
➢ Knowledge of and satisfaction with the Medical Assistance Transportation Program
➢ Satisfaction of consumers with special needs e.g. deaf and hard of hearing, older adults, people who are homeless, etc.
➢ Suggestions for improvement

3. Sampling Procedure

The Annual Mailed/Telephonic Consumer and Family Satisfaction Survey must be sent to, or conducted with, a representative sample of behavioral health service Recipients with a statistically valid sampling of Members in the adult priority population groups, family members of child and adolescent service Recipients, and special needs populations, as well as a sampling of Members who filed complaints and grievances.
The survey of Members receiving drug and alcohol services must be anonymously distributed through service Providers.

4. **Frequency of Survey and Reporting Results**

A report of the survey findings and resulting recommendations for quality improvement must be submitted to the Department as part of the annual quality management summary report, quality management plan for the upcoming year. The Consumer and Family Satisfaction Mailed/Telephonic Survey will be conducted at least annually.
# Non-Financial

## Data Reporting Requirements*

<table>
<thead>
<tr>
<th>File/Report Name</th>
<th>Description</th>
<th>Frequency</th>
<th>Data Format Transfer Mode Due Date</th>
<th>Reporting Document</th>
</tr>
</thead>
<tbody>
<tr>
<td>Transition Monitoring</td>
<td>Reports data needed for transition monitoring, i.e. eligibles, authorizations, denials, grievances</td>
<td>Weekly during first three start-up months, at a minimum</td>
<td>ASCII files via eGovernment Secure Data Exchange; Due close-of-business on Wednesday following reporting week</td>
<td>Requirements &amp; Specifications for Transition Monitoring</td>
</tr>
<tr>
<td>Quarterly Monitoring</td>
<td>Reports data needed for on-going monitoring, i.e. eligibles, authorizations, complaints, involuntary admissions, discharges and readmissions.</td>
<td>Quarterly</td>
<td>ASCII files via eGovernment Secure Data Exchange; Due 45 days after end of reporting quarter</td>
<td>Requirements &amp; Specifications Manual for Quarterly Monitoring</td>
</tr>
<tr>
<td>Aggregate Encounter</td>
<td>Reports aggregate data based on claims adjudicated, i.e. consumers, units, dollars, diagnosis, age. Also includes aggregate subcapitation data</td>
<td>Monthly until DPW is satisfied with the accuracy of person-level Encounter data</td>
<td>ASCII files via eGovernment Secure Data Exchange; Due 30 days after end of reporting month</td>
<td>Aggregate Encounter Reporting Manual</td>
</tr>
<tr>
<td>837 Reporting</td>
<td>Reports each time consumer has an encounter with provider. Format/data based on HIPAA compliant 837 format.</td>
<td>Monthly</td>
<td>ASCII files via FTP: Due last calendar day of 3rd month after the Primary Contractor paid/adjudicated the encounter.</td>
<td>HIPAA implementation guide and addenda.** PROMISe companion guides. ***</td>
</tr>
<tr>
<td>Alternative Payment Arrangement Reporting</td>
<td>Reports any payment arrangement with a provider other than fee for service.</td>
<td>Varies</td>
<td>ASCII via eGovernment Secure Data Exchange; Due 30 days after the end of a payment cycle</td>
<td>Alternative Payment Arrangement file format.</td>
</tr>
<tr>
<td>Complaints and Grievances</td>
<td>Reports aggregate data on complaints, grievances and resolutions. Also includes detail records on grievances</td>
<td>Monthly</td>
<td>ASCII files via eGovernment Secure Data Exchange; Due 30 days after end of reporting month</td>
<td>Complaint/Grievance Reporting Manual</td>
</tr>
<tr>
<td>Consumer Data. Consumer Registry/</td>
<td>Reports person-specific demographic/clinical data at registry and</td>
<td>Semi-Annually</td>
<td>ASCII via eGovernment Secure Data Exchange; Due 30 days after the</td>
<td>Performance Outcome Management</td>
</tr>
</tbody>
</table>
### Appendix M

Revised 1/1/08

<table>
<thead>
<tr>
<th>Quarterly Status (included in Performance Outcome Management System)</th>
<th>closure; i.e. birth date, priority group, service request date, independence of living. Reports status &amp; outcome data on priority group consumers, i.e. independence of living, voc/ed, residential moves</th>
<th>end of reporting quarter</th>
<th>System Reporting Manual</th>
</tr>
</thead>
<tbody>
<tr>
<td>MCO Provider File</td>
<td>Reports all providers within the network.</td>
<td>Monthly</td>
<td>ASCII via FTP; Due second Monday of the month</td>
</tr>
</tbody>
</table>

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**Behavioral HealthChoices Data Reporting Requirements**

**Non-Financial**

<table>
<thead>
<tr>
<th>File/Report Name</th>
<th>Description</th>
<th>Frequency</th>
<th>Data Format Transfer Mode Due Date</th>
<th>Reporting Document</th>
</tr>
</thead>
<tbody>
<tr>
<td>Monthly TSS Services Report</td>
<td>Report Tracks TSS hours and recipients authorized and TSS hours and recipients paid.</td>
<td>Monthly</td>
<td>Via e-mail to OMHSAS due 4 months after authorization month.</td>
<td>Letter to HealthChoices Contractor from Mike Jeffrey dated 1/21/04.</td>
</tr>
<tr>
<td>Denial Log</td>
<td>Reports each time a requested service was denied, as well as any alternatives approved.</td>
<td>Monthly</td>
<td>ASCII via eGovernment Secure Data Exchange; Due 15 days after end of reporting month.</td>
<td>Denial Log Reporting Manual.</td>
</tr>
<tr>
<td>COD Reporting</td>
<td>Reports number of network providers Screening and Assessing for co-occurring disorders as well as prevalence of co-occurring substance abuse and mental health disorders</td>
<td>Annually</td>
<td>Via email to OMHSAS due 30 days after end of reporting year.</td>
<td>Presentation on 4/4/07 Letter to Advisory Board</td>
</tr>
</tbody>
</table>
*Does not cover financial reporting requirements. The file specifications, formats, data elements and reporting requirements are available in the Proposers’ Library and are subject to change by the Department.

** HIPAA Implementation Guides and Addenda for the various types of transactions are available, free of charge, from the Washing Publishing Company at www.wpc-edi.com/hipaa/. These documents constitute the official HIPAA reporting standards as defined by the Accredited Standards Committee (ASC) X12.

*** Pennsylvania PROMISE Companion Guides for each of the types of transactions may be obtained, free of charge, by contacting OMHSAS directly. The Companion Guides provide detailed information specific to the submittal of claims and encounter transactions to Pennsylvania’s PROMISE system.
Counties that are successful in becoming the Primary Contractor for the HealthChoices program in their County, or behavioral health managed care organizations (BH-MCOs) under direct contract with the Department of Public Welfare (DPW) are allowed to retain Capitation revenues and investment income that was not expended during the contract year to reinvest in programs and services in their County. These funds, called Reinvestment Funds, must be spent in accordance with a DPW; Office of Mental Health and Substance Abuse Services (OMHSAS) approved reinvestment plan.

Reinvestment Funds provide a unique opportunity for a financial incentive to reward sound financial management practices and allow the creative use of funds to fill identified gaps in the treatment system, to test new innovative treatment approaches, and to develop cost-effective alternatives to traditional services that may create cost offsets for In-Plan Services. Reinvestment Funding is one mechanism used to achieve the Commonwealth’s expectation for continuous quality improvement of a comprehensive treatment system that not only supports recovery for persons with mental health, drug and/or alcohol treatment needs, but their families as well. This document refers to both the reinvestment plan and reinvestment plan priorities. The term “plan” refers to the entire reinvestment submission for the contract year. The “reinvestment plan priorities” are the individually named projects submitted with a program description and numbered in priority order.

This document describes the required planning process, financial reporting, allowable expenditures, and the approval process for Primary Contractors to use Reinvestment Funds. These requirements are detailed in the HealthChoices Request for Proposals (RFP), the HealthChoices Agreement, and the Financial Reporting Requirements – HealthChoices Behavioral Health Program document.

Additional Definitions Not Found in Definitions Appendix

**Non-Medical Services**– Costs that enhance service systems or service delivery but are not medical services.

**Risk and Contingency Funds** – PMPM Capitation funds received by the Primary Contractor pursuant to this Agreement, which are not expended on services (In-Plan, Supplemental, or Cost-Effective Alternatives) or administrative functions and which are in excess of the Equity Reserve required to be maintained under this Agreement. Risk and Contingency Funds do not include Reinvestment Funds or funds designated in a reinvestment plan submitted to DPW.

Planning for Reinvestment Funds

**Involvement of Stakeholders**

1. The planning process must include and document the involvement of consumers, families (including families of children and adolescents), persons in recovery, MH/MR
and Single County Authorities (SCA), and as appropriate, County Commissioners and local legislators.

2. In order for stakeholders to provide informed feedback about options for Reinvestment Funds the County and BH-MCO should present the results of data analysis performed to document utilization trends, unmet needs, populations served, outcomes achieved by the HealthChoices program to date, etc. as part of the reinvestment plan planning process.

3. Stakeholders must be involved at all stages of the planning and decision making process. Evidence of their involvement and feedback must be summarized as part of the plan submission.

4. Counties may choose to incorporate planning for Reinvestment Funds and receiving stakeholder input as part of the County Mental Health Planning process.

5. Preliminary reinvestment plans should be discussed with the OHMSAS Field Office for input regarding planned use of funds prior to submission.

**Timeframes for Submission and Approval**

1. The timeframes for submission and approval are provided as approximate dates. The dates provided are the outside dates for when submission is required. Primary Contractors may submit plans prior to the completion of the audit using estimates of the Reinvestment Funds available. Submission timeframes are calculated from the beginning and ending dates of the annual contract. Dates for review and approval may vary depending on any additional information or clarification needed. The review process is summarized below, and detailed steps are provided in Attachment 1.

2. Plans for Reinvestment Funds are submitted annually based on the HealthChoices contract year.

3. Draft plans are submitted to OMHSAS Field Office for review and comment once the amount of Reinvestment Funds are identified and confirmed by OMHSAS. This should be no later than the first day of the ninth (9th) month after the end of the contract year.

4. OMHSAS Field Office provides written feedback to the Primary Contractor within 2 weeks after receiving the draft plan.

5. Final reinvestment plans are to be submitted within 30 days of receiving OMHSAS feedback, which should occur no later than the first 2 weeks of the tenth (10th) month after the end of the contract year.

6. The Reinvestment Review Committee reviews final reinvestment plans. If there are no questions, written approval/denial will be provided within 2 weeks after the plan submission. If there are questions, the questions are provided to the Primary Contractor. Once the Primary Contractor responds to the questions by providing the requested additional information and/or submitting a revised plan, written approval/denial will be provided within 2 weeks.

7. Primary Contractors should begin implementing their approved reinvestment plan when they receive written notification that the plan is approved and when the funds to support the plan have been deposited into a restricted account as required (within thirty (30) days of plan approval).

8. If Reinvestment Funds from a subsequent year are intended to be used to continue funding a previously approved reinvestment plan priority, the Primary Contractor
should submit the previously approved plan with updated financial information related to the request for continuation funding. There should be evidence that stakeholders continue to support the plan priority and evidence of the benefit from implementing the priority. OMHSAS will expedite the review of the plan. 9. When additional funds are identified, plans must be submitted no later than 12 months from the date additional Reinvestment Funds are identified. The new plans will be reviewed at the time they are received following the same process described above. Exceeding this timeframe for submission may result in the DPW recovery of these funds.

Identification of Reinvestment Funds

1. Primary Contractors should confirm with OMHSAS, the amount of Reinvestment Funds available. Written confirmation should be received, in order to meet the above timeframes, by the middle of the (8th) month after the end of the contract year. Confirmation of funds available should occur before the draft reinvestment plan is submitted. It is understood that the amount of reinvestment money available is subject to change based on future reconciliation.

2. For reinvestment purposes only, adjustments made to prior year available funds two (2) years after submission of the contract audit will be applied to the most recent audited contract year.

3. Funds that would otherwise be available for reinvestment, but are being proposed for County Risk and Contingency, when the County is the Primary Contractor, must be identified and approved by OMHSAS. The County must submit a written request to OMHSAS for approval of Risk and Contingency Funds stating the rationale for the request prior to its letter confirming the amount of reinvestment available. A written request for approval to use Risk and Contingency Funds for reinvestment purposes must be submitted to OMHSAS and approved prior to the submission of a reinvestment plan.

4. A reinvestment plan must be submitted for approval within twelve (12) months of the time additional funds are identified for reinvestment.

Guidance on the Use of Reinvestment Funds

Allowable Uses for Reinvestment Funds

1. Start-up costs for In-Plan Services, during capacity building, including provider assistance. Any billable In-Plan Services must be submitted to the BH-MCO for payment.

2. Development and/or purchase of Medical Assistance (MA) eligible Supplemental Services that are in-lieu of or in addition to;

3. Behavioral health services that are not MA eligible (non-medical) such as purchase or renovation of a facility, vocational services, housing development, rental subsidy, respite, etc; and

4. Training and consultation that is required to implement a new service or support for MA eligibles.
Expenditures must be consistent with the conditions of the Center for Medicare and Medicaid Services (CMS) waiver, the HealthChoices RFP and Agreement.

DPW will provide a listing of MA eligible Supplemental Services. Primary Contractors may request approval of a new MA eligible Supplement Service.

Reinvestment Funds Cannot be used for:
1. Incentives payment to a BH-MCO.
2. Payment of In-Plan Services.
3. Administrative costs such as medical management, quality management activities, outcome studies, etc.
4. Training not connected to the development of a specific service or program (see Allowable Expenditures for Training) detailed below.
5. Transportation costs that are available under the Medical Assistance Transportation Program (MATP).
6. Services targeted primarily for non-Medical Assistance (MA) eligible persons.
7. Expenditures that do not comply with the Review and Approval Guidelines for Reinvestment Plans that Provide for Costs for Facility or Real Estate Purchase, Renovation or Purchase of Fixed Assets (Attachment 5).

Allowable Expenditures for Training
Training is an important component of any new service. In developing a budget as part of a reinvestment plan, the training component should be identified in the overall budget of the service. Following are two (2) options that can be used for inclusion of training costs in a reinvestment plan:

A. Training as Part of the Development of a New Service
   The training must be tied to a new service and not a stand-alone budget item.
   For example, if the Primary Contractor has determined that there is a need for a Mental Illness Substance Abuse (MISA) program, Reinvestment Funds could be allocated to cover the costs of training for the implementation of this program. However, if the Primary Contractor decided that they would like to train all County staff in MISA “best practice,” the Primary Contractor would need to use administrative dollars to fund this training since it is not tied to a specific program developed to provide services targeted for MA eligible consumers.

B. Training Built into the Service Rate
   As part of the development of new MA funded services, (such as Intensive Case Management (ICM), Family-based, etc.) which were under the auspices of OMHSAS, training was built into the overall rate setting methodology.
   This practice acknowledged that training is an important component of these new mental health services. Likewise, the Primary Contractor may build training costs into the payment rate as part of their reinvestment plan, as long as it is tied to a specific program that is targeted to serve the MA eligible population.
Allowable Expenditures for Purchase, Renovation and Fixed Assets

1. The reinvestment plan must address additional information specified in the Review and Approval Guidelines for Reinvestment Plans that Provide for Costs for Facility or Real Estate Purchase, Renovation or Purchase of Fixed Assets (Attachment 5) when a plan priority includes these Non-Medical services or supports. These guidelines specify the additional information that must be included in the reinvestment plan priority submitted and in the agreement entered into between the Primary Contractor and Subcontractor. These include:

A. Additional areas that must be addressed in the reinvestment plan description regarding ownership, analysis of the need for Non-Medical Services, availability of an on-going revenue source, etc.

B. A detailed budget of the costs associated with purchase of a facility or property, renovation, fixed assets, personnel, operating expenses, etc. must be submitted following the guidelines in Attachment 5.

C. The Primary Contractor/Provider Agreement should ensure that if the property is sold that any proceeds from the sale would be returned to the Primary Contractor. In this case a new reinvestment plan for these funds must be submitted within twelve (12) months or the funds will be considered Discretionary Funds which must be returned to the Department.

D. Costs for Non-Medical Services are not considered in the HealthChoices rate setting process and DPW has no obligation to continue to fund priorities that were approved as one-time expenditures for the purchase or renovation of a facility.

D. OMHSAS Plan Parameters

Format for Submission of Reinvestment Plans

1. The reinvestment plan must be submitted in accordance with OMHSAS established parameters.

2. A standardized format for submission of both the draft and final reinvestment plan is provided in Attachment 3. Each reinvestment plan priority for the contract year must be numbered in priority order and must be submitted on a separate form using this format. The same priority numbers must always be used on all reports to facilitate tracking. One (1) set of budget forms must be submitted listing each reinvestment plan by priority number (Attachment 4).

3. The reinvestment plan title is to include the Primary Contractor name and contract year from which the funds are identified as available for reinvestment.

4. The reinvestment plan priority format identifies the: Primary Contractor; the date of submission; the type of service to be funded In-Plan-start-up, Supplemental-In-Lieu of, Supplemental- In Addition to, or Non-Medical Only); indicate if it is a new, or continuation, and indicate the numeric priority assignment of the reinvestment plan.

5. Reinvestment plan priorities can include expenditures over several years, with the exception of In-Plan Start-up that should be completed within one year.
6. Each reinvestment plan priority must state the contract years in which Reinvestment Funds will be spent. Primary Contractors should ensure the dates for expenditure are realistic to avoid requests for extensions.

7. When determining the contract year in which the reinvestment plan priority funds will be spent, the Primary Contractor should consider the time it will take to accomplish the plan priority and the date of OMHSAS approval. If the time to approve the plan priority was delayed, the final date for spending may need to be adjusted.

8. Expenditures for a reinvestment plan priority cannot be incurred until the effective date of the OMHSAS approval letter.

9. OMHSAS reserves the right to request additional information, if necessary, in order to approve a reinvestment plan priority.

**Target Population**

1. The reinvestment plan must identify that it is targeted for the unmet or under-met needs of mental health and drug and alcohol MA eligibles.

2. It is understood that some non-MA eligible consumers may receive services in a program established to target MA eligible members. The reinvestment plan must include an estimate of the number of non-MA eligible clients to be served.

3. Reinvestment plan priorities must identify the priority populations to be served.

4. Describe the population that is targeted for the reinvestment plan priority, e.g. adults with serious mental illness, adolescents with drug and alcohol treatment needs, etc. Include an estimation of the number of persons to be served by the reinvestment plan priority.

**Description of Program or Service**

1. Reinvestment plans must include a detailed narrative description of each program or service that is consistent with, and supports the definition of the service as being either In-Plan start-up, Supplemental Services- In-Lieu of Supplemental-In-Addition to; or Non-Medical Only.

2. Describe the program or service to be funded by the reinvestment plan priority and why this service or approach is expected to improve the health outcomes for the persons targeted.

3. If a Primary Contractor is requesting the approval of a new MA eligible Supplemental Services, identify the services or services that are expected to generate cost offsets once the Supplemental Service is available.

**Description of Fund Expenditures**

1. Provide a brief summary of what the reinvestment plan priority will fund.

2. Each reinvestment plan priority must contain a description of the major budgeted items (personnel, equipment, operational costs, etc.) and cost associated with each item.

3. If the reinvestment plan priority is funding start-up costs for an In-Plan Service, list the specific start-up costs expenditures that will be funded, and the length of time start-up costs will be required e.g. 3 (three) months of staff salaries, staff training, etc. Include an offset for estimated billable services.
Appendix N
January 1, 2012

4. Requests for start-up costs for In-Place Services that will extend beyond the first year of the plan implementation may be considered if sufficiently justified.

5. Identify how the reinvestment plan priority will be financed for continuation once Reinvestment Funds have been expended, if applicable.

6. Reinvestment plan priorities with requests for Non-Medical facility, land or property purchase and/or fixed asset expenditures require submission of the specific information outlined in Review and Approval Guidelines for Reinvestment Plans that Provide for Costs for Facility or Real Estate Purchase, Renovation or Purchase of Fixed Assets (Attachment 5).

Data Analysis Supporting Request

1. Include a summary of the data analysis that supports why the target population has been chosen and why the specific service has been chosen for Reinvestment Funds. Identify the number of HC members in the target population.

2. Identify the outcomes to be achieved by the service and the data to be collected to measure the outcomes.
Description of Stakeholder Involvement in Decision Making

1. Requests must summarize stakeholder involvement in the planning and decision making process for each request.
2. It is expected that stakeholders will be provided information about the outcomes achieved by the HealthChoices program to date. This might include the current strengths and opportunities for improvement as seen by the County and BH-MCO. Such information will allow stakeholders to provide informed feedback about priorities for Reinvestment Funds.

Reinvestment Budget Forms

1. Four (4) budget forms must be submitted which break out costs based on eligibility category for HealthChoices recipients, MA recipients, Non-MA recipients and total expenditures. One set of budget forms is to be completed, listing each reinvestment plan priority submitted (Attachment 4).
2. Primary Contractors should use their best estimates to determine the number of clients in each of these three (3) categories. It is understood that members move in and out of eligibility categories.

E. Financial Requirements for Reinvestment Funds

1. Primary Contractors must place Reinvestment Funds in a separate restricted account. Bank statements for the account must be submitted monthly. Bank statements are to be reconciled monthly.
2. Reinvestment Funds can be deposited when identified, but must be placed in a restricted account within 30 days of the OMHSAS written approval of the reinvestment plan(s).
4. Report #12 must be prepared on a cash-basis (report deposits and payments in the month in which they occur). No accruals for services should be reflected in this report.
5. A separate report is required for each of the seven (7) categories of aid included in the HealthChoices program, e.g. TANF, Healthy Beginnings, SSI & Healthy Horizons with Medicare, etc.
6. Expenses are to be reported based on actual category of aid. To the extent that is not possible and the expenses must be allocated, then an allocation methodology will need to be submitted and receive prior written approval from DPW.
7. If Reinvestment Funds from more than one contract year are being utilized, a separate set of reports must be filled out for each contract year’s Reinvestment Funds.
8. Interest earned from the reinvestment account must be reported on Report #12. Expenditures of interest earned must be consistent with an approved plan.
9. Funds are withdrawn from the reinvestment account in accordance with a plan approved by OMHSAS. No funds can be distributed, or expenditures incurred, prior to the date of the OMHSAS approval letter.

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10. Primary Contractors must return any unexpended Reinvestment Funds to DPW within six (6) months of the date by which funds were approved to be spent, unless the timeframe for expenditure of these funds was extended by OMHSAS. After that time, unexpended Reinvestment Funds must be returned to DPW.

11. In the event the Agreement with the Department ends and is not renewed, all funds, except for those in DPW approved reinvestment plans, or Reinvestment Funds in a plan submitted to DPW but which DPW has not taken a positive or negative action, remaining in the Primary Contractor’s Special Revenue Fund or Enterprise Fund, or held by any Subcontractor, inclusive of Risk and Contingency Funds, not expended for the HC BH transaction, must be returned to the Department within fourteen (14) months from the expiration of the Agreement. Funds identified in a reinvestment plan submitted to DPW, but on which DPW has not taken a positive or negative action, are not considered Discretionary Funds.

F. Modifications to Approved Reinvestment Plans

1. Proposed changes or modifications to an approved reinvestment plan priority must be submitted in writing. Written confirmation of approval of a change will be issued by OMHSAS within the approval timelines described below.

2. Changes may include a request to: extend the timeframe for expenditure of funds, revise the approved program, withdraw an approved plan and propose a new plan for use of the funds, or change the amount of expenditure when approval of such a change is required.

3. A request for an extension of an approved reinvestment plan (numbered by priority) must be received 45 days prior to the end of the final contract expenditure year stated on the OMHSAS reinvestment approval letter and must indicate the reason for the extension. OMHSAS will provide a written response to a request for extension within 2 weeks. Failure to meet this 45-day requirement may result in DPW’s recovery of these funds.

4. If program or service plan modifications are requested after a reinvestment plan priority has been approved by OMHSAS, the Primary Contractor must use this same format (Attachment 3) to submit a request for change. Stakeholder involvement, and documentation of such, must occur if a new reinvestment plan priority is being proposed to substitute for a previously approved priority.

5. Any revisions to the amount approved for an individual reinvestment plan priority which is the greater of twenty-five percent (25%) or $50,000 for the priority being revised, must be approved by OMHSAS in advance. Examples include:
   a. A plan has been approved for $100,000. The Primary Contractor wishes to decrease the plan by $40,000. This change could be made without approval since the greater of 25% or $50,000 has not been exceeded, or;
   b. A plan is approved for $1M. The county wishes to increase the plan by $300,000. This change would have to be approved since the change is greater than 25% (25% equals $250,000).

6. The Reinvestment Report-Budget forms (Attachment 4) will be used to track approved changes for expenditures and reinvestment plan priorities from a contract year.
G. Annual Report on HealthChoices Reinvestment Plans

1. Submission of an **Annual Report on HealthChoices Reinvestment Plans** for approved reinvestment plans from the previous contract year and those plan priorities that continue to be funded with reinvestment dollars is required. The annual report of Reinvestment Funds is to include a program summary for each reinvestment plan priority that continues to be funded with reinvestment dollars.

2. The **Annual Report on HealthChoices Reinvestment Plans** is due on the last day of the thirteenth (13th) month from the end of the contract year. The required format for submission is attached (Attachment 7). An updated budget is required to be submitted annually.

3. OMHSAS provides a summary of all approved reinvestment plans to stakeholders. The summary is published in the OMHSAS **HealthChoices Behavioral Health Program Annual Report**.

4. A summary of the **Annual Report on HealthChoices Reinvestment Plans** is also distributed to stakeholders.
## Reinvestment Plan Approval Chart

<table>
<thead>
<tr>
<th>Step #</th>
<th>Responsible Entity</th>
<th>Step Description</th>
<th>Timeframe</th>
<th>Targeted Completion</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Contractor</td>
<td>HealthChoices Contract Audit Completed</td>
<td>4.5 months after contract year end</td>
<td>Middle of 5th month after contract year end</td>
</tr>
<tr>
<td>2</td>
<td>PHHS Comptroller</td>
<td>Audit Acceptance</td>
<td>2 months</td>
<td>Middle of 7th month after contract year end *Option to submit based on est.</td>
</tr>
<tr>
<td>3</td>
<td>Contractor</td>
<td>Identifies amount of reinvestment funds available</td>
<td>1/2 month</td>
<td>End of 7th month after contract year end</td>
</tr>
<tr>
<td>4</td>
<td>Contractor</td>
<td>Confirm with OMHSAS amount of reinvestment funds available. Submit draft reinvestment plans to OMHSAS Field Office.</td>
<td>1 month</td>
<td>First day of 9th month after contract year end</td>
</tr>
<tr>
<td>5</td>
<td>OMHSAS Field Office</td>
<td>Provide feedback to Contractor on draft plans</td>
<td>2 weeks</td>
<td>Second week of 9th month after contract year end</td>
</tr>
<tr>
<td>6</td>
<td>Contractor</td>
<td>Submit final reinvestment plans to OMHSAS Field Office</td>
<td>1 month</td>
<td>Second week of 10th month after contract year end</td>
</tr>
<tr>
<td>7</td>
<td>OMHSAS, BOQM</td>
<td>Distribute plans to DPW Reinvestment Review Team</td>
<td>Steps 7,8, &amp; 9</td>
<td>Last week of 10th month after contract year end</td>
</tr>
<tr>
<td>8-9</td>
<td>DPW Reinvestment Review Team</td>
<td>Identifies any additional information needed or approves if no additional information is required Provides feedback on final plans</td>
<td>Same as Step 7</td>
<td>Same as Step 7</td>
</tr>
<tr>
<td>10</td>
<td>OMHSAS Field Office</td>
<td>Prepares summary of Steps 10, 11, 12 &amp; 13</td>
<td>First week of 11th month after contract year</td>
<td></td>
</tr>
<tr>
<td>Step</td>
<td>OMHSAS, Director of Operations</td>
<td>Task Description</td>
<td>Timeframe</td>
<td>Notes</td>
</tr>
<tr>
<td>------</td>
<td>-------------------------------</td>
<td>-----------------</td>
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<td>-------</td>
</tr>
<tr>
<td>11</td>
<td>OMHSAS, Director Eastern or Western</td>
<td>County responses received. Prepares draft approval letter</td>
<td>1 week</td>
<td>Same as Step 10</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Approves summary and final recommendation</td>
<td>Same as Step 10</td>
<td>Same as Step 10</td>
</tr>
<tr>
<td>12</td>
<td>OMHSAS, Director Eastern or Western</td>
<td>Prepares final approval letter for BOQM Directors signature</td>
<td>Same as Step 10</td>
<td>Same as Step 10</td>
</tr>
<tr>
<td>13</td>
<td>OMHSAS, BOQM Director</td>
<td>Sends final approval letter to County</td>
<td>Same as Step 10</td>
<td>Same as Step 10</td>
</tr>
<tr>
<td>14</td>
<td>Contractor</td>
<td>Begins implementation when approval letter is received and funds have been deposited</td>
<td>30 days</td>
<td>12&lt;sup&gt;th&lt;/sup&gt; month after the contract year end</td>
</tr>
</tbody>
</table>

Note: OMHSAS approval timeframes begin when the reinvestment plan or requested plan priority revisions are received from the County.
Dear Administrator:

The _______ County HealthChoices reinvestment plan for funds generated during calendar year ____ has been approved. Acceptance of the following initiatives is confirmed.

<table>
<thead>
<tr>
<th>Type of Service</th>
<th>Budget Amount</th>
<th>In-Plan-Start-up, Supplemental, Or Non-Medical</th>
<th>Contract Expenditure Year(s)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Priority 1</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Continuation of Funding</td>
<td>$600,000</td>
<td>Supplemental</td>
<td>2002 – 2003</td>
</tr>
<tr>
<td>for Community Treatment</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Teams</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Priority 2</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Psychiatric Rehabilitation Services</td>
<td>$400,000</td>
<td>Supplemental**</td>
<td>2002 – 2003</td>
</tr>
</tbody>
</table>

HealthChoices reinvestment funds need to be kept in a separate, restricted bank account and statements for the account must be submitted to the Department each month. Funds must be deposited no later than 30 days after the date of this approval. Also, an annual report on the use of reinvestment funds during _____ will be due on ____________.
[Note: Plans that contain Bricks and Mortar will be annotated with two asterisks and will include the following statement: “**The County reinvestment plan submission is in compliance with the DPW requirements as stated in the Review and Approval Guidelines for Reinvestment Plans that Provide Costs for Facility or Real Estate Purchase, Renovation or Purchase of Fixed Assets. The HealthChoices reinvestment funds are one-time only funds and start-up costs of these services are not considered in the HealthChoices rate setting process. The Department of Public Welfare has no obligation to continue to fund services approved for this reinvestment plan.”]

Reinvestment plans should be implemented in accordance with the approved timeframes. Any delay in implementing the plan should be communicated to OMHSAS. The monitoring of HealthChoices reinvestment funds will be discussed during monthly HealthChoices monitoring meetings. However, if you have questions or concerns that require immediate attention, please be in contact with your Monitoring Team leader or Community Program Manager.

Sincerely,
Director, Bureau of Hospital and Community Operations
# HEALTHCHOICES REINVESTMENT PLAN PRIORITY

County_______________________________

Reinvestment Plan from contract year_______________ Date of Submission_______________

Name of Service_______________________ New Plan_______ Continuation Plan_________

<table>
<thead>
<tr>
<th>Reinvestment Service or Program – (check all categories that apply)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>In-Plan Start-up _____</strong></td>
</tr>
<tr>
<td><strong>Non-Medical Only _____</strong></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>Supplemental – In Lieu of _____</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>Approved ____ Procedure Code_____</td>
</tr>
<tr>
<td>Newly Proposed_____</td>
</tr>
<tr>
<td>Budget a. Clinical*_____</td>
</tr>
<tr>
<td>Budget b. Operating**_____</td>
</tr>
<tr>
<td>One-time only_____</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>Supplemental – In Addition to _____</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>Budget a. Clinical*_____</td>
</tr>
<tr>
<td>Budget b. Operating**_____</td>
</tr>
</tbody>
</table>

Priority _____of _____submitted Year(s) in which funds are to be spent __________

Target Population: (MA eligible target population, population characteristics, number people served annually)

Description of Program or Service: (Describe program, for: In-Plan start up- under one year. Indicate service is to be licensed; Supplemental In-Lieu of- why service is a cost effective alternative, staffing FTEs/qualifications; Children’s Supplemental requires BHRS program exception application; Supplemental- In Addition to – why expected to be cost effective or appropriate but not cost effective, staffing FTEs/qualifications; and Non-Medical Only- used when all costs are non-medical)
Description of Fund Expenditures: (Narrative identifying major budgeted items for clinical and operating expenses and total costs. Identify on-going funding source for program/services. Provide Attachment 5 information as applicable).

Clinical Costs* – Narrative and major budgeted items, includes personnel and benefits

Operating Costs** – Narrative and major budgeted items, includes travel, telephone, office supplies, fixed assets, facility purchase, etc. Complete Attachment 5 below if applicable.

Facility or land Purchase or Renovation: (Attachment 5: Summarize what is being purchased/renovated and ownership arrangement including who owns title. Indicate agreement for disposal of assets upon sale.)

Fixed Assets: (Identify fixed assets to be purchased - vehicles, computers, furniture, equipment, etc. Indicate County Code for purchasing will be followed for items requiring competitive bid.)

Data Analysis and Expected Outcomes: (Identify number of HC members in target population, describe unmet or under-met needs, what is expected to be achieved by the service and data to be collected to measure outcomes. For Supplemental In-Lieu of services identify the service from which cost offsets will be achieved.)

Stakeholder Involvement in Decision Making: (Stakeholder participation summarized and demonstrated support)
Instructions for Completing the Reinvestment Budget Form  
(*Initial Budget Submission and Revisions*):

The HealthChoices reinvestment plan must include a budget form. It is understood that adjustments to IBNRs, interest, and other items may impact the amounts available. Changes to the amount available and the corresponding budget should be handled as follows:

The *initial budget submission* should be included with the reinvestment plan and should reflect the exact amounts specified in the reinvestment plan. These amounts should be shown in the “Initial/Previous Budget” column.

Subsequent to the initial budget submission, *revisions* to the budget must be submitted as follows:

- An updated budget **must** be submitted with the annual reinvestment update.
- If a change is being proposed to any item within the budget, approval must be given by OMHSAS for the change if it is greater than 25% of the current priority amount or $50,000, whichever is higher. The request for approval must include a revised budget reflecting the proposed changes.
- Any changes due to IBNR adjustments or interest earned since the last budget was submitted should be reflected in the “Revision Amount” column.

Anytime revisions to the budget are being submitted, the most recent budget amounts should be reflected in the “Initial/Previous Budget” column.

When reporting actual reinvestment expenditures on Financial Report #12, the budget amounts should reflect the most recent budget amounts submitted.

- **County** – The County HealthChoices Behavioral Health program for which the reinvestment budget is being submitted.
- **Date** – The date the budget form is being prepared.
- **Reinvestment Funds from** – The contract year that the reinvestment funds are applicable to.

**Category of Eligibility** – There are four separate forms:

- HealthChoices Recipients – provide amounts that will be targeted to individuals who are enrolled in the HealthChoices Behavioral Health program.
- MA Recipients – provide amounts that will be targeted to individuals who are eligible for medical assistance benefits but NOT enrolled in the HealthChoices Behavioral Health program.
Non-MA Recipients – provide amounts that will be targeted to individuals who are not eligible for medical assistance benefits.

Total – provide totals for amounts provided on individual forms.

Allocations/Contributions – Indicate the amount anticipated to be available.

Investment/Interest Income – Indicate an estimate of any interest to be earned over the course of the reinvestment spending period. This line item cannot be $0; an estimate must be provided.

Total Available – Add Allocations/Contributions and Investment/Interest Income.

Reinvestment Services (Identify) – List each reinvestment plan item, along with the specific budget amount. Please use the same description and amount used in the reinvestment plan.

Total Reinvestment Services – Sum of the individual reinvestment services.

Remaining Balance – Allocations/Contributions plus Investment/Interest Income minus Total Reinvestment Services.
Reinvestment Funds from _______________________

(Contract Year)

Category of Eligibility - HealthChoices Recipients

<table>
<thead>
<tr>
<th>Reinvestment Account</th>
<th>Initial/Previous Budget</th>
<th>Revision Amount*</th>
<th>Revised Budget</th>
</tr>
</thead>
<tbody>
<tr>
<td>Allocations/contributions</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Investment/interest income</td>
<td></td>
<td></td>
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</tr>
<tr>
<td>TOTAL AVAILABLE</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Less: Approved distributions for:</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Reinvestment Services (Identify)</td>
<td></td>
<td></td>
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</tr>
</tbody>
</table>

TOTAL REINVESTMENT SERVICES

REMAINING BALANCE

*Revisions to any item that represent a change of >25% or $50,000 require approval from OMHSAS. An explanation **must** be provided for all budget revisions, regardless of the amount.
Reinvestment Funds from _______________________
(Contract Year)

Category of Eligibility - MA Recipients

<table>
<thead>
<tr>
<th>Reinvestment Account</th>
<th>Initial/Previous Budget</th>
<th>Revision Amount*</th>
<th>Revised Budget</th>
</tr>
</thead>
<tbody>
<tr>
<td>Allocations/contributions</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Investment/interest income</td>
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<td></td>
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<tr>
<td>TOTAL AVAILABLE</td>
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<tr>
<td>Less: Approved distributions for:</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Reinvestment Services (Identify)</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

TOTAL REINVESTMENT SERVICES

REMAINING BALANCE

*Revisions to any item that represent a change of >25% or $50,000 require approval from OMHSAS. An explanation must be provided for all budget revisions, regardless of the amount.
Reinvestment Funds from ______________________

(Contract Year)

Category of Eligibility - Non-MA Recipients

<table>
<thead>
<tr>
<th>Reinvestment Account</th>
<th>Initial/Previous Budget</th>
<th>Revision Amount*</th>
<th>Revised Budget</th>
</tr>
</thead>
<tbody>
<tr>
<td>Allocations/contributions</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Investment/interest income</td>
<td></td>
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<tr>
<td>TOTAL AVAILABLE</td>
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<tr>
<td>Less: Approved distributions for:</td>
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<tr>
<td>Reinvestment Services (Identify)</td>
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<tr>
<td>TOTAL REINVESTMENT SERVICES</td>
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<tr>
<td>REMAINING BALANCE</td>
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</tbody>
</table>

*Revisions to any item that represent a change of >25% or $50,000 require approval from OMHSAS. An explanation must be provided for all budget revisions, regardless of the amount.
Reinvestment Funds from _______________________
(Contract Year)

Category of Eligibility - Total

<table>
<thead>
<tr>
<th>Reinvestment Account</th>
<th>Initial/Previous Budget</th>
<th>Revision Amount*</th>
<th>Revised Budget</th>
</tr>
</thead>
<tbody>
<tr>
<td>Allocations/contributions</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Investment/interest income</td>
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<tr>
<td>Reinvestment Services (Identify)</td>
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</table>

TOTAL REINVESTMENT SERVICES

REMAINING BALANCE

*Revisions to any item that represent a change of >25% or $50,000 require approval from OMHSAS. An explanation **must** be provided for all budget revisions, regardless of the amount.
Review and Approval Guidelines for Reinvestment Plans that Provide for Costs for Facility or Real Estate Purchase, Renovation or Purchase of Fixed Assets

All reinvestment plan priorities containing costs for facility or real estate purchase, renovation, housing development, vehicle acquisition, and/or purchase of fixed assets must adhere to these Reinvestment Plan Guidelines and applicable provisions of the local County Code.

Reinvestment Plan Submission:
Conditions that apply to reinvestment plan priorities that contain costs for facility or real estate purchase, renovation, housing development, vehicle acquisition, and or purchase of fixed assets are:

1. Primary purpose of the reinvestment plan priority must be to serve MA eligibles with mental health and/or drug and alcohol treatment service needs.

2. The reinvestment plan priorities must contain a statement of the rationale for the development of the program and related capital costs.

3. The reinvestment plan priority must explain the financial strategy for acquiring the property, facility or vehicle and why that method is cost effective. Identify whether the facility/vehicle will be purchased or leased or will facility costs be built into the service rate.

Each County’s Housing Plan will describe the County’s housing capital development strategy and why acquisition by a housing organization is cost effective from a housing finance perspective.

4. The reinvestment plan priority must summarize the ownership arrangement between the County and provider and specify the party that holds title to fixed assets. Identify related parties when there is common ownership. Provide a detailed data analysis supporting the request as part of the reinvestment plan. The data analysis must support the need for the project proposed. The analysis should include, for example, analysis of the provider network demonstrating a gap in service, rationale for cost effectiveness of the purchase, description of underserved target population to be served, etc.

5. The County may enter an agreement to provide capital resources with a qualified housing organization in exchange for long term use restrictions. The ownership arrangement for any capital development for supportive housing should identify the property to be acquired or replaced, number of units within the overall development that the county will have access to over a specified period of time, how consumer access will be assured, how the county will be reimbursed or be assured use restrictions in the event the property goes into foreclosure. Rental subsidies can be considered in exchange for investment based on a financial analysis that the exchange is of like or greater value.

6. The reinvestment plan priority must include a budget in sufficient detail to demonstrate how the amount identified in the reinvestment plan priority request was determined. This should include budgeted items (e.g. personnel, equipment, operating costs, transportation, repairs, etc.) and associated costs as well as any pertinent assumptions.
7. The reinvestment plan priority must contain information about the source of operating funds for the continuation of the program or service after one-time reinvestment plan funds are expended.

For housing development plans, identify the number of units that will be available for a specified period of time.

8. Purchase of vehicles is not permitted for transportation to MA services of MA eligible members otherwise served by the Medical Assistance Transportation Program (MATP).

County-Provider Reinvestment Plan Agreement:
Any agreement entered into between the County and a provider for the purpose of implementing a reinvestment plan priority, which contains costs for facility or real estate purchase, renovation, vehicle acquisition, and/or purchase of fixed assets, must:

1. Be reduced to writing

2. Be targeted to Medical Assistance eligibles with mental health and/or drug and alcohol service needs.

3. Assure that the acquisition or renovation is likely to be used in the HC program for at least five years and be subject to specified disposition requirements.

4. Identify any related parties and the relationship of the related parties regarding the accomplishment of the reinvestment plan.

5. Specify ownership rights, use of the facility, and the process for disposition of fixed assets in the event a sale should occur

   Housing plans will address how restrictions of use will be passed on to future buyers in the event of property transfer for housing development by housing organizations.

6. In the event of a sale, proceeds from the sale are to be returned to the County HealthChoices program for reinvestment in programs or services for MA eligible members. This provision is not applicable to housing development plans.

7. Specify the accounting method to be used in expensing, depreciating or amortizing costs. This provision is not applicable to housing development plans.

8. Require maintenance, repair and insurance of fixed assets.

   In the case of a facility being purchased for housing, the County should specify the required maintenance and insurance of fixed assets. To ensure a property is maintained, the County may require or conduct periodic inspections to ensure compliance with HUD’s Housing Quality Standards (HQS). Failure of inspection may trigger foreclosure or other actions as specified by the County. The County should be named on the insurance of fixed assets to order for the
County to be notified if coverage ceases and failure to maintain insurance of fixed assets can also trigger foreclosure or other action as specified by the County.

9. Require competitive bidding or written estimates as required by County Code or prudent business practices.

10. Be reviewed and approved by the County Solicitor and/or other appropriate County official (e.g. MH/MR legal counsel) to ensure compliance with these Reinvestment Plan Guidelines and applicable County Code provisions.

11. Contain a budget that details the costs associated with the facility renovation or purchase of fixed assets as submitted in the County’s reinvestment plan priority. This provision is not applicable to housing development plans.
3.12 **Report #12 - Reinvestment Report**

The purpose of this report is to monitor reinvestment activity. All approved allocations to and distributions from the reinvestment account are to be shown on this report. This report must be prepared on a cash-basis (report deposits and payments in the month in which they occur). No accruals for services should be reflected on this report.

Reinvestment funds can be deposited when identified, but **must** be placed in a restricted account within 30 days of the OMHSAS written approval of the County’s reinvestment plan(s).

**IMPORTANT NOTE:** The services reported on this report should **NOT** be reported on Report #9. Report #9 should only reflect those medical services being provided under the current year’s capitation revenue.

Columns are provided for reporting the number of unduplicated recipients served, current month units of service provided and dollar amount paid for those services, as well as cumulative year to date and contract to date units of service provided and dollar amount paid. A separate report must be provided for each of the following categories of aid:

1. TANF
2. Healthy Beginnings
3. SSI w/ Medicare & Healthy Horizons
4. SSI w/o Medicare
5. Federal GA
6. GA CNO
7. GA MNO (all age groups combined)
8. Other (non-HealthChoices recipients or non-identifiable recipients)
9. Total (total of the eight categories above)

A methodology for allocating costs that are not attributable to a specific category of aid must be submitted and approved by DPW prior to implementation.

In addition, if reinvestment funds from more than one contract year are being utilized, a separate set of reports must be filed for each contract year’s reinvestment funds.

The count of unduplicated recipients should be unduplicated by each individual reinvestment service and should reflect unduplicated recipients on a contract to date basis.

*The Prior Period Balance* is the reinvestment account balance as of the last day of the prior calendar month for the “Current Period” column; the reinvestment account balance as of the last day of the prior year for the “Year to Date” column; and $0 for the “Contract to Date” column.

*Allocations/contributions* are funds transferred into the reinvestment account.

*Investment Revenue* is income generated by the undistributed funds retained in the reinvestment account. Reinvestment revenue represents earnings on prior year funds and should appear on Report #12 only.
Approved Distributions are funds withdrawn from the reinvestment account in accordance with the DPW-approved Reinvestment Plan. A written plan for reinvestment must be submitted to and approved by DPW prior to making any distribution. Administrative costs, such as bank fees, should be reported on a separate line. Any administrative costs reported must be disclosed in detail in the footnotes to these reports.

Ending Balance is the reinvestment account balance as of the end of the last day of the calendar month.

The Budgeted Amount column should reflect the amounts and services contained in the DPW-approved reinvestment plan. Budgeted Investment/Interest Income should reflect either estimated interest to be earned on HealthChoices funds deposited in the reinvestment bank account and included in the Budget Forms submitted with your reinvestment plans to DPW for approval or interest earned on funds deposited in the reinvestment bank account and allocated to approved reinvestment plans. Budgeted Amounts are not required to be allocated by rating group and can be reported only on the Total page. For electronic reporting, Budgeted Amounts may be reported in total as “Other”.

The HealthChoices Behavioral Health Program Requirements for County Reinvestment Plans requires that revisions to an individual reinvestment plan priority, which are the greater of twenty-five percent (25%) or $50,000 for the priority being revised, be approved by OMHSAS in advance. Revisions less than the preceding requirements can be made without OMHSAS approval. All revisions to budget amounts made without OMHSAS approval must be included in the footnotes to the reports.

The bank statements for the reinvestment account, as well as the bank reconciliation that reconciles the general ledger to the reinvestment account bank statements, must be submitted with each month’s report. The Department reserves the right to request additional documentation.
Reinvestment Report Form

Statement as of: ____________________________ (Reporting Date)
County: ____________________________ (County Name)
Reported By: ____________________________ (Reporting Entity)
For: ____________________________ (Year of Reinvestment Funds)
Rating Group: ____________________________ (Rating Group)

<table>
<thead>
<tr>
<th>Reinvestment Account Activity</th>
<th>Unduplicated Recipients</th>
<th>Current Period Units of Service Provided</th>
<th>Current Period $ Amount</th>
<th>Contract to Date Units of Service Provided</th>
<th>Contract to Date $ Amount</th>
<th>Budget Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Prior Period Balance</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2. Allocations/contributions</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3. Investment/interest income</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>4. SUBTOTAL (Lines 2 and 3)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>5. TOTAL (Lines 1 and 4)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Less: Approved distributions for Reinvestment Services (identify):

| 6. TOTAL |                         |                                        |                         |                                          |                          |              |
| 7. Ending Balance (Line 5 minus Line 6) |                         |                                        |                         |                                          |                          |              |

THIS REPORT FORMAT SHOULD BE USED FOR REPORTING MONTHS BEGINNING WITH 1/03.
## COUNTY ANNUAL REPORT ON HEALTHCHOICES REINVESTMENT PLANS

_______________________________ COUNTY

| Name of Service: ____________________ |
| In-Plan-Start-up_____ Supplemental _____ Non-medical _____ |
| Bricks and Mortar ______ |
| Priority _____ of _____ for Reinvestment Funds from Contract Year ______ |

### Description of Program Service:

### Progress in Implementing the Program or Service Including Expenditure of Funds:

### Impact on Target Population:

### Describe how the Program or Service is meeting the goals of HealthChoices (access, quality of life, improved health outcomes, cost effectiveness, etc.)

**Note:** An updated budget (Attachment 4) must be submitted with this report.

Prepared by: ____________________________  Date: _______________
HEALTHCHOICES DATA SUPPORT PROVIDED BY THE DEPARTMENT FOR BEHAVIORAL HEALTH MANAGED CARE ORGANIZATIONS

ON-LINE INQUIRY ACCESS:

Each Behavioral Health Managed Care Organization (BH-MCO) will be required to connect to the Pennsylvania Open System Network (POSNet) for the purpose of on-line inquiries and file transfers. Specifications and limited technical assistance will be made available through the Department’s Business Partner HelpDesk. No information made available to the BH-MCO is to be used for any purpose other than supporting their program under HealthChoices.

OMHSAS will provide hands-on training on the use and interpretation of inquiry information found on the system.

- Client Information System (CIS)
  The Department will make available to each BH-MCO access to the Department’s CIS database. This database provides eligibility history and demographic information to support the BH-MCO in meeting their obligations.

- Provider Database System
  Each BH-MCO has access to provider base information, including provider number, location, enrollment status, provider type, and specialty.

- Reference Transactions System
  This system allows BH-MCO inquiry into drug, procedure code and diagnosis code information.

ELIGIBILITY VERIFICATION:

The Department provides the BH-MCO with an additional option for verifying Medical Assistance and HealthChoices eligibility, other than CIS inquiry.

- Eligibility Verification System (EVS)
  Each BH-MCO will be provided access to the Department’s EVS. Telephone, Personal Computer software and Point of Sale device methods can be used to access this system. EVS can be used to verify Medical Assistance eligibility, PH-MCO and BH-MCO coverage, primary care practitioner and TPL information.

OMHSAS will provide hands-on training on the use and interpretation of EVS inquiry information.

DATA SUPPORT FILE TRANSMISSIONS:

The Department provides the BH-MCO with several data files for use in managing their program. These files are critical to the effective management of the program. Additional files, other than those listed as attached, may be made available upon request. The Department will transfer files online, as opposed to sending data via tape or other medium. The file formats are subject to change by the Department and by HIPAA mandates.
### Capitation Payment/Reimbursement Files:

<table>
<thead>
<tr>
<th>File Description</th>
<th>File Name</th>
<th>Purpose</th>
<th>Frequency</th>
<th>From</th>
<th>To</th>
</tr>
</thead>
<tbody>
<tr>
<td>820 Capitation</td>
<td>PMMRCCCSS.MM.zip</td>
<td>File of actual recipients paid for.</td>
<td>Monthly; Sent by the 5th of the month</td>
<td>PROMIs™</td>
<td>BH-MCOs</td>
</tr>
<tr>
<td>MCO Payment Summary File</td>
<td>MPSMYJJJ.MM.zip</td>
<td>Summary file of capitation payments by county group rate cell and date of service up to 36 months.</td>
<td>Monthly; Sent by the end of the 2nd week of the month</td>
<td>PROMIs™</td>
<td>BH-MCOs</td>
</tr>
</tbody>
</table>

### Eligibility/CIS Files:

<table>
<thead>
<tr>
<th>File Description</th>
<th>File Name</th>
<th>Purpose</th>
<th>Frequency</th>
<th>From</th>
<th>To</th>
</tr>
</thead>
<tbody>
<tr>
<td>ARM568 File</td>
<td>xxARM568.ddd</td>
<td>Report file of CIS eligibility statistics by county/district.</td>
<td>Monthly; Sent on the Monday following the first full weekend of the month</td>
<td>DPW</td>
<td>BH-MCOs</td>
</tr>
<tr>
<td>Daily Eligibility File</td>
<td>FDXXJJJS.MM.zip</td>
<td>File of any change affecting address, category of assistance, county and district indicators, and plan coverage that day for a managed care recipient.</td>
<td>Daily; Sent every state work day</td>
<td>EDS Translator</td>
<td>BH-MCOs</td>
</tr>
<tr>
<td>Monthly Eligibility File</td>
<td>FMXXJJJS.MM.zip</td>
<td>File of all MA eligible recipients who are covered by the plan at some point in the next month only. One record per recipient (most recent).</td>
<td>Monthly; Sent on the last Saturday of the month</td>
<td>EDS Translator</td>
<td>BH-MCOs</td>
</tr>
<tr>
<td>TPL File</td>
<td>xxTPL788</td>
<td>TPL data for each MCO's members.</td>
<td>Monthly; Sent by the 25th of the month</td>
<td>DPW</td>
<td>BH-MCOs</td>
</tr>
</tbody>
</table>
## Provider Files:

<table>
<thead>
<tr>
<th>File Description</th>
<th>File Name</th>
<th>Purpose</th>
<th>Frequency</th>
<th>From</th>
<th>To</th>
</tr>
</thead>
</table>
| **List of Active and Closed Provider Files** | PRV414M.MM.zip  
PRV415M.MM.zip  
(PRV414 or PRV415=Constant; M=Monthly; MM=Plan Code) | File of statewide MA providers.                  | Monthly; Sent on the 1st of the month           | PROMIS™    | BH-MCOs    |
| **Quarterly Network Provider File**  | PRV640Q.MM.zip  
(PRV640=Constant; Q=Quarterly; MM=Plan Code) | File of MCO provider returned to the MCO.        | Quarterly; Sent on the 1st day of the first month in a quarter | PROMIS™    | BH-MCOs    |
| **Response to the PRV640M Provider File** | PRM640M.MM.rpt  
(PRM640=Constant; M=Monthly; MM=Plan Code; rpt=Return Report) | Report of MCO provider records returned by DPW due to error. | Monthly; Sent within 48 hrs. of receiving the PRV640M.MM.zip | PROMIS™    | BH-MCOs    |

## Reference Files:

| Reference Diagnosis Code File         | DIAGYJJJ.MM.zip  
(DIAG=Constant; YJJJ=Last Digit Year Julian Day; MM=Plan Code) | ICD-9.                                           | Quarterly; Sent on the second Monday of the 1st month in a quarter | PROMIS™    | BH-MCOs    |
|--------------------------------------|--------------------------------|--------------------------------------------------|-------------------------------------------------|------------|------------|
| **Procedure Code Extract**           | PROCYJJJ.MM.zip  
(There are 3 files within this file.) They are: mcmod01.dat, mcpdoc01.dat, mctype01.dat  
(PROC=Constant; YJJJ=Last Digit Year Julian Day; MM=Plan Code) | MA Fee Schedule contained in three files (Procedure/Modifier Max Fee, Procedure, and Provider Type, Specialty, Place of Service). | Monthly; Sent on the 1st of the month           | PROMIS™    | BH-MCOs    |

**HIPAA Implementation Guides and Addenda for the various types of transactions are available, free of charge, from the Washing Publishing Company at www.wpc-edi.com/hipaa/. These documents constitute the official HIPAA reporting standards as defined by the Accredited Standards Committee (ASC) X12.**

***Pennsylvania PROMIS™ Companion Guides for each of the types of transactions may be obtained, free of charge, by contacting OMHSAS directly. The Companion Guides provide detailed information specific to the elements within the 834 and 820 files from the PROMIS™ system. All file layouts are available from OMHSAS free of charge upon request.***
HEALTHCHOICES BEHAVIORAL HEALTH PROGRAM
PROGRAM STANDARDS AND REQUIREMENTS
PRIMARY CONTRACTOR

APPENDIX P

HealthChoices Behavioral Health
Financial Reporting Requirements (FRR’s)

The current FRR is located at:

http://www.dpw.state.pa.us/publications/healthchoicesbehavioralhealthpublications/index.htm
Appendix Q

HEALTHCHOICES BEHAVIORAL HEALTH SERVICES

PRIORITY POPULATIONS

MENTAL HEALTH

Reference: Mental Health Bulletin, OMH-94-04
Serious Mental Illness: Adult Priority Group (available in the Proposers' Library)

In order to be in the Adult Priority Group, a person: must meet the federal definition of serious mental illness; must be age 18+, (or age 22+ if in Special Education); must have a diagnosis of schizophrenia, major affective disorder, psychotic disorder NOS or borderline personality disorder (DSM-IV or its successor documents as designated by the American Psychiatric Association, diagnostic codes 295.xx, 296.xx, 298.9x or 301.83); and must meet at least one of the following criteria: A. (Treatment History), B. (Functioning Level) or C. (Coexisting Condition or Circumstance).

A. Treatment History

1. Current residence in or discharge from a state mental hospital within the past two years; or

2. Two admissions to community or correctional inpatient psychiatric units or residential services totaling 20 or more days within the past two years; or

3. Five or more face-to-face contacts with walk-in or mobile crisis or emergency services within the past two years; or

4. One or more years of continuous attendance in a community mental health or prison psychiatric service (at least one unit of service per quarter) within the past two years; or

5. History of sporadic course of treatment as evidenced by at least three missed appointments within the past six months, inability or unwillingness to maintain medication regimen or involuntary commitment to outpatient services; or

6. One or more years of treatment for mental illness provided by a primary care physician or other non-mental health agency clinician, (e.g., Area Agency on Aging) within the past two years.

B. Functioning Level

Global Assessment of Functioning Scale (DSM-IV-R, pages 12 and 20) rating of 50 or below.

C. Coexisting Condition or Circumstance

1Adults with serious mental illness are persons age 18 and over, who currently or at any time during the past year, have had a diagnosable mental, behavioral, or emotional disorder of sufficient duration to meet diagnostic criteria specified within DSM-IV that has resulted in functional impairment which substantially interferes with or limits one or more major life activities. (See Reference for additional detail)
1. Coexisting Diagnosis:
   a. Psychoactive Substance Use Disorder; or
   b. Mental Retardation; or
   c. HIV/AIDS; or
   d. Sensory, Developmental and/or Physical Disability; or

2. Homelessness²; or

3. Release from Criminal Detention³.

In addition to the above, any adult who met the standards for involuntary treatment (as defined in Chapter 5100 Regulations - Mental Health Procedures) within 12 months preceding the assessment is automatically assigned to the high priority group.

**MENTAL HEALTH**

**Child and Adolescent**

Reference: "Child and Adolescent Target Groups 1, 2, & 3" in 1994 Community Mental Health Services Block Grant Application (Available in the Proposers' Library)

I. The Child and Adolescent Priority Group 1 includes persons who meet all four criteria below:

   A. Age: birth to less than 18 (or age 18 to less than 22 and enrolled in special education service).

   B. Currently or at any time in the past year have had a DSM-IV diagnosis (excluding those whose sole diagnosis is mental retardation or psychoactive substance use disorder or a "V" code) that resulted in functional impairment which substantially interferes with or limits the child's role or functioning in family, school or community activities.

   C. Receive services from mental health and one or more of the following:

      1. Mental Retardation
      2. Children and Youth
      3. Special Education
      4. Drug and Alcohol
      5. Juvenile Justice
      6. Health (the child has a chronic health condition requiring treatment)

   D. Identified as needing mental health services by a local interagency team, e.g., CASSP Committee, Cordero Workgroup.

²Homeless persons are those who are sleeping in shelters or in places not meant for human habitation, such as cars, parks, sidewalks or abandoned buildings.

³Applicable categories of release from criminal detention are jail diversion; expiration of sentence or parole; probation or Accelerated Rehabilitation Decision (ARD).
In addition to the above, any child or adolescent who met the standards for involuntary treatment within the 12 months preceding the assessment (as defined in Chapter 5100 -Mental Health Procedures) is automatically assigned to this priority group.

II. Second priority\(^4\) is associated with children at-risk of developing a serious emotional disturbance by virtue of:

A. A parent’s serious mental illness.
B. Physical or sexual abuse.
C. Drug dependency.
D. Homelessness.
E. Referral to the Student Assistance Programs.

**DRUG AND ALCOHOL**  
*Reference: Commonwealth of Pennsylvania Federal Fiscal Year 1996, Substance Abuse Prevention and Treatment Block Grant Application*

The priority population for drug and alcohol treatment services includes:

- Pregnant Females and Women with Children
- Intravenous Drug Users
- Adolescents
- Persons with Severe Medical Conditions, such as Tuberculosis and HIV/AIDS.
- Mentally Ill Substance Abusers

\(^4\)See reference for additional detail.
DOMESTIC WORKFORCE UTILIZATION CERTIFICATION

To the extent permitted by the laws and treaties of the United States, each proposal will be scored for its commitment to use the domestic workforce in the fulfillment of the contract. Maximum consideration will be given to those offerors who will perform the contracted direct labor exclusively within the geographical boundaries of the United States or within the geographical boundaries of a country that is a party to the World Trade Organization Government Procurement Agreement. Those who propose to perform a portion of the direct labor outside of the United States and not within the geographical boundaries of a party to the World Trade Organization Government Procurement Agreement will receive a correspondingly smaller score for this criterion. In order to be eligible for any consideration for this criterion, offerors must complete and sign the following certification. This certification will be included as a contractual obligation when the contract is executed. Failure to complete and sign this certification will result in no consideration being given to the offeror for this criterion.

I, ______________________ [title] of __________________________________________________________ [name of Contractor], a __________________________ [place of incorporation] corporation or other legal entity, (“Contractor”) located at __________________________________________________________ [address], having a Social Security or Federal Identification Number of __________________________, do hereby certify and represent to the Commonwealth of Pennsylvania (“Commonwealth”) (Check one of the boxes below):

☐ All of the direct labor performed within the scope of services under the contract will be performed exclusively within the geographical boundaries of the United States or one of the following countries that is a party to the World Trade Organization Government Procurement Agreement: Aruba, Austria, Belgium, Bulgaria, Canada, Chinese Taipei, Cyprus, Czech Republic, Denmark, Estonia, Finland, France, Germany, Greece, Hong Kong, Hungary, Iceland, Ireland, Israel, Italy, Japan, Korea, Latvia, Liechtenstein, Lithuania, Luxemburg, Malta, the Netherlands, Norway, Poland, Portugal, Romania, Singapore, Slovak Republic, Slovenia, Spain, Sweden, Switzerland, and the United Kingdom

OR

☐ ________________ percent (______ %) [Contractor must specify the percentage] of the direct labor performed within the scope of services under the contract will be performed within the geographical boundaries of the United States or within the geographical boundaries of one of the countries listed above that is a party to the World Trade Organization Government Procurement Agreement. Please identify the direct labor performed under the contract that will be performed outside the United States and not within the geographical boundaries of a party to the World Trade Organization Government Procurement Agreement and identify the country where the direct labor will be performed:

________________________________________________________________________

________________________________________________________________________

[Use additional sheets if necessary]
The Department of General Services [or other purchasing agency] shall treat any misstatement as fraudulent concealment of the true facts punishable under Section 4904 of the Pennsylvania Crimes Code, Title 18, of Pa. Consolidated Statutes.

Attest or Witness:

________________________________________
Corporate or Legal Entity's Name

___________________________ __________________________
Signature/Date

___________________________ __________________________
Signature/Date

___________________________ __________________________
Printed Name/Title

___________________________ __________________________
Printed Name/Title
HEALTHCHOICES BEHAVIORAL HEALTH SERVICES
GUIDELINES for MENTAL HEALTH MEDICAL NECESSITY CRITERIA

ADULT

PSYCHIATRIC INPATIENT SERVICES

Admission (must meet criteria I, II, and III):

A physician has conducted an evaluation and has determined that:

I. The person has a psychiatric diagnosis or provisional psychiatric diagnosis, excluding mental retardation, substance abuse or senility, unless these conditions coexist with another psychiatric diagnosis or provisional psychiatric diagnosis, and

II. The person cannot be appropriately treated at a less intense level of care because of the need for:

   * 24 hour availability of services for diagnosis, continuous monitoring and assessment of the person's response to treatment,
   * availability of a physician 24 hours a day to make timely and necessary changes in the treatment plan,
   * the involvement of a psychiatrist in the development and management of the treatment program, and
   * 24 hour availability of professional nursing care to implement the treatment plan and monitor/assess the person's condition and response to treatment.
   * 24 hour clinical management and supervision,

and

III. The severity of the illness presented by the person meets one or more of the following:

   * The person poses a significant risk of harm to self or others, or to the destruction of property.
   * The person has a medical condition or illness which cannot be managed in a less intensive level of care because the psychiatric and medical conditions so compound one another that there is a significant risk of medical crisis or instability.
   * The person's judgment or functional capacity and capability has decreased to such a degree that self-maintenance, occupational, or social functioning are severely threatened.
Appendix T

* The person requires treatment which may be medically unsafe if administered at a less intense level of care.
* There is an increase in the severity of symptoms such that continuation at a less intense level of care cannot offer an expectation of improvement or the prevention of deterioration, resulting in danger to self, others, or property.

Continued stay (must meet criteria I and II):

I. The severity of the illness presented by the person meets one or more of the following:

* persistence of symptoms which meet admission criteria; or
* development of new symptoms during the person's stay which meet admission criteria; or
* there is an adverse reaction to medication, procedures, or therapies requiring continued hospitalization; or
* there is a reasonable expectation based on the person's current condition and past history, that withdrawal of inpatient treatment will impede improvement or result in rapid decompensation or the re-occurrence of symptoms or behaviors which cannot be managed in a treatment setting of lesser intensity.

and

II. The person continues to need the intensity of treatment defined under Admission Criterion II; and

* a physical examination is conducted within 24 hours after admission; and
* a psychiatrist conducts a psychiatric examination within 24 hours after admission; and
* the person participates in treatment and discharge planning; and
* treatment planning and subsequent therapeutic orders reflect appropriate, adequate and timely implementation of all treatment approaches in response to the person's changing needs.

Discharge Indicators (must meet I or II):

I. The person no longer needs the inpatient level of care because:

* The symptoms, functional impairments and/or coexisting medical conditions that necessitated admission or continued stay have diminished in severity and the person's treatment can now be managed at a less intensive level of care; and
Appendix T

* The improvement in symptoms, functional capacity and/or medical condition has been stabilized and will not be compromised with treatment being given at a less intensive level of care; and
* The person does not pose a significant risk of harm to self or others, or destruction of property; and
* There is a viable discharge plan which includes living arrangements and follow-up care

or

II. Inpatient psychiatric treatment is discontinued because:

* A diagnostic evaluation and/or a medical treatment has been completed when one of these constitutes the reason for admission; or
* The person withdraws from treatment against advice and does not meet criteria for involuntary commitment; or
* The person is transferred to another facility/unit for continued inpatient care.

PARTIAL HOSPITALIZATION

Admission (must meet criteria I, II, and III):

I. A mental health professional, as defined in Chapter 5210.3 of the Partial Hospitalization regulations, has conducted an evaluation and has determined that the person meets one of the following:

* The person has an established history of a psychiatric disorder, excluding mental retardation, substance abuse or senility, unless these conditions co-exist with other psychiatric symptomatology, and is presenting symptoms which require this level of care; or
* The person does not have an established psychiatric history, but a psychiatrist, or physician, or a licensed clinical psychologist has been consulted and has confirmed the presence of a psychiatric disorder that requires this level of care; or
* The person has had an evaluation by a psychiatrist, a physician, or a licensed clinical psychologist at another mental health treatment facility, (e.g., inpatient, outpatient or crisis intervention) and is being directly referred to this level of care; or
* The person needs a diagnostic evaluation that cannot be performed at a lesser level of care.

and

II. The partial hospital level of care is appropriate because:
* The person has the capacity to participate in the partial hospitalization level of care; and
* The person has a community based network of support that enables him/her to participate in the partial hospitalization level of care; and
* The person exhibits sufficient control over his/her behavior such that he/she is judged not to be an imminent danger to self, others or property.

and

III. The severity of the symptoms presented by the person meets one or more of the following:

* The person's judgment or functional capacity and capability is compromised to such a degree that self-maintenance, occupational, educational or social functioning are significantly impaired, and the severity of the presenting symptoms is such that the success of treatment at a less intense level of care is unlikely; or
* The person requires treatment which may be unsafe if administered at a less intense level of care; or
* Sufficient clinical gains have not been made within a less intensive level of care, and the severity of presenting symptoms is such that the success of treatment at a less intense level of care is unlikely; or
* Co-existing, non-psychiatric medical conditions preclude treatment at a less intensive level of care because the psychiatric and medical conditions so compound one another that there is a significant risk of medical crisis or instability.

**Continued Stay Criteria (must meet criteria I and II)**

I. One or more of the symptoms or conditions which necessitated admission persist, or new symptoms develop which meet admission criteria, and the person meets one or more of the following:

* The person has not completed the goals and objectives of the Individualized Treatment Plan that are necessary to warrant transition to a less intensive level of care; or
* The person demonstrates a current or historical inability to sustain/maintain gains without a comprehensive program of treatment services provided by the partial hospital program; or
* Attempts to reduce the intensity and structure of the therapeutic program have resulted in, or are likely to result in, exacerbation of the psychiatric illness as manifested by regression of behavior and/or the worsening of presenting symptomatology; or
* Attempts to increase the person's level of functioning or role performance in the areas of interpersonal, occupational or self-management functioning have resulted in exacerbation of psychiatric illness as manifested by
Appendix T

regression of behavior and/or the worsening of presenting symptomatology; or
* An adverse reaction to medication, procedures or therapies requires frequent monitoring which cannot be managed at a less intensive level of care.

and

II. The partial hospital program provides the following service elements:
* The person is receiving active treatment within the framework of a multi-disciplinary individualized treatment plan approach; and
* There is the involvement of a psychiatrist in the development and management of the treatment program and discharge plan; and
* The treatment plan includes a discharge plan and is reviewed and modified, as appropriate, by the treatment team to respond to changes in the person's clinical presentation or lack of progress; and
* The person is an active participant in treatment and discharge planning; and
* Where clinically appropriate, and with the person's informed consent, timely attempts are made by the treatment team, and documented in the treatment plan, to involve the family and other components of the person's community support network in treatment planning and discharge planning.

Discharge Indicators (must meet I or II):

I. The person no longer needs the partial hospital level of care because:
* The symptoms, functional impairments and/or coexisting medical conditions that necessitated admission or continued stay have diminished in severity and the person's treatment can now be managed at a less intensive level of care; and
* The improvement in symptoms, functional capacity and/or medical condition has been stabilized and will not be compromised with treatment being given at a less intensive level of care; and
* There is a viable discharge plan with which service and care providers identified for after-care treatment, if needed, and support have concurred.

or

II. The partial hospital level of care is discontinued because:
* The diagnostic evaluation has been completed when this constitutes the reason for admission; or
* The person withdraws from treatment against advice and does not meet criteria for involuntary commitment; or
* The person is transferred to another facility/unit for continued care.

**PSYCHIATRIC OUTPATIENT CLINIC**

**Admission (must meet criteria I and II):**

I. A mental health professional determines that the outpatient level of care is appropriate and there is the potential for the person to benefit from outpatient care. The person must meet at least one of the following condition elements:

* The person has a psychiatric illness exhibited by reduced levels of functioning and/or subjective distress in response to an acute precipitating event; or

* The person is exhibiting signs or symptoms of a psychiatric illness, associated with reduced levels of functioning and/or subjective distress; or

* The person has a history of psychiatric illness and presents in remission or with a residual state of a psychiatric illness, and without treatment there is significant potential for serious regression,

and

II. A comprehensive diagnostic evaluation, including an assessment of the psychiatric, medical, psychological, social, vocational and educational factors important to the person, is conducted.

**Continued Stay (must meet criteria I, II and III):**

I. The person has a current psychiatric diagnosis or provisional psychiatric diagnosis.

and

II. The treatment team determines that:

* The person continues to exhibit one or more signs or symptoms that necessitated admission and can be expected to benefit from the outpatient level of care; or

* The person has developed new signs or symptoms that meet admission criteria and could be expected to benefit from the outpatient level of care; or

* There is a reasonable expectation based on the person's clinical history that withdrawal of treatment will result in decompensation or recurrence of signs or symptoms.

III. The services provided to the person meet the following criteria:
Appendix T

* The person is an active participant in treatment and discharge planning; and
* A psychiatrist reviews and approves the treatment plan; and
* The treatment plan includes a discharge plan and is reviewed and modified, as appropriate, by the treatment team to address changes in the person's clinical presentation and response to treatment; and
* The person is receiving treatment within the framework of a multidisciplinary individualized treatment plan approach.

Discharge Indicators

* The person no longer meets continued stay criteria; or
* The person withdraws from treatment against advice and does not meet criteria for involuntary treat
Appendix T - Part A

HEALTHCHOICES BEHAVIORAL HEALTH SERVICES
GUIDELINES for MENTAL HEALTH SERVICE NECESSITY CRITERIA

ADULT

TARGETED CASE MANAGEMENT SERVICES

Admission (must meet criteria I and II):

An individual who meets the minimum staff requirements for an Intensive Case Manager as defined by Chapter 5221, Mental Health Intensive Case Management or a Resource Coordinator as defined by Mental Health Bulletin OMH-93-09 —Resource Coordination: Implementation; July, 30, 1993 and has received training on the use of the environmental matrix has conducted an evaluation and has determined that:

I. The person meets either the eligibility criteria for Resource Coordination Services as defined by Mental Health Bulletin OMH-93-09 —Resource Coordination: Implementation; July, 30, 1993 or Intensive Case Management Services as defined by Chapter 5221, Mental Health Intensive Case Management.

An adult who needs to receive targeted case management services but who does not meet the requirements identified above may be eligible for targeted case management services upon review and recommendation by the County Administrator.

and

II. The person is in need of Targeted Case Management Services as indicated through utilization of the Targeted Case Management-Adult Environmental Matrix and in conjunction with clinical information and the professional judgement of the reviewer.

Continued Stay and/or Change of Level of Need (must meet criteria I and II):

The consumer must be reassessed at the point of concurrent review, but no less frequently than six month intervals, and when there are significant changes in the individual’s situation that warrants a change in level of TCM services.

I. The consumer continues to meet at least 2 out of the 3 of part A Admission Criteria.
II. The person is in need of Targeted Case Management Services as indicated through utilization of the Targeted Case Management-Adult Environmental Matrix and in conjunction with clinical information and the professional judgement of the reviewer.

**Discharge Indicators**

I. Targeted Case Management may be terminated when one of the following criteria is met:

A. The consumer receiving the service determines that Targeted Case Management is no longer needed or wanted and the consumer no longer meets the continued stay criteria; or

B. Determination by the targeted case manager in consultation with his/her supervisor or the director of targeted case management, and with written concurrence by the county administrator that targeted case management is no longer necessary or appropriate for the adult receiving the service and the consumer no longer meets the continued stay criteria; or

C. The consumer receiving the service determines that Targeted Case Management is no longer wanted, however, the consumer does meet continued stay criteria; or

D. The consumer has moved outside of the current geographical service area (e.g., county, state, country); or

E. The consumer is undergoing long-term incarceration and/or long-term hospitalization or long-term skilled-nursing care without a discharge or anticipated discharge date.

**TCM ENVIRONMENTAL MATRIX — ADULTS INSTRUCTIONS**

The Environmental Matrix - Adults is a scale that evaluates the functional level of consumers on the six activities identified by regulation as Targeted Case Management activities. Cultural competency will be recognized throughout the entire evaluation process and the entire document. Individuals must be assessed in the following areas, in a face-to-face interview with the evaluator. Individuals should be reassessed as needed, but no less than every six months.

1. Assessment and Service Planning
2. Informal Support and Network Building
Appendix T-B (2)

3. Use of Community Resources
4. Linking and Accessing Services
5. Monitoring of Service Delivery
6. Problem Resolution

The scale has a range from 0 to 5 with the following values for each activity:

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<tr>
<td>No assistance Needed</td>
<td>Minimal assistance needed</td>
<td>Needs Moderate assistance in this area</td>
<td>Needs Significant assistance in this area</td>
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All six activities are ranked on the above scale. The evaluator must complete the environmental matrix in a face-to-face, strengths-based assessment interview with the consumer. Evaluators should incorporate in their assessment a recognition/determination of cultural strengths (i.e., extended family, allocation of family resources, the decision making process, values, etc.). The evaluator should consider the individual’s strengths and needs in the following life domains for each assessment area in order to produce a score that reflects the full dimension of need:

- Housing/living situation
- Education/vocation
- Income/benefits/financial management
- Mental Health treatment
- Alcohol and other drug use.
- Socialization/support
- Activities of daily living
- Medical treatment
- Legal situation
- Transportation issues
- Criminal justice system involvement

Each area is defined at the “1”, “3”, and “5” levels (See attached Environmental Matrix) and the subtotal score is divided by 6 to obtain the EM Score (when scoring the individual, refer to the Environmental Matrix TCM Service Scoring Grid which identifies the expected frequency of TCM contact needed for the individual for that particular assessment area). Scoring levels on individual assessment areas may be gradated to the 0.5 level only; this allows for minor differentiation of consumer need without compromising the integrity of the scale.

Looking at the behavior, inclusive of the lowest level of functioning, of the consumer during the last ninety (90) days, rate the consumer’s functional level in each of the six areas. Please note that the rating for each area should be made in whole numbers; in cases where there are extraordinary factors that make the assignment of whole numbers extremely difficult, if not impossible, 0.5 points may be added to or subtracted from the base scores. The sum of the six (6) scores should then be taken and divided by 6 and the
resulting subtotal score should be reviewed and compared to other known factors that may affect the consumer’s need for service. This should be noted on the scoring sheet. If after averaging the scores, the average is lower by at least 2 points than any one value given in any one assessment area (e.g., if a person’s average is 2 and he/she received a score of 4 in any one area), the evaluator must provide written justification for assignment to the level that corresponds to the average, rather than the higher value.

The Environmental Matrix score, your professional judgement *, and other information (e.g., cultural factors, records of past treatment, psychiatric evaluations, psychosocial summaries) that impacts on the consumer’s level of need should then be considered and the Recommended Level of TCM service should be entered on the recommended level of TCM line of the Scoring Sheet. (These levels are consistent with minimum levels of contact as defined in Chapter 5221, Intensive Case Management regulations and Bulletin OMH-93-09, Resource Coordination: Implementation.) If the recommended level of TCM service differs from the Environmental Matrix score, the difference must be justified with professional judgement in “Other Factors/Issues Affecting Score” section of the scoring sheet. Note: The level of service indicated by the assessment represents the individual’s needs at the time of assessment. Service intensity could change as an individual’s needs and/or desires for service change.

Please note:

☐ Although a person may not meet the eligibility criteria and/or the Environmental Matrix formulary, inclusive of professional judgement and other information that impacts on the individual’s need for the service, he/she may be authorized for Targeted Case Management Services upon the recommendation of the County Administrator and/or designee.

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<tr>
<th>ENVIRONMENTAL MATRIX</th>
<th>TCM SERVICE SCORING GRID</th>
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<tr>
<td>MATRIX LEVEL</td>
<td>NEED LEVEL</td>
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<tr>
<td>4.0 – 5.0</td>
<td>I. ICM</td>
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<td>1.5 – 3.9</td>
<td>II. RCM</td>
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<tr>
<td>0.0 - 1.4</td>
<td>NO TCM NEEDED</td>
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ASSESSMENT & SERVICE PLANNING

The consumer is able to provide meaningful and accurate information regarding own mental health status and needs. The consumer, with possible assistance from the targeted case manager, identifies, formulates, and expresses personal goals and objectives and can correlate these into concrete service needs and activities. The TCM should take into consideration that the behavioral health system may pose a number of barriers which serve as obstacles to service planning (i.e., language, perceived/actual institutional racism/discrimination, etc.)

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0= Consumer does not need/or request assistance in this area.

1= Consumer is able to provide meaningful/relevant/accurate information regarding own mental health status. Consumer is able to identify and formulate and express personal goals and objectives with minimal assistance from others. Consumer is able to translate/correlate these goals and objectives, with minimal direction, into concrete service needs and activities.

3= Consumer needs and/or requests moderate assistance in identifying and conveying information regarding own mental health status/problems. Consumer needs and/or requests moderate assistance from others in order to identify, formulate, and express personal goals and objectives. Consumer needs and/or requests moderate assistance from others to translate/correlate needs and goals into concrete service needs and activities.

5= Consumer needs and/or requests significant assistance from others to provide any meaningful information regarding own mental health status and/or needs. Consumer is unable to express personal goals nor objectives without assistance. Consumer needs and/or requests significant assistance from others to design/formulate service plan and activities.

USE OF COMMUNITY RESOURCES

The consumer is able to identify, understand, and articulate daily living needs as well as those community/neighborhood resources that may be needed to meet these needs. The consumer may need additional support from the targeted case manager in utilizing the services that may go beyond the realm of traditional mental
Appendix T-B (2)

health/substance abuse services. TCM must recognize cultural and linguistic needs as an important element in articulating daily living needs and resources. Many services may not be available in the immediate community and be less effective if located outside the community.

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**0=** Consumer does not need/or request assistance in this area.

**1=** Consumer is able, when encouraged, to identify and articulate daily living needs. Consumer is able to access, navigate, and utilize community/neighborhood resources with minimal assistance. Consumer’s needs may be fulfilled through the use of existing community resources such as social/religious groups, libraries, stores, directories, and public transportation and consumer is able to utilize these with minimal assistance.

**3=** Consumer needs and/or requests moderate assistance in identifying daily living needs as well as those community resources needed to meet these needs. When directed to community resources such as social/religious groups, libraries, stores, directories, and public transportation, the consumer may require and/or request moderate assistance to access and utilize these resources in order to accomplish a planned task.

**5=** Consumer is unable to identify nor understand daily living needs. Consumer is not familiar with community/neighborhood resources and has had very few, if any, positive experiences while living in the community. Consumer needs and/or requests significant assistance to access, navigate, or utilize existing community resources.

**INFORMAL SUPPORT NETWORK BUILDING**

The consumer identifies, communicates, and interacts with family, friends, significant others, and community groups from whom the consumer may gain informal support. The TCM should recognize that service system barriers may impede the consumer from interacting with family, friends, significant others and community groups. The consumer may need the assistance of the targeted case manager and/or others to identify, enhance and/or maintain existing relationships and the encouragement to develop new ones.
0= Consumer does not need/or request assistance in this area.

1= Consumer is able to identify and provide meaningful/accurate/relevant information about family, friends, significant others, and social/religious groups with whom consumer interacts and from whom consumer may gain informal support. Consumer is able, with minimal assistance, to access and maintain positive relationships with these people and groups who provide personal social support and/or companionship.

3= Consumer needs and/or requests moderate assistance in identifying and communicating with family, friends, significant others, and social/religious groups from whom consumer may gain informal support. Consumer needs and/or requests moderate assistance from others in order to enhance and/or maintain existing relationships and to develop new ones.

5= Consumer is unable to identify nor interact with family, friends, significant others, and/or social/religious groups who may serve as personal supports. Consumer has few, if any, personal or familial relationships and is unable/unwilling to interact positively, if at all, with these persons or groups. Consumer needs and/or requests significant assistance from others to elicit information and support on his/her behalf.

**LINKING AND ACCESSING SERVICES**

The consumer is able to locate, gain access, and maintain contact and services with the service providers that have been identified as needed in the treatment or service plan. The treatment or service plan must recognize the cultural and linguistic needs of the consumer. At times, the targeted case manager may be needed to provide assistance in nontraditional and/or assertive ways to successfully gain and maintain these resources.

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0= Consumer does not need/or request assistance in this area.

1= Consumer is able, with minimal assistance from others, to locate and gain access to services identified in the treatment or service plan. Consumer is able, when
Appendix T-B (2)

encouraged, to establish and maintain appointments/services with appropriate service providers with minimal assistance. Consumer needs and/or requests minimal assistance by others to successfully gain access to and to maintain contact with community resources and services.

3= Consumer needs and/or requests moderate assistance in locating and gaining access to services identified in the treatment or service plan. Consumer may require and/or request moderate assistance, often in nontraditional ways, to access, establish, and maintain contact and services with the identified service providers.

5= Consumer is unable and/or unwilling to locate or gain access to services identified in the treatment or service plan. Consumer’s identified needs are so immense or so unusual that assertive and creative efforts outside of the usual and normal practice must be employed in order to help the person gain the resources and services identified. Consumer needs and/or requests significant (frequent and continual) assistance by others to successfully gain access to and to maintain contact with community resources and services.

MONITORING OF SERVICE DELIVERY

The consumer gauges and communicates her/his satisfaction with the progress that has been made and with the services offered/delivered by the service providers identified in the treatment plan. The consumer suggests possible needed revisions and/or additions to the treatment/service plan. The TCM should recognize that language and culture has much to do with expressions of satisfaction/dissatisfaction and be prepared to assist the consumer in suggesting changes in the treatment plan/service plan or actual provider.

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0= Consumer does not need/or request assistance in this area.

1= Consumer is able to communicate, when encouraged, his/her opinion of the progress and satisfaction with the service provider and/or the delivered services as well as the need for revisions to the treatment/service plan. Consumer is able and willing to participate in intra- and inter-agency as well as cross-systems reviews of the need for and appropriateness of the specific services delivered. Minimal assistance from others is needed and/or requested to ensure that the consumer is satisfied with the services received.
3= Consumer needs and/or requests moderate assistance in determining and communicating his/her satisfaction with the service provider and with the services delivered. Consumer needs and/or requests moderate assistance in identifying what progress has been made and the possible need for revisions to the treatment/service plan.

5= Consumer is almost totally dependent on others to see that progress is being made and to suggest needed revisions to the treatment/service plan. Consumer needs and/or requests significant assistance to communicate effectively and realistically about her/his progress and satisfaction with the service provider and/or the services delivered.

**PROBLEM RESOLUTION**

The consumer is able to resolve issues and overcome barriers, including those that are cultural and linguistic in nature, that prevent her/him from receiving needed treatment, rehabilitation, and/or support services as well as entitlements. The consumer is aware of and able to utilize complaint/grievance procedures as well as additional appropriate advocacy supports. The targeted case manager, when requested and or needed, may be called upon to not only help the consumer with these tasks but also to provide information to the County Office of Mental Health and/or the BHMCO in order to overcome barriers and to assist the consumer in obtaining needed services.

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<td>0=</td>
<td>Consumer does not need/or request assistance in this area.</td>
<td>Consumer needs and/or requests minimal assistance to resolve issues and overcome barriers that prevent him/her from receiving treatment, rehabilitation and/or support services.</td>
<td>Consumer is able, with moderate assistance and encouragement, to identify issues that need to be resolved but is unable, without direct assistance from others, to formulate steps or implement actions that would overcome barriers that prevent him/her from receiving treatment, rehabilitation and/or support services.</td>
<td>Consumer needs and/or requests significant assistance, to identify and resolve issues that prevent him/her from receiving treatment, rehabilitation and/or support services.</td>
<td>Consumer needs and/or requests significant assistance, to identify and resolve issues that prevent him/her from receiving treatment, rehabilitation and/or support services.</td>
<td>Consumer needs and/or requests significant assistance, to identify and resolve issues that prevent him/her from receiving treatment, rehabilitation and/or support services.</td>
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services. Consumer is totally dependent on others to recognize and to take steps to overcome these barriers. Resolution may require the intervention of the County Office of Mental Health and/or the modification of existing services or the development of new services.

TARGETED CASE MANAGEMENT
ENVIRONMENTAL MATRIX - ADULT

<table>
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<th>Agency</th>
<th>County</th>
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CONSUMER INFORMATION:

Name:

(Last)       (First)     (MI)

Parent/Guardian Name:

Identifying Number(s):

Date of Birth:        /    / 

(MM)/(DD)/(YYYY)

Social Security Number:    -    -

CIS/BSU/MCO Number:

PHMCO:

BHMCO:

Form Completed by:

Date Completed:

The purpose of this form is to assess what environmental and cultural factors help to determine an individual’s need for the various levels of case management services. Please complete this form utilizing the individual’s behavior during the last ninety days as a basis for scoring each indicator. Please see the Scoring Sheet for additional information on determining the Environmental Matrix Score and its meaning for level of care assignments.
ENVIRONMENTAL MATRIX ADULT SCORING SHEET

CONSUMER NAME: ____________________________________________

ID#(SOCIAL SECURITY/CIS/BSU): ______________________________________

SCORES:

1. Assessment and Service Planning _____________________________________
2. Use of Community Resources __________________________________________
3. Informal Support Network Building _____________________________________
4. Linking and Assessing Services _________________________________________
5. Monitoring of Service Delivery _________________________________________
6. Problem Resolution ___________________________________________________

SUBTOTAL __________________________

ENVIRONMENTAL MATRIX SCORE = SUBTOTAL ÷ 6=

______________

OTHER FACTORS/ISSUES AFFECTING SCORE:

_____________________________________________________________________

_____________________________________________________________________

_____________________________________________________________________
# ENVIRONMENTAL MATRIX
## TCM SERVICE SCORING GRID

<table>
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<tr>
<th>MATRIX LEVEL</th>
<th>NEED LEVEL</th>
<th>INTENSITY OF CARE</th>
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<tbody>
<tr>
<td>4.0 – 5.0</td>
<td>ICM</td>
<td>At least 1 contact every 14 days (Face to face contact strongly recommended).</td>
</tr>
<tr>
<td>1.5 – 3.9</td>
<td>RC</td>
<td>At least 1 face to face contact every two months</td>
</tr>
<tr>
<td>0.0 – 1.4</td>
<td>NO TCM NEEDED</td>
<td>Alternative services may be needed and if necessary, referrals should be made.</td>
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</table>

*professional judgment:* opinion based on a thorough and ethical analysis of facts, data, history, and issues in accordance with one’s training and experience.

**RECOMMENDED LEVEL OF TARGETED CASE MANAGEMENT SERVICE:**

**CONSUMER:** __________________________________________ DATE: __________

**PERSON COMPLETING THE FORM:** ______________________ DATE: __________

**APPROVED LEVEL OF TARGETED CASE MANAGEMENT SERVICE:**

**REVIEWER:** ______________________ DATE: __________
HEALTHCHOICES BEHAVIORAL HEALTH SERVICES
GUIDELINES for MENTAL HEALTH MEDICAL NECESSITY CRITERIA

CHILDREN AND ADOLESCENTS

PSYCHIATRIC INPATIENT HOSPITALIZATION
RESIDENTIAL TREATMENT
PSYCHIATRIC PARTIAL HOSPITALIZATION PROGRAMS
PSYCHIATRIC OUTPATIENT TREATMENT

Purpose

The purpose of this document is to provide decision-making criteria for the admission of children and adolescents to four (4) treatment environments under regulation. This document provides a clear interpretive framework, in accordance with Office of Mental Health and Substance Abuse Services (OMHSAS) program, and Office of Medical Assistance Programs (OMAP) payment regulations, for deciding when to treat, continue or discontinue treatment, and refer elsewhere for other services. These criteria will serve the basis for decision-making for Managed Care Organizations (MCOs), county Mental Health/Mental Retardation (MH/MR) offices, and prescribers of children's mental health services in general, as well as for providers delivering their respective services to children qualifying for Medical Assistance (MA) coverage. This document provides a common set of criteria for reference by all the decision-makers in a child's care. These four (4) sets of criteria are intended to further consistency between the child's treatment needs and the broader philosophy of individualized service delivery in the most appropriate and least restrictive setting as guided, respectively, by the principles of the Child and Adolescent Service System Program (CASSP) and the Community Service Program (CSP).

Background

The Office of Mental Health and Substance Abuse Services (OMHSAS) produced Title 55 PA Code Chapters 5100, 5300, 4210, 5200, 5310, and 5210 to regulate the general delivery of services in community psychiatric inpatient, outpatient, residential, and partial hospitalization settings, while OMAP produced Title 55 PA Code, Chapters 1151 and 1153 to regulate M.A. payment for these services. Additional clarity for psychiatric residential treatment is provided in OMHSAS's proposed Chapter 5215 regulations. However, as more mental health services are developed for delivery in the home and community, in conjunction with a growing emphasis on providing services in the least restrictive environments necessary, greater clarity is required for mental health providers, case managers, interagency teams, and third party payers, including Managed Care Organizations and their sub-contractors, to make coordinated treatment determinations concerning appropriateness of admissions, continued stay, and discharge planning. It is for this reason that the criteria provided below have been developed.
Presented in the opening section which precede the criteria, is a summary outline of the major aspects of service delivery, including: CASSP principles, the function of each of the four (4) treatment environments, and the importance of prescribing the least restrictive setting necessary. More detail is provided by the addenda in the document. Following the introduction are the individual "Admission Criteria" for each service. Each set of criteria is divided into three (3) sections, the first for determining "Admission", the second for determining the appropriateness of "Continued Stay," and the third for identifying "Discharge Criteria."

For ease of reading in the following text, "child(ren) and adolescent(s)" shall be commonly referred to as "child(ren)," unless otherwise indicated.

**Introduction**

The mental health system has undergone substantial structural change from an emphasis on community segregation and maintenance of children with emotional disorders, to one of community integration and fostering increasing independence of individuals (see Mental Health/Mental Retardation Act of 1966 and the Mental Health Procedures Act of 1976 with subsequent amendments). These changes are further reflected in the development of the Child and Adolescent Service System Program (CASSP) and its philosophy. The OMHSAS summary representation of CASSP, is provided below:

The CASSP philosophy of collaborative service delivery to children, adolescents and their families undergirds all treatment methods. CASSP involves all child-serving systems including mental health, mental retardation, education, special education, children and youth services, drug and alcohol, juvenile justice, health care, and vocational rehabilitation. It should also include informal community supports and organizations. This philosophy is essential to making decisions to provide treatment for children. It is also the foundation for the development of these criteria. These principles are represented in the following six summary statements:

1. **Child-centered** - Services are planned to meet the individual needs of the child, rather than to fit the child into an existing service. Services should be developmentally appropriate and child-specific, and should also build on the strengths of the child and family to meet the mental health, social and physical needs of the child.

2. **Family-focused** - Services recognize that the family is the primary support system for the child. The family participates as a full partner in all stages of the decision-making and treatment planning process, including implementation, monitoring and evaluation. A family may include biological, adoptive and foster parents, siblings, grandparents and other relatives, and other adults who are committed to the child. The development of mental health policy at state and local levels should include family representation.

3. **Community-based** - Whenever possible, services should be delivered in the child's home community, drawing on formal and informal resources to promote the child's successful participation in the community. Community resources include not only mental health
professionals and provider agencies, but also social, religious and cultural organizations and other natural community support networks.

(4) Multi-system - Services should be planned in collaboration with all the child-serving systems involved in the child's life. Representatives from all these systems and the family should collaborate to define the goals for the child, develop a service plan, develop the necessary resources to implement the plan, and provide appropriate support to the child and family.

(5) Culturally competent - Culture determines our world view and provides a general design for living and patterns for interpreting reality that are reflected in our behavior. Therefore, services that are culturally competent are provided by individuals who have the skills to recognize and respect the behavior, ideas, attitudes, values, beliefs, customs, language, rituals, ceremonies and practices characteristic of a particular group of people.

Note: Pennsylvania's cultural competence initiative has focused specifically on African Americans, Latinos, Asian Americans and Native Americans who have historically not received culturally appropriate services.

(6) Least restrictive/least intrusive - Services should take place in settings that are the most appropriate and natural for the child and family and are the least restrictive and intrusive available to meet the needs of the child.

These principles encompass not only the psychological, but the physical, cognitive, and sociocultural development of children, which include the child's dependency on family, community, and environmental influences in general. From these principles, the four services for which "Admission Criteria" are provided below, can be understood as components within a wider network of service options.

Severity of Symptoms

The child's expression of impairment in any of the following should be considered in the design of the individual's treatment: judgement, thought, mood, affect, impulse control, psychosocial, psychomotor retardation/excitation, physiological functioning and/or cognitive/perceptual abilities. Challenging behaviors closely associated with social contexts such as family, school, or other community activities must also be considered when determining an appropriate treatment design, and the concomitant discharge planning.

Intensity of Treatment

The intensity and range of treatment varies for each of the four services. Psychiatric Inpatient and Residential Treatment are out of home services which provide highly intensive treatment for the purpose of returning children home, or to a homelike setting. Partial Hospitalization and Psychiatric Outpatient provide services of varying intensity depending on the child's need for therapeutic support to remain home. The therapeutic function and emphasis of each of the four
services to return a child home, or to prevent out-of-home placements, depends strongly on the interaction between the therapist, the parents/guardians, and the child, for the effectiveness of the treatment plan developed.

Psychiatric Inpatient hospitalization provides the most restrictive level of care. The setting is locked and highly focused toward the delivery of intensive, short term treatment. It serves as an appropriate placement for children expressing the sudden onset of acute symptoms, and/or requiring treatment which cannot be managed outside of a 24 hour, secure setting.

Residential Treatment facilities provide a stable, open, community living setting for the delivery of comprehensive mental health treatment with 24 hour monitoring and a strong supportive environment from which the child is able to reenter the community. This is a longer term treatment option for children who require the comprehensive treatment and professional support of this setting to prevent a need for inpatient hospitalization.

Partial hospitalization lies between the most restrictive and community-based levels of care. A partial hospitalization treatment program offers a wide range of treatment in a setting segregated from the child's natural setting for part of the day. Effective treatment and stabilization of the child must be possible within the partial hospital program hours prescribed in the treatment plan. Partial hospitalization provides an opportunity to observe a child's behavior and the effects of treatment, for the purpose of developing and confirming a proper course of treatment designed for the effective reintegration of the child into the community.

Outpatient treatment is for children and their families who are seeking help and believe there is a need for mental health services. Services and treatment approaches include, diagnostic testing, crisis intervention services, behavior therapy, individual, group and family psychotherapy, medication, and similar services. The child should be able to maintain sufficient stability in his/her existing support network, to be treated effectively within the hours of outpatient treatment prescribed in the treatment plan. Treatment and services should be directed toward helping the child to remain integrated with his/her natural community and work to prevent the necessity of a more restrictive or intrusive service.

**Least Restriction**

The four services addressed in this bulletin are presented in descending order of restrictiveness and in increasing order of community integration. The need for greater or lesser restrictiveness must be adjusted to the individual's need for active treatment as reflected in the treatment plan. Increased restrictiveness of setting improves the convenience and opportunity for immediate intervention in the delivery of treatment. However, less restrictive environments should be considered to prevent the removal of children from their families, peers, and normalized settings in the community. Each service provides treatment with the object of helping a child with acute
behavioral problems or serious emotional disturbance to increase his or her functional capacity, in order to increase his/her ability to reintegrate into the community. Therefore, the goals of treatment may be summarized by the following:

- amelioration of symptoms such that less restrictive and/or less intrusive services can be planned and introduced;
- stabilization of medical regimen for children requiring psychotropic medication so they may remain in the least restrictive setting possible;
- prevention of regression/recidivism by improving the child's level of functioning and ability for self maintenance;
- coordination of the treatment and discharge plan on an ongoing basis with the family and the appropriate agencies to provide the necessary community based supports, including wraparound services; and
- increase in the age-appropriate interactiveness in a variety of settings [see Community Integration Attachment in Appendix C].

**Psychiatric Inpatient Hospitalization**

Admission of a child for psychiatric inpatient treatment is most appropriately based on a diagnosis by a certified child and adolescent psychiatrist. In the absence of a child and adolescent psychiatrist, a diagnosis may be appropriately provided by a Board Certified psychiatrist. When a certified psychiatrist is not available, a diagnosis may be provided by a Board eligible psychiatrist or a licensed physician contingent on confirmation by a Board Certified psychiatrist within forty-eight (48) hours of admission, or as indicated by the regulations governing this service. However, any time the most appropriate specializing physician is unavailable to perform the necessary diagnostic services, this should be documented and explained.

Diagnostic references for the purpose of the documentation below must conform to the most current edition of the Diagnostic and Statistical Manual (DSM).

**ADMISSION CRITERIA**

(Must meet I and II)

I. DIAGNOSTIC EVALUATION AND DOCUMENTATION

A. Presenting illness is diagnosed on DSM IV Axis I or Axis II, as part of a complete multiaxial, face-to-face diagnostic examination (MR or D&A cannot stand alone) and in accordance to ICD-9 codes, by a licensed physician\(^5\) contingent on

\(^5\) Diagnosis by a resident physician with training license must receive confirmation within 24 hours.
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confirmation by a child and adolescent psychiatrist or Board Certified psychiatrist within forty-eight (48) hours of admission.

AND

B. Psychiatric Inpatient Treatment is prescribed by the diagnosing psychiatrist, and/or as required by Pennsylvania regulation, indicating that this is the most appropriate, and least restrictive service to meet the mental health needs of the child;

AND

C. Documentation in the current psychiatric evaluation that the treatment, 24-hour supervision, and observation, provided in the Psychiatric Inpatient setting, are necessary as a result of:
   - severe mental illness or emotional disorder, and/or
   - behavioral disorder indicating a risk for safety to self/others;

AND

D. Based on the patient's current condition and current history, reasonable, documented treatment within a less restrictive setting has been provided by a mental health professional, and/or careful consideration of treatment within an environment less restrictive than that of a Psychiatric Inpatient Hospitalization, and the direct reasons for its rejection, have been documented;

AND

E. A complete strengths-based evaluation, including identifying the strengths of child's family, community, and cultural resources, must be completed prior to admission, or within 120 hours in the event of an emergency admission.

II. SEVERITY OF SYMPTOMS

A. Significant risk of danger is assessed for any of the following,
   1. child HARMING HIM/HERSELF
   2. child HARMING OTHERS
   3. DESTRUCTION TO PROPERTY which is:
      a. life-threatening, OR
      b. in combination with "B", "C", or "D" below;
         OR

B. There is an acute occurrence or exacerbation of impaired judgement or functional capacity and capability, for the child's developmental level, that interpersonal skills, and/or self-maintenance in home/school/community is/are severely compromised;

OR
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C. There are endangering complications in either of the following:
1. complicating factors of the child's psychiatric illness or treatment would
seriously threaten the child's health safety due to a lack of capacity for
self-care; OR
2. due to a coexisting medical condition where the child has a medical
condition or illness which, as a result of a psychiatric condition, cannot be
managed in a less intensive level of care without significant risk of
medical crisis or instability;
OR

D. The severity of the child's symptoms are such that continuation in a less intense
level of care cannot offer either an expectation of improvement, or prevention of
deterioration, as identified in the above three categories of "II."

Requirements for Continued Stay
(Must meet I and II. Complete documentation for each is required, and additional
documentation as indicated in Appendix B.)

I. DIAGNOSTIC EVALUATION AND DOCUMENTATION
A. The initial evaluation and diagnosis is updated and revised as a result of a face-
to-face diagnostic examination by the treating psychiatrist;
AND
B. Continued Psychiatric Inpatient Treatment is prescribed by the diagnosing
psychiatrist, and/or as required by Pennsylvania regulation, indicating and
documenting that this is the least restrictive, appropriate service to meet the
mental health needs of the child, and the discharge implementation plan;

II. SEVERITY OF SYMPTOMS
A. Severity of illness indicators and updated treatment plan support the likelihood
that: substantial benefit is expected as a result of continued active intervention
in a psychiatric inpatient setting, without which there is great risk of a
recurrence of symptoms; OR severity is such that treatment cannot be safely
delivered at a lesser level of care, necessitating hospitalization;
AND
B. Although child is making progress toward goals in the expected treatment
process, further progress must occur before transition to a lesser level of care is
advisable. The necessary changes must be identified in an updated treatment
plan, and the treatment team review must recommend continued stay;
OR
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C. The symptoms or behaviors that required admission, continue with sufficient acuity that a less intensive level of care would be insufficient to stabilize the child's condition;

OR

D. Appearance of new symptoms meeting admission criteria.

III. DISCHARGE CRITERIA

A child not meeting criteria as established in Section II, SEVERITY OF SYMPTOMS, of the CONTINUED STAY CRITERIA, must be discharged.

Residential Treatment Facilities

Admission of a child to a JCAHO Accredited Residential Treatment Facility is most appropriately based on a diagnosis by a certified child and adolescent psychiatrist. In the absence of a child psychiatrist a diagnosis may be appropriately provided by a Board Certified psychiatrist. However, any time the most appropriate specializing physician is unavailable to perform the necessary diagnostic services, this should be documented and explained. Admission to a Non-JCAHO Accredited Residential Treatment Facility is most appropriately based on a diagnosis as described above for JCAHO accredited facilities, or by a licensed psychologist specializing in treatment for children and adolescents.

Diagnostic references for the purpose of the documentation below must conform to the most current edition of the Diagnostic and Statistical Manual (DSM).

ADMISSION CRITERIA
(Must meet I and II or III)

I. DIAGNOSTIC EVALUATION AND DOCUMENTATION

A. Diagnosis on DSM IV Axis I or Axis II, as part of a complete multiaxial, face-to-face diagnostic examination (MR or D&A cannot stand alone) and in accordance to ICD-9 codes, by a psychiatrist (as defined in Chapter 5200.3 of the Pennsylvania Code) for JCAHO accredited facilities, or by a psychiatrist or a licensed psychologist for Non JCAHO accredited facilities;

AND

B. Residential Treatment service is prescribed by the diagnosing psychiatrist or psychologist, as appropriate to the accreditation of the facility, indicating that this is the most appropriate, least restrictive service to meet the mental health needs of the child;

AND
C. Documentation in the current psychiatric/psychological evaluation\(^{6}\) that the treatment, 24-hour supervision, and observation, provided in the Residential Treatment setting, are necessary as a result of:

- severe mental illness or emotional disorder, and/or
- behavioral disorder indicating a risk for safety to self/others;

   AND

D. Reasonable, documented treatment within a less restrictive setting has been provided by a mental health professional, and/or careful consideration of treatment within a less restrictive environment than that of a Residential Treatment Facility, and the direct reasons for its rejection, have been documented;

   AND

E. Placement in a Residential Treatment Facility must be recommended as the least restrictive and most clinically appropriate service for the child, by an interagency service planning team as currently required by the OMHSAS and OMAP. Following PA School Code, Sections 1306-1309 and 2561, when a child is removed from the school setting for the purpose of receiving mental health treatment, it is expected that the appropriate school system will be involved in the child's educational planning and the interagency team. In the event that conditions prevent the possibility of parental or child involvement, attempts to involve the child and parents and/or reasons explaining their non-involvement must be fully documented and presented to an interagency team;

   AND

F. A complete strengths-based evaluation, including identifying the strengths of child's family, community, and cultural resources, must be completed prior to admission.

\(^{6}\) A current psychiatric/psychological evaluation is one which has been conducted within sixty (60) days prior to admission to the program. A psychiatric/psychological evaluation for a child placed on a waiting list during which time the thirty (30) day maximum has passed, shall continue to be "current" for an additional thirty (30) days.

(updated 9/10/09)
II. SEVERITY OF SYMPTOMS

The child's problematic behavior and/or severe functional impairment discussed in the presenting history and psychiatric/psychological examination must include at least one (1) of the following:

A. Suicidal/homicidal ideation
B. Impulsivity and/or aggression
C. Psycho-physiological condition (i.e.- bulimia, anorexia nervosa)
D. Psychomotor retardation or excitation.
E. Affect/Function impairment (i.e.- withdrawn, reclusive, labile, reactivity)
F. Psychosocial functional impairment
G. Thought Impairment
H. Cognitive Impairment

III. OBSERVATION

The child's problematic behavior and/or severe functional impairment discussed in the presenting history and psychiatric/psychological examination requires further observation for clarification under section II. Allowable for up to fifteen (15) calendar days within which time the examining psychiatrist/psychologist must clarify the criteria for admission under II AND/OR recommend development of a discharge plan. Should it be found that the child does not fit the criteria for admission, an appropriate discharge plan is to be developed with the interagency team, and the child discharged under the provisions of that plan.

A. Troubling symptoms of the child which have been described by members of the family (and/or representatives of the community or school), persist but,
   - they are not observed on a psychiatric inpatient unit, or
   - they are denied by the child in outpatient or partial hospitalization treatment,
   such that the residential treatment milieu provides an ideal opportunity to observe and treat the child;

   OR

B. Child's symptoms have not sufficiently improved despite responsible comprehensive treatment at a lower level of care, which has involved the participation of an interagency team.

REQUIREMENTS FOR CONTINUED STAY
(Must meet I and II)

I. DIAGNOSTIC EVALUATION AND DOCUMENTATION (see also, Appendix A)
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A. The initial evaluation and diagnosis is updated and revised as a result of a face-to-face diagnostic examination by the appropriate treating psychiatrist or psychologist; AND

B. Less restrictive treatment environments have been considered in consultation with the Interagency Service Planning Team; AND

C. There is the clinically determined likelihood of substantial benefit as a result of continued active intervention in the Residential Treatment setting, without which there is great risk of a recurrence of symptoms; AND

D. Any other clinical reasons supporting the rejection of other alternative services in favor of continuing Residential Treatment; AND

E. Residential Treatment service is prescribed by the diagnosing psychiatrist/psychologist following a current face-to-face psychiatric evaluation, indicating and documenting that this is the least restrictive, appropriate service to meet the mental health needs of the child, and the discharge implementation plan.

II. SEVERITY OF SYMPTOMS

A. Severity of illness indicators and updated treatment plan support the likelihood that: substantial benefit is expected as a result of continued active intervention in a psychiatric residential treatment setting, without which there is great risk of a recurrence of symptoms; OR severity is such that treatment cannot be safely delivered at a lesser level of care; AND

B. The treatment team review recommends continued stay, documenting the need for the child's further improvement, with the corresponding modifications in both treatment plan and the discharge goals; AND

C. Although child is making progress toward goals in the expected treatment process, further progress must occur before transition to a lesser level of care is advisable. The necessary changes must be identified in an updated treatment plan, and the treatment team review, in conjunction with an interagency team, must recommend continued stay; OR
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D. The symptoms or behaviors that required admission, continue with sufficient acuity that a less intensive level of care would be insufficient to stabilize the child's condition;

OR

E. Appearance of new symptoms meeting admission criteria.

III. DISCHARGE CRITERIA

A. A child admitted under Sections I and III only, of the ADMISSION CRITERIA must be discharged within fifteen (15) calendar days of admission, unless a subsequent face-to-face psychiatric evaluation clarifies child's eligibility under Section II.

B. A child not meeting criteria as established in Section II, SEVERITY OF SYMPTOMS, of the CONTINUED STAY CRITERIA, must be discharged.

Partial Hospitalization Programs

Admission of a child to a Partial Hospitalization Program is most appropriately based on a diagnosis by a certified child and adolescent psychiatrist. In the absence of a child and adolescent psychiatrist, a diagnosis may be appropriately provided by a Board Certified psychiatrist. A diagnosis may otherwise be provided as indicated by the regulations governing this service. However, any time the most appropriate specializing physician is unavailable to perform the necessary diagnostic services, this should be documented and explained.

Diagnostic references for the purpose of the documentation below must conform to the most current edition of the Diagnostic and Statistical Manual (DSM).

ADMISSION CRITERIA

(Must meet I and II or III)

I. DIAGNOSTIC EVALUATION AND DOCUMENTATION

A. Diagnosis on DSM IV Axis I or Axis II as part of a complete multiaxial diagnostic examination (MR or D&A cannot stand alone) by a psychiatrist or psychologist (as defined in Chapter 5200.3 of the Pennsylvania Code);

AND

B. Behaviors which indicate a risk for safety to self/others, and/or decreased functioning for the child's developmental level, such that:

1. this behavioral disturbance requires regular observation and treatment, but does not require 24-hour supervision, and
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2. reasonable treatment within a less restrictive setting has been attempted by a mental health professional, or treatment in a less restrictive setting has been considered and documented, but is rejected directly in favor of partial hospital treatment;

AND

C. Partial hospitalization must be recommended as the most clinically appropriate and least restrictive service available for the child, by the treatment team [as described in PA 55 §5100.2.] to also include: child, parent/guardian and/or caretaker, and case manager;

AND

D. Removal of a child from his/her regular classroom for all or part of the school day necessitates the incorporation of an interagency planning team (in accordance with Chapter 5210.24,(b), except when partial provides acute hospital diversion. [The interagency planning team must include the appropriate representative from the child's local school in compliance with PA School Code, Sections 1306-1309 and 2561, and establish that the child's mental health needs cannot be otherwise met with appropriate supports in a school setting];

AND

E. A treatment plan [See PA 55 §5210.35], to include a complete strengths-based assessment of the child, including identifying the strengths of child's family, community, and cultural resources, can be completed prior to admission or within five (5) days of service in the partial hospitalization program;

AND

F. In the event that conditions prevent the possibility of parental or child involvement, attempts to involve the child and parents, and/or reasons explaining their non-involvement, must be fully documented and presented to the interagency team.

II. SEVERITY OF SYMPTOMS
The child's problematic behavior and/or severe functional impairment discussed in the presenting history and psychiatric examination must include at least one (1) of the criterion in A through F with a severity level as indicated in "B" above.

A. Suicidal/homicidal ideation
B. Impulsivity and/or aggression
C. Psycho-physiological condition (i.e.- bulimia, anorexia nervosa)
D. Psychomotor retardation or excitation
E. Affect/Function impairment (i.e.- withdrawn, reclusive, labile, reactivity)
F. Psychosocial functional impairment
III. OBSERVATION
The child's problematic behavior and/or severe functional impairment discussed in the presenting history and psychiatric examination requires further observation for clarification under section II. Allowable for up to fifteen (15) calendar days within which time the examining psychiatrist must clarify the criteria for admission under II AND/OR recommend development of a transition plan. Should it be found that the child does not fit the criteria for admission, an appropriate transition plan is to be developed with the interagency team, and the child discharged under the provisions of that plan.

A. Troubling symptoms of the child which have been described by members of the family (and/or representatives of the community or school), persist but,
   - they are not observed on a psychiatric inpatient unit, or
   - they are denied by the child in outpatient treatment, such that the day treatment milieu and return to home environment daily, provides an ideal opportunity to observe and treat the child;
   OR

B. Child's symptoms have not sufficiently improved despite responsible comprehensive treatment at a lower level of care, which has involved the participation of an interagency team in planning, coordinating and providing this treatment, and the interagency team currently recommends this level of treatment.

REQUIREMENTS FOR CONTINUED STAY
(Must meet I and II)

I. DIAGNOSTIC EVALUATION AND DOCUMENTATION (see also, Appendix A)
   A. The initial evaluation and diagnosis is updated and revised as a result of a current face-to-face diagnostic examination by the treating psychologist or psychiatrist;

   AND

   B. Less restrictive treatment modalities have been considered;

   AND

   C. There is the clinically determined likelihood of substantial benefit as a result of continued active intervention in the Partial Hospitalization Program, without which there is great risk of a recurrence of symptoms;

   AND
D. Any other reasons supporting the rejection of other alternative services in favor of continuing Partial Hospitalization;

II. SEVERITY OF SYMPTOMS
   A. Severity of illness indicators and updated treatment plan support the likelihood that: substantial benefit is expected as a result of continued active intervention in a partial hospitalization program, without which there is great risk of a recurrence of symptoms; OR severity is such that treatment cannot be safely delivered at a lesser level of care;
   
   B. The treatment team review recommends continued stay, documenting the need for the child's further improvement, with the corresponding modifications in both treatment plan and the discharge goals;
      AND
   
   C. Child is making progress toward treatment goals in the expected treatment process as evidenced by reductions in the problematic signs, symptoms, and/or behaviors the child presented upon admission; and the treatment team or interagency team review recommends continued stay, documenting the need for further improvement and the corresponding modifications in both treatment plan and the discharge goals;
      OR
   
   D. The symptoms or behaviors that required admission, continue with sufficient acuity that a less intensive level of care would be insufficient to stabilize the child's condition;
      OR
   
   E. The appearance of new problems, symptoms, or behaviors meet the admission criteria.

III. DISCHARGE CRITERIA
   A. A child admitted under Sections I and III only, of the ADMISSION CRITERIA must be discharged within fifteen (15) calendar days of admission, unless a subsequent face-to-face psychiatric evaluation clarifies child's eligibility under Section II.
   
   B. A child not meeting criteria as established in Section II, SEVERITY OF SYMPTOMS, of the CONTINUED STAY CRITERIA, must be discharged.

Psychiatric Outpatient Treatment (Clinics)

Admission of a child for Psychiatric Outpatient Treatment (clinic) is most appropriately based on a diagnosis by a certified child and adolescent psychiatrist. In the absence of a
child and adolescent psychiatrist, a diagnosis may be appropriately provided by a Board Certified psychiatrist. A diagnosis may otherwise be provided by a developmental pediatrician or otherwise as indicated by the regulations governing this service. However, any time the most appropriate specializing physician is unavailable to perform the necessary diagnostic services, this should be documented and explained.

Diagnostic references for the purpose of the documentation below must be from the most current edition of the Diagnostic and Statistical Manual (DSM).

**ADMISSION CRITERIA**
(Must meet I and II)

**I. DIAGNOSTIC EVALUATION AND DOCUMENTATION**

A. Diagnosis on DSM IV Axis I or Axis II, as part of a complete multiaxial, face-to-face assessment (MR or D&A cannot stand alone), by a Mental Health Professional (see Title 55. Public Welfare § 5200.3) as reviewed and approved by a psychiatrist or licensed psychologist (see Title 55. Public Welfare § 5200.22(d) and § 5200.31);

AND

B. Behaviors indicate *minimal* risk for safety to self/others and child must not require inpatient treatment or a psychiatric residential treatment facility.

**II. SEVERITY OF SYMPTOMS**

A. Service must be recommended as the most clinically appropriate and least restrictive service available for the child, by the treatment team director [described in PA 55 §5100.2], as informed by the treatment team [described in PA 55 §5210.34]. Parent(s)/guardian(s), and/or caretaker, as appropriate, case manager (when one is assigned) and the child must be involved in the planning process. Where a parent or the child are not or cannot be involved, the attempts to involve either or both and the reasons for non-involvement must be documented. *The treatment team should otherwise recommend the most appropriate alternatives should treatment at an outpatient clinic not be recommended;*

AND

B. There is serious and/or persistent impairment of developmental progression and/or psychosocial functioning due to a psychiatric disorder, requiring treatment to alleviate acute existing symptoms and/or behaviors; or to prevent relapse in the child with symptoms and/or behaviors which are in partial or complete remission;

OR

C. Significant psychosocial stressors and/or medical condition increasing the risk that the child's functioning will decrease for his/her developmental level;
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OR

D. Symptoms improve in response to comprehensive treatment at a higher level of care, but child is still in need of outpatient treatment to sustain and reenforce stability;

OR

E. Requires prescription and monitoring of medications to mitigate the effects of the child's symptoms.

REQUIREMENTS FOR CONTINUED STAY
(Must meet I and II)

I. DIAGNOSTIC EVALUATION AND DOCUMENTATION
A. Revised and updated diagnosis by a Mental Health Professional (see Title 55. Public Welfare § 5200.3) as reviewed and approved by a psychiatrist or licensed psychologist (see Title 55. Public Welfare § 5200.31);
   AND

B. There is significant family (including the child) cooperation and involvement in the treatment process, except where the involvement of family members other than the child would be clinically counter-productive or legally prohibited.

II. SEVERITY OF SYMPTOMS
A. Child is making progress toward goals, and the treatment team review recommends continued stay;

OR

B. The presenting conditions, symptoms or behaviors continue such that natural community supports alone are insufficient to stabilize the child's condition;

OR

C. The appearance of new problems, symptoms, or behaviors meet the admission criteria.

III. DISCHARGE CRITERIA
A child not meeting criteria as established in Section II, SEVERITY OF SYMPTOMS, of the CONTINUED STAY CRITERIA, must be discharged.

FUNCTION OF THE FOUR SERVICES

Inpatient Hospitalization:
• Inpatient hospitalization provides a locked setting for the delivery of acute care.
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- Inpatient hospitalization combines security and restrictiveness with intensive treatment, for the purpose of ameliorating symptoms and reducing the need for such intensity of service by establishing within the child the self-control and/or capacity for constructive expression and more adaptive interpersonal skills necessary to continue treatment in a more natural and less restrictive setting.

- Inpatient hospitalization provides service for children with serious mental and/or serious emotional or behavioral problems who require the coordinated, intensive and comprehensive treatment available from a multi-disciplinary team within a secure setting.


- Treatment components include: major diagnostic assessments, medical and psychiatric treatment, and psychosocial rehabilitation (to include educational components, as appropriate to the child's development).

**Residential Treatment Facilities:**

- Residential Treatment Facilities provide a safe environment within a restrictive setting for the delivery of psychiatric treatment and care. However, it is an unlocked, and otherwise, less restrictive, more flexible alternative than inpatient hospitalization for the delivery of acute care and for the provision of transitional care from an acute inpatient setting.

- Residential Treatment Facilities offer the comprehensive and intense services needed for the purpose of ameliorating symptoms, by establishing within the child the self-control, the capacity for constructive expression, and the adaptive interpersonal skills necessary to continue in a more natural and less restrictive setting.

- Residential Treatment Facilities provide service for children with serious mental and/or serious emotional or behavioral problems who require the coordinated, intensive and comprehensive treatment available from a multi-disciplinary team within a structured, residential setting.

- Treatment components include: major diagnostic assessments, psychiatric and other medical treatment, and psychosocial rehabilitation. Psychosocial rehabilitation is an important vehicle through which psychiatric residential treatment facilities provide culturally competent service. These services provide the child with community linkages and the real world competency necessary for his/her successful return to the community.

- Residential Treatment Facilities must collaborate with the school district of residency, and, if different, the school district where the child in treatment is enrolled, to ensure the child receives educational instruction in the least restrictive setting appropriate to meet their needs while accommodating their behavioral and
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psychiatric difficulties (see Commonwealth of Pennsylvania, OMH-95-07; BEC 19-93; OCYF.

- Parents/guardians are actively involved in the treatment planning process and provided the opportunity to address the treatment of the child in the broader context of the family system. They may receive other additional supports necessary to develop the therapeutic environment the child needs to return home or to other community settings, including training and family therapy. Also, parents/guardians are to be informed of the appropriate parent support and advocacy groups available [see addendum], or any other involvement consistent with the applicable regulations.

Partial Hospitalization Programs:

- Partial hospitalization provides a less restrictive, more flexible alternative than inpatient hospitalization for the delivery of acute care, by providing transitional and diversionary care from an acute inpatient setting.

- Partial hospitalization provides a short-term, intensive outpatient treatment as a transition to Outpatient Clinic services. Its purpose is to reduce the child's need for restrictive therapeutic settings for treatment, and help the child develop the necessary self-control and/or capacity for constructive expression, including more adaptive interpersonal skills, to make the transition to interacting more fully in family and community environments.

- Partial hospitalization provides service for children with serious mental and/or psychosocial disorders who require the coordinated, intensive and comprehensive treatment available from a multi-disciplinary team within a single setting (see "Settings" below).

- Partial hospitalization provides day, after school, weekend, and evening service for children with mental and/or psychosocial disorders, so that:
  - the child receives the additional support necessary to interact effectively and cooperatively with family members, thereby helping to insure the family bond;
  - parents/guardians can receive family therapy/treatment consistent with the treatment of their child.

- Partial hospitalization uses group approaches to the treatment of children with serious mental and/or psychosocial disorders.

- Treatment components include: major diagnostic assessments, medical and psychiatric treatment, psychosocial rehabilitation (to include educational and prevocational components, as appropriate to the child's development), individual and group therapies and opportunities for family therapy. Recognizing the responsibility of the school districts to provide an educational program for all children, full day or school day partial hospitalization programs must collaborate with the school district of residency and the school district where the child in
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treatment is enrolled, to incorporate an educational program within the therapeutic milieu.

**Program Range** - Partial hospitalization programs vary in the intensity and purpose of the services offered. The range of programs includes, on the one end, those serving a more acute population as a step-down from inpatient treatment, or as a preventive for a more restrictive treatment setting. On the other end are programs serving those with more long standing impairments, where clinical judgement suggests that partial hospitalization is therapeutically necessary to return the child or maintain the child in a stable condition while providing effective treatment.

**Settings** - Child partial hospitalization programs serve a range of age groups from pre-school to late teens, and they also occur in a variety of settings. Typical settings may be characterized individually or in combination by place, such as, school settings, clinics, and free-standing units; by specified time of service, such as, morning, afternoon, all day, after-school, and evening, and some have 24 hour emergency phone service; and by established age categories, such as, pre-school, children, and adolescents. In those provided in public and private school settings serving the general population, the school system and the mental health system collaborate closely in meeting the educational and mental health needs of the child. Many facilities described as “free-standing” are designed specifically for those children who require a secure setting for mental health treatment, and the coordination of education and treatment in the same setting. In other settings, such as a mental health agency, the educational component must be designed and developed to meet the child's needs in collaboration with the mental health agency.

**Outpatient Treatment:**
- Provision of services which are less restrictive, more flexible yet effective supports for patients discharged from in-patient or partial hospitalization. In this way outpatient services provide for the delivery of transitional care from a more restrictive setting.
- Prevent the need for more intense services, or accompany more enhanced or community based services, to help the child develop the necessary self-control, and/or capacity for constructive expression, including cultivating more adaptive interpersonal skills for effective participation in the child's natural setting.
- Provision of service for children with mental and/or psychosocial disorders who require the periodic support provided by this treatment, to remain stable and ensure the effectiveness of a treatment plan.
- Provision of after school service for children with mental and/or psychosocial disorders, so that:
  - parents/guardians can receive the additional support necessary to maintain a therapeutic environment for the child;
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○ parents/guardians can receive family therapy consistent with the treatment of their child.

Should service require removing the child during regular school hours, this service, and any subsequent plan to continue service during this time, must be documented with an explanation of the child's condition which necessitates such intervention.

- Treatment components include: major diagnostic assessments, medical and psychiatric treatment. Recognizing the responsibility of the Department of Education to provide an educational program for all children, the therapist must collaborate with the school or school district, but only when appropriate and as necessary to assist in the child's Individualized Education Plan when one has been or should be developed. Where such collaboration is problematic, the reasons must be clearly documented.

Treatment Range- Outpatient treatment varies in both intensity and purpose. Intensity may be reflected in the number and length of visits as well as the duration and types of service offered. The range of service provides support for a more acute population and for those without long standing impairments, where clinical judgement suggests that outpatient treatment is therapeutically necessary to return the child to or maintain the child in a stable condition. Outpatient treatment may serve as a step-down from inpatient treatment and partial hospitalization, and to prevent the need for a more restrictive treatment setting. It also serves children, and their families, experiencing distress who may need the support of short term services to ameliorate the presiding condition or stress.

Outpatient treatment is clearly identified by the setting from which it is offered. In concordance with Title 55 Public Welfare, Chapter 5200 Psychiatric Outpatient Clinics, the domain of this level of treatment for the scope of this document is the clinic, exclusive of partial hospitalization and other day-treatment programs.

Continued Stay Service Documentation

The following list of information should be documented for all four services.

1. Routine assessments and treatment updates chart child's progress.

2. The establishment and documentation of active treatment must include, the implementation of the treatment plan, the therapy provided, documentation of the family's participation and interagency collaboration, cultural competency, and active discharge planning.

3. Current active treatment is focused upon stabilizing or reversing symptoms necessitating admission.

4. Current active treatment is focused on ameliorating symptoms and increasing the child's level of functioning.
5. The level of professional expertise and intervention are appropriate to address the child's current condition(s).

6. The initial discharge criteria formulated for the child have been reviewed and revised, as necessary in the course of developing the discharge plan.

7. The treatment plan and strengths-based evaluation has been updated to reflect the child's progress, medication status, continuing needs and the provider's efforts to meet the identified needs. The treatment plan addresses any necessary supports for the child's successful transition into the community, including mental health and other community-based services, and the natural resources of the family. It incorporates a plan to form appropriate transitional linkages in preparation for discharge to a less restrictive setting.

8. The treatment team programmatically reduces intensity of treatment as the child progresses toward the expected date of discharge, and forms linkages with community and family supports.

9. Type, duration and frequency of services provided to the child, and the outcome of each service must be well documented, i.e.- individual, group and family therapy; education, training and community involvement; family participation in treatment; any special activities; and medication administration and monitoring.

10. As the child improves clinically, active treatment facilitates and increases contact of the child with the community (including home and school) to which the child will return.

11. The provision of services supports the child's involvement in age appropriate activities and interests.

12. In special programs where the child does not attend the local school, there must be a current Individualized Education Plan and/or plan to provide the child an educational program in collaboration with the local school or school district on record at the PRTF.

13. Family (parent, guardian or custodian) is actively involved in the treatment planning and/or process. Should conditions prevent the possibility of such involvement, attempts to involve parents and/or reasons explaining their non-involvement must be fully documented and presented to an interagency team.

14. Continued inpatient hospitalization must be recommended by the treatment team (to also include child, parent/guardian, case manager [when one is assigned], current treating or evaluating therapist).
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15. All appropriate documentation follows the child as the child makes the transition to other therapeutic services, be they more or less intense.

Community Integration Questionnaire

1. Are the child's interest areas? and strengths? documented, with a plan to explore new interests and strengths for the child?

2. Have the child's community and family support network, and cultural resources been explored for the purpose of involving the child in his/her own community, and recorded?

3. Has there been recruitment of family members, or other significant individuals, to participate as designated support persons?

4. Do you have a list of the available services, events and activities in the community? [Both the child's home community and the community surrounding the therapeutic center, if different].

5. What activities has the child been involved in over the past two months? Is there a plan to continue this involvement?

6. Does the treatment plan include community integrative activities, such as:
   - planned parental supervised activities?
   - age appropriate, child independent participation in planned community activities [such as: Traditional events; school sponsored clubs and gatherings; extra-curricular classes (ie. dance, music, martial arts, etc); church or community center picnic, etc.]?
   - opportunity for child-peer interaction in the community [such as: visits to neighborhood friends (including overnight visits); participation in peer group activities [such as: neighborhood "hoops", stick ball, parties and informal gatherings].
   - [other activities- specify in treatment plan].

OR, for children who may be more severely impaired:
   - staff oversite of planned parental supervised activities?
   - staff supervised activities for parent/child interaction? for child/community peer interaction?
   - staff supervised activities in the community?
   - planned reentry into the regular classroom (independently, or with a therapeutic staff support)?

7. Do you have a plan of reinforcement for a child's successful participation outside of the treatment setting? and a crisis intervention plan for the child while outside of the treatment setting?
8. Do the **progress notes** detail the outcome of the home/community integrative activity?

9. Do you have a data gathering form or instrument to **measure the outcome** of a child's participation in a home/community activity?

10. Do you have a **plan to expand** the child's home/community/cultural participation?
References

American Psychiatric Association

Commonwealth of Pennsylvania


1985 "Description of Services and Service Areas." Title 55 PA Code, Chapter 4210, Harrisburg, Commonwealth of Pennsylvania, Office of Mental Health. Title 55 PA Code, Chapters 1151 and 1153 Commonwealth of Pennsylvania, Office of Medical Assistance Programs.


INTRODUCTION:

Generally absent in both regulation and the literature on behavioral health, are admission guidelines for behavioral health services delivered to children in their homes, schools, and daily community activities. The availability of these services is required under the federal ruling titled the Omnibus Budget Reconciliation Act of 1989 (Public Law 101-239) as specifically described in the section called Early and Periodic Screening, Diagnosis and Treatment (EPSDT). Implementation of OBRA '89 in Pennsylvania was established through the Medical Assistance Bulletin 1241-90-02 of October 15, 1990. While there has been a strong focus on development and expansion of needed services to respond to children with behavioral health treatment needs in multiple child serving systems, more work is required to regulate use of services. Clearly, with concerns about containing cost while enhancing the efficacy of treatment affecting decisions on service delivery, guidelines are needed to bridge the purpose, function, and expectations of these services with actual service delivery. Up to now, the primary connection has been the determination of medical necessity, in combination with the application of the Child and Adolescent Service System Program (CASSP) principles, and a variously applied understanding of the "Wraparound" philosophy of care. The guidelines and classification system presented in this document and subsequent revisions, provide a basis for admitting children and adolescents to behavioral health services delivered in the home, and school, or elsewhere in the community, under EPSDT, and within the context of multiple child serving systems. For ease of reading in the text which follows "child" will refer to both child and adolescent unless otherwise stated.

CASSP principles and the Wraparound philosophy of care provide the foundation supporting the effort to provide mental and behavioral health services to children in their homes and communities. It is understood here that home/community delivered services are not simply intended to be a replacement for all other clinic and hospital based services. These relatively new services are to address the increasingly complex needs of children receiving services in multiple child serving systems (i.e.- child welfare, juvenile justice, education, mental retardation, and drug & alcohol) and offer an alternative to some of the functions clinic/hospital based services have previously played, because home/community delivered services are considered more appropriate to specific tasks of directed treatment.

Home/community delivered behavioral health services are specifically appropriate for children and adolescents who require intervention at the sites where their problematic behaviors occur. This eliminates
the necessity to understand and treat problems, behaviors, or activities in an abstract form dissociated from their actual occurrence, and allows direct intervention. In this way the clinician observes and learns directly from the child's behavior in the natural context, but it also allows the child and clinician to formulate together the language and symbolic references to the problem and the strategies for resolution. Thus the interaction between the child and clinician is not dependent on first understanding an abstract expression of the problem, and allows the child to firmly establish the practicality of the therapeutic intervention. The clinician is not solely dependent on informants and the child receiving treatment for information, nor does the child need to transfer change which occurs in the clinic or institutional setting to the family or community setting where the problem primarily manifests.

The purpose for any recommended service must be justified and clearly stated whether they are clinic or home based. Also, the recommendation for services must carefully consider not only treatment for an identified problem, but the child's multi-system involvement, willingness to engage in treatment, the confidentiality concerns of both the child and family, and whether safety issues require a certain level of restrictiveness in the treatment planning for a particular child or adolescent. Making the decision for the type and level of service is not always easy, but the rationale for the decision made is necessary. Building the rationale requires the appropriate diagnostic and life domain assessments, treatment and interagency team involvement, and the spirit of building a cooperative effort to enhance the intervention in order to achieve the goals of treatment.

HOME/COMMUNITY SERVICES

The behavioral health system has undergone substantial structural change from an emphasis on community segregation and maintenance of children with emotional disorders, to one of community integration and skill development essential in fostering increasing independence of individuals and families (see Mental Health/Mental Retardation Act of 1966 and the Mental Health Procedures Act of 1976 with subsequent amendments). The change in emphasis from providing service to children exclusively in established sites, such as clinics and hospitals, and residential and day treatment centers, to serving children individually where they live, learn and play in the community is reflective of this overall change. These changes are supportive of the wraparound philosophy of care to the extent that these community delivered services are often identified as "wraparound services." Wraparound is a philosophy which promotes developmentally appropriate behavior, activities, skills, and social skills for the child in his/her natural context through focusing on his/her individualized strengths and needs. More broadly, it promotes the opportunity for family independence from professional treatment and therapeutic supports. Family autonomy in the care of children with special needs may be fostered through skill development and assisting the family in the development of their informal support network. An understanding of the social contexts of the child or adolescent, including school and community as well as home, is essential to determining the appropriate sites for interventions and the resources available. When professional services provide a necessary treatment, the service(s) must be focused on accomplishing a set of goals, and incorporate into the planning the appropriate tapering of the service or the replacement of the service with informal and other non-behavioral health therapeutic supports.

The Office of Mental Health and Substance Abuse Services (OMHSAS) has promoted the development of expanded behavioral health services in response to the need for services delivered to children in natural community settings. In Pennsylvania these services have multiple references including, "EPSDT mental health services", "expanded mental health services," "psychosocial rehabilitative services" and "wraparound mental health services". However, EPSDT refers to more than the services considered in

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the Level of Care protocols to follow. "enhanced" is a term relative to the services currently offered and therefore not necessarily restricted to community based services, and "wraparound" is a philosophy of care and implementation within which professional services may play a role. For clarity in this paper, the services are called simply by their association with home and community. Other psychosocial rehabilitative services which are offered on provider-site, such as therapeutic summer programs and after-school programs are not incorporated into the protocol for home/community services. It is in the application that home/community services must be medically necessary, adhere to the requirement of EPSDT service provision, and should be consistent with the wraparound process.

Treatment objectives may be characterized in at least three ways, individualized, generalized, and service specific. Individualized objectives for the child and family must be created as part of a treatment process which is strengths-based and developmentally appropriate. The generalized objectives reflected in the admission guidelines for clinic and hospital based services are as follows: ameliorate symptoms such that less restrictive and/or less intrusive services can be planned and introduced; stabilization of medical regimen for children requiring psychotropic medication which helps them to effectively receive the least restrictive/least intrusive services possible; promotion of psychosocial growth and development and prevention of regression/recidivism by improving the child's level of functioning and ability for self maintenance; coordination of the treatment and discharge plan on an ongoing basis with the appropriate agencies to provide the necessary natural community based supports; and increase in age-appropriate interactivity in a variety of settings [see "Community Integration Questionnaire" in Reference Form D (p. 27)]. Some objectives more specific to the home/community services have been mentioned above, such as: development and practice of interpersonal skills as necessary to enhance parent/child, child/adult, and child/peer relations; identification of personal, family and community resources and exploring their usage; and directly relating therapeutic aims with social contexts and laying the groundwork for treatment which references the problem (a higher level of abstraction) such as occurs in clinic based treatment.

Home and community services are developed and tailored specifically to meet individualized child and family needs (see Table 2). Specialized therapeutic services on the Medical Assistance fee schedule are: Mobile Therapy, Behavioral Specialist Consultant (Doctoral Level), Behavioral Specialist Consultant (Master's Level), Therapeutic Staff Support (TSS), and Summer Therapeutic Activities Program. Each of the first four services is distinct and described in Medical Assistance Bulletin 01-94-01, issued January 11, 1994 on "Outpatient Psychiatric Services for Children Under 21 Years of Age." The last is a new program which is described in Medical Assistance Bulletin 50-96-03, issued April 25, 1996. All of these services are provided for the purpose of improving and developing the capacity of the treated child or adolescent, and the family, thereby contributing toward the independence of the family as a unit. The need for these services will vary according to the severity of the child's problems and the richness of the resources of the child, the family, and the community.

In this edition of the guidelines for behavioral health home/community services, guidelines for the delivery of home and community behavioral health services to children with mental retardation have been added. The Office of Mental Retardation supports the provision of services in homes and communities. These behavioral health services provide discrete short term, goal oriented rehabilitative interventions to children with mental retardation. The availability of these services helps to ensure that children with mental retardation receiving mental retardation services have access to additional therapeutic interventions when medically necessary and to assist them remain in their communities.
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The structural changes in the behavioral health system are reflected in the development of the Child and Adolescent Service System Program (CASSP) and its philosophy. Within the body of this Bulletin is emphasized the importance of consistency in the services with the CASSP principles. The OMHSAS summary representation of the CASSP principles, is provided below.

CASSP PRINCIPLES

The CASSP philosophy of collaborative service delivery to children, adolescents and their families undergirds all treatment methods. CASSP involves all child-serving systems including mental health, mental retardation, education, special education, children and youth services, drug and alcohol, juvenile justice, health care, and vocational rehabilitation. It should also include informal community supports and organizations. This philosophy is essential to making decisions to provide treatment for children. It is also the foundation that motivates the development of these guidelines. These principles are represented in the following six summary statements:

(1) **Child-centered** - Services are planned to meet the individual needs of the child, rather than to fit the child into an existing service. Services should be developmentally appropriate and child-specific, and should also build on the strengths of the child and family to meet the mental health, social and physical needs of the child.

(2) **Family-focused** - Services recognize that the family is the primary support system for the child. The family participates as a full partner in all stages of the decision-making and treatment planning process, including implementation, monitoring and evaluation. A family may include biological, adoptive and foster parents, siblings, grandparents and other relatives, and other adults who are committed to the child. The development of mental health policy at state and local levels should include family representation.

(3) **Community-based** - Whenever possible, services should be delivered in the child's home community, drawing on formal and informal resources to promote the child's successful participation in the community. Community resources include not only mental health professionals and provider agencies, but also social, religious and cultural organizations and other natural community support networks.

(4) **Multi-system** - Services should be planned in collaboration with all the child-serving systems involved in the child's life. Representatives from all these systems and the family should collaborate to define the goals for the child, develop a service plan, develop the necessary resources to implement the plan, and provide appropriate support to the child and family.

(5) **Culturally competent** - Culture determines our world view and provides a general design for living and patterns for interpreting reality that are reflected in our behavior. Therefore, services that are culturally competent are provided by individuals who have the skills to recognize and respect the behavior, ideas, attitudes, values, beliefs, customs, language, rituals, ceremonies and practices characteristic of a particular group of people.

**Note:** Pennsylvania's cultural competence initiative has focused specifically on African Americans, Latinos, Asian Americans and Native Americans who have historically not received culturally appropriate services.
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(6) **Least restrictive/least intrusive** - Services should take place in settings that are the most appropriate and natural for the child and family and are the least restrictive and intrusive available to meet the needs of the child.

These principles encompass not only the psychological, but the physical, cognitive, and socio-cultural development of children, which include the child's dependency on family, community, and environmental influences in general. From these principles, the home/community delivered services for which "Admission Guidelines" are provided below, can be understood as components within a wider network of service options.

**CLASSIFICATION SYSTEM:**

Because the collective of home/community behavioral health services is appropriate to treat the full range of symptom severity, an organizational system for associating intensity of service with severity of need is essential. This is different from the current clinic and hospital based services which associate the individual service with the severity of need, such that inpatient hospitalization is associated with higher severity of symptoms than that of partial or outpatient. By dividing the community delivered services into four levels of intensity from least to most, these services roughly parallel the four traditional categories of clinic and hospital based services: Outpatient; Partial Hospitalization; Residential Treatment; and Inpatient Hospitalization. Services are further divided into two types: treatment and therapeutic support. With intensity of service defined by the amount of time the service is provided, as related to the type of service provided, the four levels of home/community delivered services may be identified as contiguous segments along a continuum of intensity.

The first of the four levels describes the criteria for the children with the least severe need who are eligible for the service. Each of the successive levels represents an increase in the severity level for which it is designed. Criteria for children with mental retardation are identified in the first two levels only with the recognition that if these children display greater severity in their symptomatology they may receive an axis I diagnosis. Because all of the home/community delivered services are available for each of the levels, the variation in intensity must be ranked by how much service is delivered. Time is selected as a general measure of quantity for each of the levels, because it is already used in this way to determine payment when a rate is assigned to the service. At this writing, the range of hours for each of the levels is not identified, however the levels represent a proportional relationship between both, the identified levels of severity and the range of services within each.

There are a maximum of four components to each of the levels. In order of presentation in the guidelines and the table: the first part identifies the type and extent of the emotional and behavioral disturbance, including the degree of endangerment; the second requires assurance that the child or adolescent and the family is amenable to treatment in community settings; while the third assures that there is the professional opinion that the service necessary is at this level of intensity. The fourth level applies only to the two least intensive levels and tends to serve the purpose of observation in community settings; the second assures that there is the professional opinion that the service necessary is at this level of intensity. The fourth level applies only to the two least intensive levels and tends to serve the purpose of observation based on an initial assessment of need which needs greater clarity. As the two highest levels involve a higher severity of symptoms, "observation" for the purpose of determining the problem does not apply. Differentiation between the levels rests primarily with the severity of the problem, and the ability to treat in the community but it also includes the risk of endangerment allowed. More care is required of the assessment of endangerment, but the other categories solicit the psychiatrist or psychologist to elaborate their justification. The usual
process for determining improvement or relapse and identifying service and therapeutic support needs, should guide the use of the services.

Using a continuum of severity expresses schematically the importance of allowing children to flow from one category to another as indicated by the child's needs (see Table 2, below). However, suggesting discrete categories with fixed ranges may be interpreted in a manner contradictory to the value of a continuum in providing fluidity. The association of fixed ranges of time with each level is complicated by the potential mix in the available array of services such as clinic based services, services from other child serving systems, or the inclusion of informal family and community supports. These issues beg the question of whether the severity levels may be so firmly attached to the hours of service that a child associated with one level must "officially" be reduced to another level, in order to reduce the hours of home/community based services; though the "true" severity level is higher, and the child, in truth continues to receive a high number of hours of service, but from other sources. Ideally, each severity level would have a range of hours for serving a child in each of three categories: clinic/hospital services; home/community services; and the service inherent in the personal support network. However, the usual application of admission guidelines is to structure the use of a specific service or service category, and that is the exercise here. The establishment of a recommended range of hours for the delivery of home/community services is not addressed, except to suggest an adjustable range of times depending on the other services used or functions served by family members, and that there is a proportional increase in the expectation of the maximum amount of service within each category.

For the purpose of establishing a reasonable framework, it will be assumed that the hours assigned do not consider the complicating factors of other services and other therapeutic supports, or temporary reductions of service to assess progress. The next task will be to set up a system of values for any additional services and therapeutic supports which can be used as weights to identify a child with the appropriate level.

GUIDELINE FORMATION:

Working toward furthering consistency between children's treatment needs and the broader philosophy of individualized service delivery in the most appropriate manner, is a complex task. Generalizing work such as, the principles of the Child and Adolescent Service System Program (CASSP), the values presented in a variety of CASSP publications, and the wraparound philosophy of care, provide a theoretical basis, and though this body of work has much room to grow, it is time to develop the tools of implementation. The work of admission guidelines for home/community based services is an important beginning to provide a unified basis for decision-making. It is one of the essential instruments needed for behavioral health providers, case managers, interagency teams, and third party payers (including Managed Care Organizations and their sub-contractors), to coordinate service determinations among themselves and with families (including friends and community services as appropriate). Such coordination is vital to foster confidence in the appropriateness of admissions to any of the recommended treatment modalities, as well as continued stay, and appropriate discharge planning.

Inherent in these guidelines is a framework for implementing the wraparound concept in service delivery and developing discrete individualized service programs. Individualized treatment plans may coordinate a number of services but importantly, the functions of the services must be identified so that they build upon actual strengths, actual needs are addressed by the services. It is also important to help develop family and community resources to meet these needs. Traditional outpatient and partial hospitalization
services are examples of other services which may be coordinated with home/community delivered services when medically necessary. Home/community treatment is for children who: may be effectively treated at home; who require comprehensive wraparound planning for transition from a more restrictive setting back to the home and community; who may require a treatment support system while in the community until an effective family and community support network can be activated. These services provide a full range of intensity to the child in his/her natural setting, depending on the evaluated need of the child. In considering the intensity of home/community service, delivery involves three basic elements of consideration: severity of presenting problem, appropriate intensity of service, and the least restrictive and/or intrusive service necessary. These elements are considered separately below.

SEVERITY OF SYMPTOMS

Symptom severity is often more apparent to the clinician than it is easy to describe. Levels with identifiable indicators can make the process of assessing severity easier. Additional descriptive information remains important to provide clarifying documentation in the child or adolescent's record. Each of the four levels represented in these guidelines requires an assessment of the child's expression of emotional and behavioral disturbance in any of the following categories for consideration in the design of the individual's treatment: judgement, thought, mood, affect, impulse control, psychosocial, psychomotor retardation/excitation, physiological functioning and/or cognitive/perceptual abilities. Also important is an assessment of the impact of any disturbance on social skill development and the relationship between them. Gaging the severity of any of these presenting symptoms is ultimately left to the judgement of the clinician in his or her review. If severity is otherwise linked to endangerment or imminent risk of out-of-home or out-of-school placement, descriptors may be crafted to indicate relative severity. Challenging behaviors closely associated with social contexts such as family, school, or other community activities must be considered when determining an appropriate treatment design involving home/community services, or any combination of home/community and the more conventional services. The severity of presentation determines the extent of service need. The severity of expression for a child with mental retardation must be evaluated in relation to the individual child’s behavioral norm or “baseline.” The design of the treatment plan must also consider the concomitant discharge planning.

INTENSITY OF TREATMENT

The intensity and range of treatment varies for each of the home/community services available for children (see Table 1). But because different treatment plans call for different combinations of services to treat a variety of children or adolescents who could be assessed at the same level of severity, intensity is associated with a multiplicity of service options and gauged by the amount of total service time needed. However, one division has been made, establishing two tiers of service based on the professional level of the service. The first is "home/community professional behavioral health services," such as Mobile Therapy and Behavioral Specialist Consultant, and the second is "home/community behavioral health implementation-therapeutic support services," such as Therapeutic Staff Support (TSS) and Therapeutic Staff Support Aid (TSSA). The professional services are those performed by highly credentialed individuals who also play a critical role in the development of the treatment plan. Therapeutic support services require personnel who have specific training and a Bachelor's degree or, for TSSAs, a High School diploma. Their role is to assist the child or adolescent, and the family, in the follow-through of the treatment plan.
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Of the four severity levels, the last two listed are intended to divert the child or adolescent from out-of-home services, or serve as a step down following the child's discharge from any in-patient or out-of-home placement. Highly intensive community delivered treatment is often needed to prevent out-of-home placement, and/or to help children to return to their natural home, school, and community from an out-of-home placement. This works by directly associating the therapeutic process of treatment with effective adaptation to the social environment. The first two severity levels allow a lower range of service intensity to assist the child and family. All the levels provide treatment, but they also encourage the family's developmental process in unassisted interaction. The therapeutic function and emphasis of each of the four service levels depends strongly on the cohesiveness of the interagency and treatment teams and the interaction between the behavioral health staff, the parents/custodians, and the child, for the effectiveness of the treatment plan developed.

LEAST RESTRICTIVE/LEAST INTRUSIVE

Structural differences between the two kinds of services allow each to be scaled differently along the CASSP principle of providing the least restrictive and least intrusive services necessary. The site-based services, clinics and hospitals, may be scaled on a continuum of restrictiveness from more to less. Restrictiveness essentially refers to the degree the child or person is separated from the general community and integrated into a treatment community. For off-site delivery of services, or those delivered to individuals in their homes, schools, or other community settings, scaling restrictiveness does not apply. However, these services may be scaled on a continuum of intrusiveness, if intrusiveness is to be understood as the degree to which service is integrated into the natural setting and the lifestyle of the individual(s) served. It is through this understanding that it may be asserted that mental and behavioral health services in the lives of clients are not "natural," but an intervention intended to be time-limited. Of course, depending on the severity of the problem, the network of inclusion/support and the other environmental/ ecological factors, the time required for individuals' successful treatment will vary. It is these last three elements which are used to formulate the classification system in the guideline.

Home/community services are generally regarded as the least restrictive service options for children who need intensive behavioral health services. However, by delivering services to children in their homes and communities these services may potentially be the most intrusive. Traditionally, intensive behavioral health services were designed to provide treatment in settings separate from the community, such as inpatient and partial hospitalization settings, residential treatment facilities, and outpatient clinics. This segregation of children from greater community involvement for the period of treatment has become the defining characteristic of restrictiveness and allows consideration of these services on a continuum from least restrictive to more restrictive. Home/community services parallel the intensity available in the traditional services, but because these services engage the child in family and community activities home/community services are not easily characterized as restrictive. However, they may be identified with intrusiveness due to their close involvement with, and presence in the daily activities of the child receiving treatment, and the family.

The four levels for the delivery of the home and community addressed in this bulletin, are presented in ascending order of service intensity and professional intervention. The need for greater or lesser intensity of service must be adjusted to the individual's need for active treatment as reflected in the evaluation and the treatment plan. Increased intensity of service may improve the effectiveness of treatment by providing convenience and opportunity for more responsive intervention. Reducing levels of intervention is a necessary element of therapy directed toward fostering and developing independence in the

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relationship formations of children with their families, peers, and functioning in normalized settings in the community. Also, care must be taken to avoid the development of a dependency relationship between any family members and behavioral health professionals which result in a non-therapeutic alliance. Each service level provides treatment with the object of helping children with acute behavioral problems or serious emotional disturbance to increase their ability to integrate into the community and culture of their respective families by increasing his or her capacity for self control.

ADMISSION GUIDELINES:

Criteria for each level of Home/community service is based on the individual severity indicators. In the admission guidelines described below is a process for deciding when to treat, continue, or discontinue treatment and refer elsewhere for other services. However, the concept of tapering, or systematically reducing the intensity of the services delivered has been added here. The guideline is divided into five (5) sections: I- Diagnostic Evaluation and Documentation; II- Severity Levels and Service Correlates; III- Therapeutic Support Criteria; IV- Continued Care; and V- Discharge and Service Transition. The first three include the evaluation and documentation criteria for Admission, the fourth and fifth are for determining the appropriateness of continuing, tapering, and discontinuing care.

As these guidelines are written, it is assumed that any child or adolescent receiving services has a case manager, that children with mental retardation have a county MH/MR case manager, and that all children with multiple systems involvement have incorporated into the planning process an interagency team. Concerning the structure of Section II which associates the severity of the presenting problem with four contiguous levels, each level proposes corresponding ranges of hours for both professional behavioral health services and behavioral health therapeutic support services. For the purpose of clarity in the structure, the hours proposed assume there are no other services provided to the individual in treatment. Nor do they carry any presumption of the richness of the home/community therapeutic supports available to the child or adolescent in treatment. However, both the system and community therapeutic supports are critical to the appropriate determination of service hours to be delivered. It is for this reason that Table 2 has been included. This table provides two matrices, one for reviewing the problems of the child and the other for the strengths of the child, family and community. Each lists the possible domains and settings affected. The matrices are designed to help in the decision-making process when determining the appropriate mix of services, and the appropriate adjustment for the amount of the services in each severity level in Section II below. Such determinations should be used and documented as an adjustment of time within the severity level selected, and it is expected that this is a natural part of any interagency or treatment team process.
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explained. As part of the assessment process and the development of treatment recommendations, the prescriber addresses the concerns and recommendations of the case manager and the interagency team.

Diagnostic references for the purpose of the documentation below must be from the most current edition of the Diagnostic and Statistical Manual (DSM). The most current edition in use at this writing is the DSM IV; for ease of reading, the text following will reflect this edition. For further convenience in reading, "child and adolescent" will follow the form of "child", unless otherwise indicated.

I. DIAGNOSTIC EVALUATION AND DOCUMENTATION

A. Mental Health

1. Diagnosis on DSM IV Axis I or Axis II, as part of a complete multi-axial, face-to-face evaluation (MR or D&A cannot stand alone);

   AND

2. Evaluation indicates:

   a. child has, or is at serious risk of developing, an emotional or behavioral disturbance, or mental illness; and

   b. clinic based treatment is not sufficient or appropriate to effectively serve the child/family; and

   c. behaviors indicate manageable risk for safety to self/others while in the community, and child must not require inpatient treatment or a psychiatric residential treatment facility; and/or

   d. the child needs home/community mental health treatment as a result of documented emotional and behavioral disturbance of functioning:

      1) within the family or other community-based residential setting, or

      2) in the school setting, or

      3) resulting in limitations in social and community interactions; or

   e. a combination of mental health needs that cannot be met without treatment delivered to the child in the community by mental/behavioral health professionals.

   OR

B. Mental Retardation

1. Diagnosis on DSM IV Axis II and Axis IV, as part of a complete multi-axial, face-to-face evaluation (MR cannot stand alone), without a diagnosis on Axis I;

   AND

2. Evaluation indicates:

   a. an onset of remarkable or crisis behavior(s) in a child or adolescent with mental retardation; and/or

   b. a notable adverse change in the baseline behavior of a child or adolescent with mental retardation; and

   c. a medical condition has been ruled out; and

   d. existing mental retardation services are no longer sufficient or appropriate to effectively serve the child/family; and

   e. behaviors indicate manageable risk for safety to self/others while in the community, and child must not require inpatient treatment or a residential treatment facility; and/or
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f. the child needs home/community behavioral health treatment as a result of a documented behavioral disturbance functioning:

1) within the family, foster care, family living or other community-based setting, or
2) due to behavior which results in limitations in social and community interactions; or

g. a combination of behavioral health needs that cannot be met by existing mental retardation services without treatment delivered to the child in the community by additional behavioral health professionals.

AND

C. Parent(s)/guardian(s), and/or care giver as appropriate, a lead case manager and the child to his/her fullest ability must be involved in the planning process. Where a parent (or legal guardian) or the child are not or cannot be involved, the attempts to involve either or both and the reasons for non-involvement must be documented. The interagency team should otherwise recommend the most appropriate alternatives should home/community service alone be insufficient to serve the child's needs;

AND

D. There is:

1. serious and/or persistent impairment of developmental progression not attributable to mental retardation and/or psychosocial functioning due to a serious emotional disturbance or psychiatric disorder;

   OR

2. an onset of remarkable or crisis behavior(s) in a child or adolescent with mental retardation;

   AND/OR

3. a notable adverse change in the baseline behavior a child or adolescent with mental retardation resulting in significant measurable reduction in psychosocial functioning with respect to the existing developmental disorder, requiring treatment to alleviate acute existing symptoms and/or behaviors; or to prevent relapse in the child with symptoms and/or behaviors which are in partial or complete remission;

   OR

E. Significant psychosocial stressors and/or medical condition increasing the risk that the child's functioning will decrease for his/her developmental level when developmental level is unrelated to mental retardation;

   OR

F. Behaviors or symptoms improve in response to comprehensive treatment at a higher level of care, but child needs home/community treatment to sustain and reinforce stability;

   OR

G. Requires medication, and time limited monitoring of the medications is needed to mitigate the effects of the child's symptoms until the child and/or family can assume this role.
II. SEVERITY LEVELS and SERVICE CORRELATES

(See also Table 1)

Service volume and intensity must be recommended as the most clinically appropriate and least intrusive necessary for the child, by the prescriber, as informed by the interagency team.

(Must meet A or B or C or D)

A. MH - Level 1 (Least) - DSM IV Axis I/II diagnosis
   (MR or D&A cannot stand alone)
   Home/Community Professional Mental Health Services
   Home/Community Mental Health Therapeutic Support Services
   (Must meet 1, 2, and 3; OR 4)

1. Service must be recommended as the most clinically appropriate service available for the child, by the prescriber as informed by the case manager and interagency team, and

   a. There is serious and/or persistent impairment of developmental progression and/or psychosocial functioning due to a psychiatric disorder other than mental retardation, requiring treatment to alleviate acute existing symptoms and/or behaviors; or to prevent relapse in the child for the prescribed period of time to allow the therapeutic process to hold its effectiveness with symptoms and/or behaviors which are in partial or complete remission; or

   b. Significant psychosocial stressors and/or medical condition increasing the risk that the child's functioning will decrease for his/her developmental level, require home/community based intervention to develop resources within the child and/or family to provide the balance to these stressors needed to continue the child in remission and/or to promote effective adaptation; or

   c. Symptoms improve in response to comprehensive treatment at a higher level of care, but child is still in need of direct home/community based treatment to reinforce stability; or

   d. Requires medication and home/community based monitoring of medications to help the child (and family) understand the importance of adhering to the therapy recommended to mitigate the effects of the child's symptoms, and establish a pattern of following the prescription; AND

2. Child's behavior is assessed to be manageable in the home/community setting, child is assessed to be responsive to the implementation of a community-based treatment plan in the professional judgment of the appropriate behavioral health professional, as a result of:

   a. the delivery of the professional care required to serve the child's specific treatment occurring on site; and

   b. documented commitment by the primary care givers (usually parent/guardian) to the treatment plan; AND

3. The severity and expression of the child's symptoms are such that:
Appendix T-B (2)

a. continuation with a less intense level of care cannot offer either an expectation of improvement, or prevention of deterioration, as identified above; and
b. on-site intervention in the home or community offers a more effective preventive to longer term consequences.

OR

4. OBSERVATION

The child's problematic behavior and/or severe functional impairment discussed in the presenting history and psychiatric examination requires further observation for clarification under Section II. Allowable for up to fifteen (15) days within which time the examining psychiatrist must clarify the child's eligibility for admission under Section II AND/OR recommend development of a transition plan. Should it be found that the child does not fit the guidelines for admission, an appropriate transition plan is to be developed with the interagency team, and the child discharged under the provisions of that plan.

a. Troubling symptoms of the child which have been described by members of the family, persist (and/or representatives of the community or school) but,
   - they are not observed on a psychiatric inpatient unit, or they are denied by the child in outpatient or partial hospitalization treatment, such that observation of the child in natural settings provides an ideal opportunity to observe and treat the child; or
b. Child's symptoms have not sufficiently improved despite well-planned comprehensive treatment in site-based levels of care, which has involved the participation of an interagency team.

A. MR- Level 1 - DSM IV Axis II/IV diagnosis
   (MR cannot stand alone)
   Home/Community Professional Behavioral Health Services
   Home/Community Behavioral Health Therapeutic Support Services
   (Must meet 1, 2, and 3)

1. Service must be recommended as the most clinically appropriate service available for the child, by the prescriber as informed by the lead case manager and interagency team, and

a. There is significant change or amplification in exhibited behaviors as indicated by an increase in frequency (average number of events per day), duration (after first day, the increase in number of consecutive days), and/or locations; and
b. Behavior presents serious risk of self injury, or injury to others, or destruction of environment; and

  c. Significant psychosocial stressors are present affecting a decrease in the child's functioning; and/or

  d. Requires medication and home/community based monitoring of medications to help the child (and family) understand the importance of adhering to the therapy recommended to mitigate the effects of the child's symptoms, and establish a pattern of following the prescription;
Appendix T-B (2)

AND

2. Child's behavior is assessed to be manageable in the home/community setting, child is assessed to be responsive to the implementation of a community-based treatment plan in the professional judgment of the appropriate behavioral health professional, as a result of:

a. the delivery of the professional care required to serve the child's specific treatment occurring on site; and
b. there is documented commitment by the primary care givers (usually parent/guardian) to the treatment plan;

AND

3. The severity and expression of the child's behaviors are such that:
   a. continuation with a less intense level of care cannot offer either an expectation of improvement, or prevention of deterioration, as identified above; and
   b. on-site intervention in the home or community offers a more effective preventive approach to longer term consequences.

B. MH - Level 2 - DSM IV Axis I/II diagnosis
(MR or D&A cannot stand alone)
Home/Community Professional Mental Health Services
Home/Community Mental Health Therapeutic Support Services
(Must meet 1, 2, and 3; or 4)

1. Risk of child harming him/herself or others, or causing destruction to property, is assessed low in the child's current problematic behavioral or functional impairment; presenting history and psychiatric examination, and

a. Must include at least one (1) of the criterion below:
   1) Suicidal/homicidal ideation
   2) Impulsivity and/or aggression
   3) Psycho-physiological condition (i.e.- bulimia, anorexia nervosa)
   4) Psychomotor retardation or excitation
   5) Affect/Function impairment (i.e.- withdrawn, reclusive, labile, reactivity)
   6) Psychosocial functional impairment
   7) Thought Impairment (i.e.- psychosis)
   8) Cognitive Impairment; and/or
b. Presence of very impaired judgement or functional capacity and capability, for the child's developmental level which is not attributable to mental retardation such that interpersonal skills, and/or self-maintenance in home/school/community is/are highly compromised;

AND
Appendix T-B (2)

2. Behavior is assessed to be manageable in the home/community setting, and degree of risk is assessed to be responsive to, and effectively reduced by the implementation of a treatment plan in the professional judgment of the advising physician or mental health professional, as a result of:

   a. the delivery of the professional care required to serve the child's specific treatment occurring on site; and
   b. documented commitment by the primary care givers usually parent/guardian to the therapeutic plan;

      AND

3. The severity and expression of the child's symptoms are such that:

   a. continuation with a less intense level of care cannot offer either an expectation of improvement, or prevention of deterioration, as identified above; and
   b. on-site intervention in the home or community offers a more effective preventive to longer term consequences.

   OR

4. OBSERVATION:

   The child's problematic behavior and/or severe functional impairment discussed in the presenting history and psychiatric examination requires further observation for clarification under Section II. Allowable for up to fifteen (15) days within which time the examining psychiatrist must clarify the child's eligibility for admission under Section II AND/OR recommend development of a transition plan. Should it be found that the child does not meet the guidelines for admission, an appropriate transition plan is to be developed with the interagency team, and the child discharged under the provisions of that plan.

   a. Troubling symptoms of the child which have been described by members of the family, persist (and/or representatives of the community or school) but, they are not observed on a psychiatric inpatient unit, or they are denied by the child in outpatient or partial hospitalization treatment, such that observation of the child in natural settings provides an ideal opportunity to observe and treat the child; or
   b. Child's symptoms have not sufficiently improved despite well planned comprehensive treatment in site-based levels of care, which has involved the participation of an interagency team.

   MR - Level 2 - DSM IV Axis II/IV diagnosis
   (MR cannot stand alone)
   Home/Community Professional Behavioral Health Services
   Home/Community Behavioral Health Therapeutic Support Services
   (Must meet 1, 2, and 3)

1. Service must be recommended as the most clinically appropriate service available for the child, by the prescriber as informed by the lead case manager and interagency team, and
Appendix T-B (2)

a. There is significant change or amplification in exhibited behaviors as indicated by an increase in frequency (average number of events per day), duration (after first day, the increase in number of consecutive days), and/or locations; and
b. Behavior has resulted in self-injury, or injury to others, or destruction to environment; and
c. Significant psychosocial stressors are present affecting a decrease in the child's functioning or an escalation of the child's symptoms; and/or
d. Requires medication and home/community based monitoring of medications to help the child (and family) understand the importance of adhering to the therapy recommended to mitigate the effects of the child's symptoms, and establish a pattern of following the prescription;

AND

2. Child's behavior is assessed to be manageable in the home/community setting, child is assessed to be responsive to the implementation of a community-based treatment plan in the professional judgment of the appropriate behavioral health professional, as a result of:

a. the delivery of the professional care required to serve the child's specific treatment needs occurs on site; and
b. there is documented commitment by the primary care givers (usually parent/guardian) to the treatment plan;

AND

3. The severity and expression of the child's behaviors are such that:

a. continuation with a less intense level of care cannot offer either an expectation of improvement, or prevention of deterioration, as identified above; and
b. on-site intervention in the home or community offers a more effective preventive approach to longer term consequences.

C. MH - Level 3 (Intensive)

Home/Community Professional Mental Health Services
Home/Community Mental Health Therapeutic Support Services
(Must meet 1, 2, and 3)

1. Severe functional impairment discussed in the presenting history and psychiatric examination, is assessed in the child's problematic behavior in home, school or community, and there is risk of an out-of-home or out-of-school placement. In addition, there may be risk of danger in child harming him/herself, harming others, and/or demonstrated destruction to property; and

a. Must include at least one (1) of the criterion below:

1) Suicidal/homicidal threats or intensive ideation
2) Impulsivity and/or aggression
Appendix T-B (2)

3) Psycho-physiological condition (i.e.- bulimia, anorexia nervosa)
4) Psychomotor retardation or excitation.
5) Affect/Function impairment (i.e.- withdrawn, reclusive, labile, reactivity)
6) Psychosocial functional impairment
7) Thought Impairment (i.e.- psychosis)
8) Cognitive Impairment; and/or,

b. There is an exacerbation of severely impaired judgement or functional capacity and capability for the child's developmental level, which is not attributable to mental retardation, such that interpersonal skills, and/or self-maintenance in home/school/community is/are severely compromised;

AND

2. Behavior is assessed to be manageable in the home/community setting, and degree of risk is assessed to be responsive to, and effectively reduced by the implementation of a treatment plan in the professional judgment of the advising physician or mental health professional, as a result of:

a. the delivery of the professional care required to serve the child's specific treatment occurring on site; and
b. documented commitment by the primary care givers (usually parent/guardian) to the treatment plan; and

2) if endangerment/destruction is a relevant feature of the presenting problem, both adolescent and primary care giver develop a safety plan which at least the care giver signs;

AND

3. The severity and expression of the child's symptoms are such that:

a. continuation with a less intense level of care cannot offer either an expectation of improvement, or prevention of deterioration, as identified above; and
b. on-site intervention in the home or community offers a more effective preventive to longer term consequences.

D. MH - Level 4 (Highly Intensive)

Home/Community Professional Mental Health Services
Home/Community Mental Health Therapeutic Support Services
(Must meet 1, 2, & 3)

1) The severe functional impairment discussed in the presenting history and psychiatric examination is assessed in the child's problematic behavior in home, school or community and there is a high risk of an out-of-home or out-of-school placement, or a resumption of out-of-home/school placement for a child transitioning back to home or school. In addition, there may be demonstrated risk of endangerment involving child harming self or others, or destruction to property, due to emotional or behavioral problems, or mental illness;

a. Must include at least one (1) of the criterion below:
Appendix T-B (2)

1) Suicidal/homicidal threatening behavior or intensive ideation
2) Impulsivity and/or aggression
3) Psycho-physiological condition (i.e.- bulimia, anorexia nervosa)
4) Psychomotor retardation or excitation.
5) Affect/Function impairment (i.e.- withdrawn, reclusive, labile, reactivity)
6) Psychosocial functional impairment
7) Thought Impairment (i.e.- psychosis)
8) Cognitive Impairment; and

b. There is an exacerbation of severely impaired judgement or functional capacity and capability for the child's developmental level, which is not attributable to mental retardation, such that interpersonal skills, and/or self-maintenance in home/school/community is/are severely compromised; AND

2. Behavior is assessed to be manageable in the home/community setting, and degree of risk is assessed to be responsive to, and effectively reduced by the implementation of a treatment plan in the professional judgment of the advising physician or mental health professional, as a result of:

a. the delivery of the professional care required to serve the child's specific treatment needs occurs on site; and
b. there is documented commitment by the primary care giverers (usually parent/guardian) to the therapeutic plan; and

c. if endangerment/destruction is a relevant feature of the presenting problem, both adolescent and primary care giver develop a safety plan which, at least the care giver signs; AND

3. The severity and expression of the child's symptoms are such that:

a. continuation with a less intense level of care cannot offer either an expectation of improvement, or prevention of deterioration, as identified above; and
b. on-site intervention in the home or community offers a more effective preventive to longer term consequences.

III. SUPPORT CRITERIA

The on-site clinical expertise necessary must be available as appropriate to the SEVERITY OF SYMPTOMS or BEHAVIORS. There must be family commitment to the treatment process of the child or adolescent. The treatment must support community integrative objectives including development of the child/adolescent's network of personal, family, and community support.
IV. CONTINUED CARE

A. Child must be reevaluated and continue to meet criteria for admission (Section I); AND

B. Child shows:
   1. measured improvement and/or begins to demonstrate alternative/replacement behaviors (show indicators in the evaluation);
   \textit{or}
   2. increased or continued behavioral disturbance with continued expectation for improvement (show rationale in the treatment plan);
   \text{AND}

C. Treatment plan is addressing the behavior within the context of the psychosocial stressor(s)/event(s);
   \text{AND}

D. Interagency service plan recommends continuation of care.

The child/adolescent must meet Admission Criteria for Section II, Level 3 or lesser levels of severity. Whenever service is provided for a term greater than three (3) months, there must be a quarterly review of the child being served which clarifies the child's progress, progress toward developing community linkages, and the necessity for continuing Home/community service rather than another service appropriate to the child's needs or discharge from behavioral health services altogether. The Interagency Service Plan must be updated and attached to the Treatment Plan.

V. DISCHARGE AND SERVICE TRANSITION GUIDELINES

A. Mental Health
   Prescriber, with the participation of the interagency team, determines that home/community service:
   1. results in an expected level of stability and treatment goal attainment such that no additional home/community services are necessary and discharge occurs;
   \text{OR}
   2. should be maintained as follows:
      a. continued at the current level; \textit{or}
      b. continued with a reduced number of hours as a result of the child's improvement, and/or the child's network of family and friends, and/or the activity of community members and services; \textit{or}
      c. increased due to changes in the context and/or adjustments in the treatment plan; \text{OR}
   3. ceases to be effective, requiring reassessment of services and alternative planning prior to authorization of any further home/community mental health services; \text{OR}
Appendix T-B (2)

4. interferes with the development of a service-independent lifestyle, requiring reassessment of the treatment plan and careful analysis of the benefits derived in light of the potential for problems created;
   
   OR

5. A child admitted under Section IIB only, of the ADMISSION Guidelines must be discharged within fifteen (15) days of admission, unless a subsequent face-to-face psychiatric evaluation clarifies child's eligibility under Section IIA;
   
   OR

B. Mental Retardation

   Prescriber, with the participation of the interagency team, determines that home/community service:

   1. results in an expected level of stability and treatment goal attainment for the intervention such that the child meets:
      a. baseline behavior, or
      b. expected positive behavioral response, and/or
      c. that no additional home/community services are necessary;
         
         OR

   2. should be:
      a. discontinued because it ceases to be effective, requiring reassessment of services and alternative planning prior to authorization of any further home/community behavioral health services; or
      b. continued with a reduced number of hours as a result of the child’s improvement, and/or the child’s network of family and friends, and/or the activity of community members and services; or
      c. increased due to changes in the context and/or adjustments in the treatment plan;
         
         OR

   3. the services provided create a service dependency interfering with the development of the child's progress toward his/her highest functional level, requiring reassessment of the treatment plan and careful analysis of the benefits derived in light of the potential for problems created;
      
      OR

C. The parent/guardian (or other legally responsible care giver if applicable) or adolescent, 14 years old or older, requests reduction in service or termination of the service.
BEHAVIORAL HEALTH REHABILITATION SERVICES UNDER EPSDT:
Home/Community Services

TABLE OF SECTION II SEVERITY LEVELS AND SERVICE CORRELATES
WITH CORRESPONDING PROPORTIONAL ORDERING OF TREATMENT HOURS
(All Services Are to Be Determined On an Individual Basis for the Child or Adolescent)

(Table does not represent EPSDT psychosocial rehabilitative services provided on provider sites, such as After-school and Summer Therapeutic Activities Programs)

<table>
<thead>
<tr>
<th>Level 1 (Least)</th>
<th>Level 2 (Moderate)</th>
<th>Level 3 (Intensive)</th>
<th>Level 4 (Highly Intensive)</th>
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<tbody>
<tr>
<td>(Must meet A, B, &amp; C; OR D)</td>
<td>(Must meet A, B, &amp; C; OR D)</td>
<td>(Must meet A, B, and C)</td>
<td>(Must meet A, B, and C)</td>
</tr>
</tbody>
</table>

I. & II. [Combined] DIAGNOSTIC INDICATORS BY LEVEL

A. Service must be recommended as the most clinically appropriate for the child, by the prescriber, as informed by the interagency team, and

A. Risk of harming [self, others, or property] is assessed low in the child's current problematic behavior or functional impairment and presenting history; and psychiatric or psychological examination must include:

A. Severe functional impairment is assessed in the child's problematic behavior in the home, school, or community; there is risk of an out-of-home or out-of-school placement; may be risk of danger of child harming him/herself, others, and/or demonstrated destruction to property; and

A. High risk of out of home placement, or demonstrated risk of endangerment, involving child harming self or others, or destruction to property, due to emotional or behavioral problems, or mental illness; and/or the severe functional impairment in the home, school, or community, and

1. Children with a Diagnostic Indicator on AXIS I

<table>
<thead>
<tr>
<th>a. There is serious and/or persistent impairment of developmental progression and/or</th>
<th>a. Assessment of at least one (1) of the following: 1. Suicidal/homicidal</th>
<th>a. Assessment of at least one (1) of the following: 1. Suicidal/homicidal threats</th>
<th>a. Assessment of at least one (1) of the following: 1. Suicidal/homicidal</th>
</tr>
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<td>psychosocial functioning due to a serious emotional disturbance or psychiatric disorder, requiring treatment to alleviate acute existing symptoms and/or behaviors; or to prevent relapse in the child for the prescribed period of time to allow the therapeutic process to hold its effectiveness with symptoms and/or behaviors which are in partial or complete remission;</td>
<td>ideation 2. Impulsivity and/or aggression 3. Psycho-physiological condition (i.e.- bulimia, anorexia nervosa) 4. Psychomotor retardation or excitation</td>
<td>or intensive ideation 2. Impulsivity and/or aggression 3. Psycho-physiological condition (i.e.- bulimia, anorexia nervosa) 4. Psychomotor retardation or excitation.</td>
<td>threatening behavior or intensive ideation 2. Impulsivity and/or aggression 3. Psycho-physiological condition (i.e.- bulimia, anorexia nervosa) 4. Psychomotor retardation or excitation.</td>
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<td>or and/or</td>
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<td>and/or</td>
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<tr>
<td>b. Significant psychosocial stressors and/or medical condition increasing the risk that the child's functioning will decrease for his/her developmental level require home/community based intervention to develop resources within the child and/or family to provide the balance to these stressors needed to continue</td>
<td>b. Presence of very impaired judgement or functional capacity and capability, for the child's developmental level, such that interpersonal skills, and/or self-maintenance in home/school/community is/are highly compromised, are not attributable to mental retardation;</td>
<td>b. There is an exacerbation of severely impaired judgement or functional capacity and capability, for the child's developmental level, such that interpersonal skills, and/or self-maintenance in home/school/community is/are highly compromised, are not attributable to mental retardation;</td>
<td>b. There is an exacerbation of severely impaired judgement or functional capacity and capability, for the child's developmental level, such that interpersonal skills, and/or self-maintenance in home/school/community is/are severely compromised, are not attributable to mental retardation;</td>
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<td>the child in remission; or</td>
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<tr>
<td>c. Symptoms improve in response to comprehensive treatment at a higher level of care, but child is still in need of direct home/community based treatment to reinforce stability; or</td>
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<tr>
<td>d. Requires medication and home/community based monitoring of medications to help the child (and family) understand the importance of adhering to the therapy recommended to mitigate the effects of the child's symptoms, and establish a pattern of following the prescription;</td>
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<td>AND/OR</td>
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</table>

2. Children with a Diagnostic Indicator on AXIS II (without a diagnosis on Axis I)

<p>| a. There is an onset of remarkable behaviors which could escalate to a crisis | a. There is an onset of remarkable or crisis behaviors. |                     |                           |
| b. Behavior presents serious risk of self-injury, or injury to others, or destruction of | b. Behavior has resulted in self-injury, or injury to others, or destruction to environment; and |                     |                           |</p>
<table>
<thead>
<tr>
<th>Level 1 (Least)</th>
<th>Level 2 (Moderate)</th>
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<td>environment; and</td>
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</table>

- **c.** There is significant change from baseline behavior, or amplification in exhibited behaviors, as indicated by the frequency, intensity, duration, of the behavior(s), and/or locations where the behavior(s) occur(s); **and/or**

- **d.** Requires medication and home/community based monitoring of medications to help the family, and the child, consistent with the child’s age and cognitive abilities, to understand the importance of adhering to the therapy recommended to mitigate the effects of the child's symptoms, and establish a pattern of following the prescription;

**B.** Behavior is assessed to be manageable in the home/community setting, and degree of risk is assessed to be responsive to, and effectively reduced by the implementation of a behavior management plan in the professional judgment of the advising physician or mental health professional, as a result of:

1. the delivery of the professional care required to serve the child's specific treatment needs occurs on site; **and**

2. there is documented commitment by the primary care givers (usually parent/guardian) to the therapeutic plan.

3. if endangerment/destruction is a relevant feature of the presenting problem, both adolescent and primary care giver develop a safety plan which, at least the care giver signs.

3. if endangerment/destruction is a relevant feature of the presenting problem, both child or adolescent and primary care giver develop a safety plan which, at least the care giver signs.

**AND**
### Appendix T-B (2)

<table>
<thead>
<tr>
<th>Level 1 (Least)</th>
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</table>

**C.** The severity and expression of the child's symptoms are such that:
1. continuation with a less intense level of care cannot offer either an expectation of improvement, or prevention of deterioration, as identified above; *and*
2. on-site intervention in the home or community offers a more effective preventive to longer term consequences.

**D. OBSERVATION - 15 days**
1. Troubling symptoms of the child (described by family/ school/others) persist though
   - not observed on a psychiatric inpatient unit, *or*
   - they are denied by the child in outpatient or partial hospitalization treatment,
     *such that* observation of the child in natural settings provides the opportunity to assess and treat the child; *OR*

2. Child's symptoms have not sufficiently improved despite responsible comprehensive treatment in other levels of care, involving the interagency team.

### III. SUPPORT CRITERIA

The on-site clinical expertise necessary must be available as appropriate to the SEVERITY OF BEHAVIORS. There must be family commitment to the treatment process of the child or adolescent. The treatment must support community integration objectives including development of the child/adolescent's network of personal, family, and community support.

### IV. CONTINUED CARE

Whenever service is provided for a term greater than three (3) months, there must be at least a quarterly review of the child being served which clarifies the child's progress, progress toward developing community linkages, and the necessity for continuing home/community service.

1. Child must be reevaluated *and* continue to meet criteria for admission (I); *and*
2. Child shows:
   a) measured improvement *and/or* begins to demonstrate alternative/replacement behaviors (show indicators in the evaluation); *or*
   b) increased *or* continued behavioral or emotional disturbance with continued expectation for improvement (show rationale in the treatment plan); *and*
3. Review includes consideration/evaluation of alternative Levels of Care, therapeutic approaches, informal approaches, and resources.
4. Treatment plan must be updated addressing the presenting problem within the context of the psychosocial stressor(s)/event(s);
indicating that service should be:

a) continued with a reduced number of hours as a result of the amelioration of original indication for service, and/or activity of community members and services, and/or the child's network of family and friends; or

b) increased due to changes in the context and/or adjustments in the treatment plan; and

5. Interagency service plan must be updated to reflect the recommendation to continue care and be attached to the treatment plan.

V. DISCHARGE CRITERIA

A. Prescriber, with the participation of the interagency team, determines that home/community service:

1. results in an expected level of stability and treatment goal attainment for the intervention such that the child meets:
   a. baseline behavior, or
   b. expected positive behavioral response, and/or
   c. that no additional home/community services are necessary;

   OR

2. should be discontinued because it ceases to be effective, requiring reassessment of services and alternative planning prior to authorization of any further home/community behavioral health services;

   OR

3. the services provided create a service dependency interfering with the development of the child's progress toward his/her highest functional level, requiring reassessment of the treatment plan and careful analysis of the benefits derived in light of the potential for problems created;

   OR

B. The parent/guardian (or other legally responsible care giver if applicable) or adolescent, 14 years old or older, requests reduction in service or termination of the service.
MATRICES OF CURRENT PROBLEMS AND CURRENT STRENGTHS BY DOMAIN AND SETTING

Matrix of Current Problems

<table>
<thead>
<tr>
<th>Domain</th>
<th>Home</th>
<th>School</th>
<th>Community</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medical</td>
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<td>Behavioral</td>
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<td>Emotional</td>
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<td>Cognitive/Learning</td>
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<td>Interpersonal</td>
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<td>Leisure</td>
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<td>Unique/Other</td>
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Matrix of Current Strengths

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<tr>
<th>Domain</th>
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<th>School</th>
<th>Community</th>
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<td>Medical</td>
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<td>Unique/Other</td>
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REFERENCE FORM A

Expectations for All Individualized Community Based Enhanced Mental Health Services:

Individualized community based enhanced mental health services can be used in the home, community, or school, separately or in combination, as medically necessary. The child’s emotional or behavioral disturbance should be carefully evaluated along the following parameters: thought, mood, affect, judgement, insight, impulse control, psychomotor retardation /excitation, physiological functioning, cognitive/perceptual abilities, psychosocial functioning as manifested in interpersonal and social skills, and motivation. Social contexts, such as home, school, and neighborhood/community must be understood in order to determine the appropriate sites of services as well as the resources within each context. Service planning determines the unique combination of individualized community based enhanced mental health services, other child serving systems and/or traditional mental health services.

The following represent specific expectations regarding the utilization of all individualized, community based enhanced mental health services subject to this document. Treatment and its documentation should be consistent with the following:

- Nature of emotional or behavioral disturbance, mental illness, or serious at-risk status is clear and is clearly demonstrated.

- Each proposed or utilized mental health service has a clearly documented rationale, with a specific role in addressing the child’s medically necessary needs. Services, separably and in combination, constitute the least restrictive and least intrusive services which are medically necessary.

- Service decisions are substantially determined by an interagency process based on child-driven needs.

- Proposed treatment is demonstrated to meet identified, individualized needs and strengths, addressing child’s development in multiple life domains.

- Ongoing efforts are being made to utilize community resources, whenever possible.

- Parents and guardians have requested or otherwise support the use of proposed services.

- Proposed treatment involves a plan, and subsequent demonstrated efforts to implement plan with active participation by parents, guardians, and other responsible adults.

- Treatment involves teaching and support of efforts by parents, guardians, and other responsible adults, and those activities specifically identified within the treatment plan as appropriate for involved mental health staff, rather than substitute care.

- Treatment involves ongoing integrated and supervised efforts by all service providers, which includes a lead case manager.

- Potential medication needs are being addressed or considered.
- Lack of improvement within a level of care is subject to careful clinical and systemic analysis by the team prior to either an increase or decrease of services or change in level of services.

- Exceptions to any of the above are clearly identified with explanation or rationale, and discussed with the interagency team.
FUNCTION OF HOME/COMMUNITY SERVICES

- Provision of services which are less restrictive, more flexible yet effectively provides therapeutic supports for patients discharged from in-patient, residential treatment facilities, or partial hospitalization. In this way home/community services provide for the delivery of transitional care from a more restrictive setting.

- Prevent the need for more restrictive or higher level of services. To help the child develop the necessary self-control, and/or capacity for constructive expression, including cultivating more adaptive interpersonal skills for effective participation in the child's natural setting.

- Provision of service for children with mental and/or psychosocial disorders who require treatment directly in the setting where symptoms typically manifest, to remain stable and ensure the effectiveness of a treatment plan.

- Provision of after-school service for children with mental and/or psychosocial disorders, so that:
  - Parents/guardians can develop the behavioral patterns necessary to provide the additional support necessary to maintain a therapeutic environment for the child;
  - Parents/guardians can receive family therapy consistent with the treatment of their child.

Should service involve a child removed from school during regular school hours, this service, and any subsequent plan to continue service during this time, must be documented with an explanation of the child's condition which necessitates such intervention.

- Treatment components include: major diagnostic evaluations, medical and psychiatric treatment, and psychosocial rehabilitation. Recognizing the responsibility of the Department of Education to provide an educational program for all children, the therapist must collaborate with the school or school district, but only when appropriate and as necessary to assist in the child's Individualized Education Plan when one has been or should be developed. Where such collaboration is desired but not possible the reasons must be clearly documented.

TREATMENT RANGE- Home/community treatment varies in intensity, duration and purpose. Intensity may be reflected in the number and length of visits as well as the professional level of the service. The duration and types of service offered will vary according to the severity of the child's symptomatology and the complexity of the intervention required as described in the treatment plan. The range of service includes therapeutic support identified in four levels corresponding with the levels of severity established for Severe (but Inpatient Treatment not required), Residential Treatment Facility, Partial Hospitalization, and Outpatient Treatment, where clinical judgement suggests that outpatient treatment is therapeutically necessary to return the child to, or maintain the child in a stable condition. Home/community treatment may serve as a step-down from inpatient treatment, a residential treatment facility, and partial hospitalization, and to prevent the need for a more restrictive treatment setting. It also serves children, and their families, experiencing distress who may need the therapeutic support of short term services to ameliorate the presiding condition or stress.
REFERENCE FORM C

Continued Stay Service Documentation
For Mental Health Services

The following list of information should be documented for the four service levels.

1. Routine evaluations and treatment updates chart child's progress.

2. The establishment and documentation of active treatment must include, the implementation of the treatment plan, the therapy provided, documentation of the family's participation and interagency collaboration, cultural competency, and active discharge planning.

3. Current active treatment is focused upon stabilizing or reversing symptoms necessitating admission.

4. Current active treatment is focused on ameliorating symptoms and increasing the child's level of functioning.

5. The level of professional expertise and intervention are appropriate to address the child's current condition(s).

6. The initial discharge guidelines formulated for the child have been reviewed and revised, as necessary in the course of developing the discharge plan.

7. The treatment plan and strengths-based evaluation has been updated to reflect the child's progress, medication status, continuing needs and the provider's efforts to meet the identified needs. The treatment plan addresses any necessary therapeutic supports for the child's successful transition into the community, including mental health, substance abuse, mental retardation and other community-based services, and the natural resources of the family. It incorporates a plan to form appropriate transitional linkages in preparation for discharge to less intrusive and non-restrictive services.

8. The treatment team programmatically reduces intensity of treatment as the child progresses toward the expected date of discharge, and through working with an interagency team forms linkages with community and family supports.

9. Type, duration and frequency of services provided to the child, and the outcome of each service must be well documented, i.e.- individual, group and family therapy; education, training and community involvement; family participation in treatment; any special activities; and medication administration and monitoring.

10. As the child improves clinically, active treatment facilitates and increases contact of the child with the community (including home and school) to which the child will return.

11. The provision of services supports the child's involvement in age appropriate activities and interests as outlined in the treatment plan.
12. In special programs where the child does not attend the local school, there must be a current Individualized Education Plan and/or plan to provide the child an educational program in collaboration with the local school or school district on record at the PRTF.

13. Family (parent, guardian or custodian) is actively involved in the treatment planning and/or process. Should conditions prevent the possibility of such involvement, attempts to involve parents and/or reasons explaining their non-involvement must be fully documented and presented to an interagency team.

14. Continued inpatient hospitalization must be recommended by the treatment team (to also include child, parent/guardian, case manager [when one is assigned], current treating or evaluating therapist).

15. All appropriate documentation follows the child as the child makes the transition to other therapeutic services, be they more or less intense.
REFERENCE FORM D

Community Integration Questionnaire

1. Are the child's interest areas? and strengths? documented, with a plan to explore new interests and strength's for the child?

2. Have the child's community and family support network, and cultural resources been explored for the purpose of involving the child in his/her own community, and recorded?

3. Has there been recruitment of family members, or other significant individuals, to participate as designated support persons?

4. Do you have a list of the available services, events and activities in the community? [Both the child's home community and the community surrounding the therapeutic center, if different].

5. What activities has the child been involved in over the past two months? Is there a plan to continue this involvement?

6. Does the treatment plan include community integrative activities, such as:
   - planned parental supervised activities?
   - age appropriate, child independent participation in planned community activities [such as: Traditional events/celebrations; school sponsored clubs and gatherings; extra-curricular classes (i.e. dance, music, martial arts, etc); church/community center/playground activities, etc.]?
   - opportunity for child-peer interaction in the community [such as: visits to neighborhood friends (including overnight visits); participation in peer group activities (such as: neighborhood "hoops", stick ball, parties and informal gatherings].
   - [other activities- specify in treatment plan].

OR, for children who may be more severely impaired:
   - staff oversight of planned parental supervised activities?
   - staff supervised activities for parent/child interaction?
      - for child/community peer interaction?
   - staff supervised activities in the community?
   - planned reentry into the regular classroom (independently, or with a therapeutic staff support)?

7. Do you have a plan of reinforcement for a child's successful participation outside of the treatment setting? and a crisis intervention plan for the child while outside of the treatment setting?

8. Do the progress notes detail the outcome of the home/community integrative activity?

9. Do you have a data gathering form or instrument to measure the outcome of a child's participation in a home/community activity?

10. Do you have a plan to expand the child's home/community/cultural participation?
Bibliography:

American Psychiatric Association

Commonwealth of Pennsylvania
Developed by
Commonwealth of Pennsylvania
Department of Public Welfare
Office of Mental Health and Substance Abuse Services
1997

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Office of Mental Health
PO Box 2675
Harrisburg, PA 17105-2675
APPENDIX T - Part B (3)

HEALTHCHOICES BEHAVIORAL HEALTH SERVICES
GUIDELINES for BEHAVIORAL HEALTH MEDICAL NECESSITY CRITERIA

CHILDREN AND ADOLESCENTS

The Family Based Mental Health Services Program
(1st Edition)

INTRODUCTION:

The Family Based Mental Health Services Program (FBMHS) represents an important option within the array of services for children and adolescents up to age 21, and their families. Utilization of the FBMHS program occurs following referral for this service and the subsequent determination by the FBMHS treatment team that the service is clinically appropriate. FBMHS is available to children who are at risk for out-of-home placement due to a severe emotional or behavioral disorder, or due to a severe mental illness. FBMHS is also used as a step-down for children returning to their family, which may include natural or substitute care families, following out-of-home placement.

These Family Based Mental Health Services Program guidelines for medical necessity (and its subsequent revisions) provide a basis for the referral of children and their families for this service. [See FBMHS program standards in State Plan Under Title XIX of the Social Security Act, Amendment, Effective Date July 1, 1990 Attachment 3.1A, Section 13.(d)(I), available in the HealthChoices Proposers' Library].

PROGRAM PHILOSOPHY & ORGANIZATION:

Consistent with the CASSP principles and philosophy, the guiding tenets of FBMHS are that children grow-up best in their own home, that the family is a resource and partner in the treatment process, that treatment utilizes strengths in addressing areas of need and concern, and that coordination among other human service systems and with the community is essential. In addition, while the child receives treatment, services also work to enhance the family role as a resource and partner in the treatment process.

The Family Based Mental Health Services Program is a discrete service provided by a team composed of either two child mental health professionals or one child mental health professional and a child mental health worker, which is comprehensive in scope, incorporating intensive home therapy, casework services, family support services and 24 hour, 7 day availability for crisis stabilization. Each team maintains a caseload of up to eight (8) families to ensure the intensity of service and team availability to the families they serve. Team members receive supervision together as an integral part of an ongoing program for the families served. In addition, there is an ongoing training curriculum that extends over a three year period designed specifically for Family Based Mental Health Service Team members.
The service is broadly conceived for flexible use in the home and community. The specific frequency and schedule of face-to-face contacts are developed collaboratively with the family, based on needs at that time. This allows the team to provide for individual family needs when they are closely associated with the child’s treatment, such as time for family education/training regarding therapeutic components and skill building for the child and family. The team also works with the family to identify resources available to them. Teams are available to provide 24 hour service, and they also work with other systems when they are involved with the child and family, such as Drug and Alcohol Services, Children and Youth, Juvenile Justice, special education, etc. Clinical treatment within FBMHS is guided by the recognition of the normal growth and development of children at different ages, and supports family caretaking and functioning through collaborative, conjoint family meetings, which can include different combinations of family members and community members as indicated. Due to its commitment to support both the development of children and the integrity of the family, FBMHS, while primarily treatment, also serves a preventive function. The needs of all the children within a family, not just the child in response to whom services were initiated, are actively considered and included as part of the treatment process.

Services offered by the FBMHS program include formal individual and family therapy sessions with the child and/or family. In addition, program service requirements include the following:

- Crisis intervention and stabilization;
- Emergency availability;
- Ongoing information-gathering in support of active treatment;
- Collaborative development and modification of the treatment plan;
- Clinical intervention by each team member with the child in attaining identified treatment goals and objectives within the treatment plan, including: remediation of child’s symptoms (i.e. behavioral, affective, cognitive, thought impairments, etc.), improvement of family relationships, community integration, and other aspects of psychosocial competence and skill development in the home, school, or community;
- Support for the parents in implementing effective behavior management and parenting approaches specific to the presenting problems of their child;
- School-based consultation and intervention as needed;
- Referral, coordination, and linkage to other agencies, social services, and community services, as appropriate;
- Assistance in obtaining relief services such as babysitters, homemakers, respite care and supportive services such as transportation and recreation, and developing a network in order to receive these services.

*The Family Support Service (FSS) is a requirement in the Family Based Mental Health Services Program under Health Choices. Family-Based Family Support Services (FBMHS) are formal and informal services or tangible goods which are needed to enable a family to care for and live with a*
child who has a serious emotional disturbance. FBMHS/FSS include supportive services and tangible goods, which facilitate achievement of the child’s treatment goals. If a child is in temporary out-of-home placement, FBMHS/FSS should be used to facilitate the return of the child to the natural family and in this instance should be available to both the natural family as well as the foster family.

A cost component for FBMH/FSS is built into the HealthChoices capitation rate. As such, it is recommended that the provider and the BH-MCO agree to a method for setting aside an appropriate percentage of the FBMHS provider fee for the purchase of services or goods needed to further the child’s treatment goals.

The FBMHS budget identifies administrative and program costs which include family support services.

- The FBMHS unit of service is billed for activities or direct services which are provided by the Family-Based team members using existing procedure codes. Only such FBMHS units are reported as encounter data.

- There is no separate reporting requirement for FBMH Family Support Services.

- The provider must have an accounting system that identifies revenue sources and expenditures.

ADMISSION CRITERIA
(Must meet I and II)

I. DIAGNOSTIC EVALUATION AND DOCUMENTATION
A. Diagnosis on DSM IV Axis I or Axis II, as part of a complete multiaxial, face-to-face assessment (MR or D&A cannot stand alone), by a Mental Health Professional (see Title 55, Public Welfare § 5200.3). A psychiatrist, physician or licensed psychologist determines that the child is eligible and recommends the FBMHS program (State Plan Under Title XIX of the Social Security Act, Amendment, Effective Date July 1, 1990 Attachment 3.1A, Section 13.(d)(I));
  AND

B. Other less restrictive, less intrusive services have been provided and continuation in this less intensive level of care cannot offer either an expectation of improvement or prevention of deterioration of the child’s and the family’s condition;
  OR

  Child has been discharged from an Inpatient Hospitalization or a Residential Treatment Facility, and other less restrictive, less intrusive services cannot offer either an expectation of improvement or prevention of deterioration of the child’s and the family’s condition;
  AND

C. Behaviors indicate manageable risk for safety to self/others and child must not require treatment in an inpatient setting or a psychiatric residential treatment facility.
II. SEVERITY OF SYMPTOMS

A. Treatment is determined by the treatment team to be necessary in the context of the family in order to effectively treat the child,

AND

1. the family recognizes the child’s risk of out of home placement and the problem of maintaining their child at home without intensive therapeutic interventions in the context of the family;

AND/OR

2. the child is returning home and FBMHS is needed as a step down from an out-of-home placement;

AND

B. The child's problematic behavior and/or severe functional impairment discussed in the presenting history and psychiatric/psychological examination must include at least one (1) of the following:

1. Suicidal/homicidal ideation
2. Impulsivity and/or aggression
3. Psycho-physiological condition (i.e.- bulimia, anorexia nervosa)
4. Psychomotor retardation or excitation.
5. Affect/Function impairment (i.e.- withdrawn, reclusive, labile, reactivity)
6. Psychosocial functional impairment
7. Thought Impairment
8. Cognitive Impairment

AND

C. Following referral, service must be recommended as the most clinically appropriate and least restrictive service available for the child, by the FBMHS treatment team. Parent(s)/guardian(s), and/or caretaker, as appropriate, case manager (when assigned) and the child must be involved in the planning process;

AND

D. There is serious and/or persistent impairment of developmental progression and/or psychosocial functioning due to a psychiatric disorder or serious emotional disturbance, requiring treatment in the home and family involvement to alleviate acute existing symptoms and/or behaviors; or to prevent relapse in the child with symptoms and/or behaviors which are in partial or tentative remission;

OR
E. There is an exacerbation of severely impaired judgement or functional capacity and capability, for the child's developmental level, such that interpersonal skills, and/or self-maintenance in the home is severely compromised, and intervention involving the child and family is necessary;

    OR

F. Significant psychosocial stressors are affecting the child and the family as a whole, increase the risk that the child's functioning will decrease for his/her developmental level;

    OR

G. Symptoms improve in response to comprehensive treatment at a higher level of care, but child needs FBMHS to sustain and reinforce stability while completing the transition back to home and community.

REQUIREMENTS FOR CONTINUED CARE
(Must meet I and II)

I. DIAGNOSTIC EVALUATION AND RECOMMENDATION
A. Recommendation to continue FBMHS must occur:
   1. by the treatment team every 30 days through an updated and revised treatment plan, and
   2. by a psychiatrist, licensed psychologist, or physician at the end of 32 weeks, with an updated diagnosis;

    AND

B. There is significant family (including the child) cooperation and involvement in the treatment process.

    AND

C. An updated treatment plan by the treatment team indicates child’s progress toward goals, the progress of the child and family as a unit, and revision of goals to reflect documented changes, and the child and family involvement in the treatment planning process.

II. SEVERITY OF SYMPTOMS
A. Child and the family are making progress toward goals, and the treatment team review recommends continued stay;

    OR

B. The presenting conditions, symptoms or behaviors continue, such that family and natural community supports alone are insufficient to stabilize the child's condition;

    OR

C. The appearance of new conditions, symptoms or behaviors meeting the admission criteria.
III. SUPPORT CRITERIA
The on-site clinical expertise necessary must be available as appropriate to the SEVERITY OF BEHAVIORS. There must be family commitment to the treatment process of the child or adolescent. The treatment must support community integrative objectives including development of the child/adolescent's network of personal, family, and community support.

IV. CONTINUED CARE DOCUMENTATION
A. Child must be reevaluated every 30 days for the purpose of updating the treatment plan and continue to meet Requirements for Continued Care.
   1. The review of the child being served must:
      a) clarify the child's progress within the family context and progress toward developing community linkages; and
         1) clarify the goals in continuing FBMHS; and
         2) the need for continuing FBMHS if continuation beyond 32 weeks is recommended; and
      b) whenever FBMHS service is considered for a term greater than 32 weeks:
         1) a psychiatrist, licensed psychologist, or physician must update the diagnosis; and
         2) review includes consideration/evaluation of alternative Levels of Care, therapeutic approaches, informal approaches, and resources; and

B. Child demonstrates:
   1. measured improvement and/or begins to demonstrate alternative/replacement behaviors (document indicators in the evaluation); or
   2. increased or continued behavioral disturbance with continued expectation for improvement (indicate rationale in the treatment plan); and

C. Treatment plan is addressing the behavior within the context of the child's problem and/or contributing psychosocial stressor(s)/event(s); and

D. Treatment plan is updated to reflect recommendation to continue care.

V. DISCHARGE AND SERVICE TRANSITION GUIDELINES
A. The treatment team, determines that FBMHS:
   1. up to 32 weeks of FBMHS services has been completed; and/or
   2. the service results in an expected level of stability and treatment goal attainment for the intervention such the child meets:
      a) expected behavioral response, and/or
      b) the FBMHS program is no longer necessary in favor of a reduced level of support provided by other services, or
   3. FBMHS should be discontinued because it ceases to be effective, requiring reassessment of services and alternative planning prior to offering further FBMHS; or
   4. creates a service dependency interfering with the family-child development and the development of the child's progress toward his/her highest functional level; requiring reassessment of the treatment plan and careful analysis of the benefits derived in light of the potential for problems created;

OR
B. The parent/guardian (or other legally responsible care giver if applicable) or adolescent (14 years old or older) requests a reduction in service or complete termination of the service.
# TABLE OF FAMILY BASED MENTAL HEALTH SERVICES PROGRAM ADMISSION CRITERIA

<table>
<thead>
<tr>
<th>Family Based Mental Health Services</th>
<th>(Must meet I/II and III)</th>
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<tbody>
<tr>
<td><strong>I. &amp; II. [Combined] DIAGNOSTIC INDICATORS</strong></td>
<td>[Axis I or Axis II; D&amp;A on Axis I, and MR on Axis II do not stand alone] (Must meet A, B, C &amp; D)</td>
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<tr>
<td><strong>A.</strong> Service must be recommended as the most clinically appropriate for the child, by the prescriber, as informed by the treatment team as an alternative to out-of-home placement or as a step down from inpatient hospitalization or Residential Treatment, or as a result of little or no progress in a less restrictive/intrusive service,</td>
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<td><strong>AND</strong></td>
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<td><strong>B.</strong> Severe functional impairment is assessed in the child’s presenting behavior. The intensity of service is determined on an individualized basis according to the following parameters: severity of functional impairments, risk of out-of-home placement, and risk of endangerment to self, others or property.</td>
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<td>1. There is serious and/or persistent impairment of developmental progression and/or psychosocial functioning due to a psychiatric disorder or serious emotional disturbance, requiring treatment to alleviate acute existing symptoms and/or behaviors; or to prevent relapse in the child for the prescribed period of time to allow the therapeutic process to hold its effectiveness with symptoms and/or behaviors which are in partial or complete remission; and</td>
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<tr>
<td>2. Treatment is determined by the treatment team to be necessary in the context of the family in order to effectively treat the child, and</td>
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<tr>
<td>a. the family recognizes the child's risk of out-of-home placement and the problem of maintaining their child at home without intensive therapeutic interventions in the context of the family; and/or</td>
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<tr>
<td>b. the child is returning home and FBMHS is needed as a step down from an out-of-home placement; and</td>
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<td>3. Presence of at least one (1) of the following:</td>
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<td>a. Suicidal/homicidal threatening behavior or intensive ideation</td>
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<tr>
<td>b.</td>
<td>Impulsivity and/or aggression</td>
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<tr>
<td>c.</td>
<td>Psycho-physiological condition (i.e.- bulimia, anorexia nervosa)</td>
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<td>d.</td>
<td>Psychomotor retardation or excitation.</td>
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<tr>
<td>e.</td>
<td>Affect/Function impairment (i.e.- withdrawn, reclusive, labile, reactivity)</td>
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<tr>
<td>f.</td>
<td>Psychosocial functional impairment</td>
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<tr>
<td>g.</td>
<td>Thought Impairment</td>
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<tr>
<td>h.</td>
<td>Cognitive Impairment</td>
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</table>

and

4. There is an exacerbation of severely impaired judgement or functional capacity and capability, for the child's developmental level, such that interpersonal skills, and/or self-maintenance in home/school/community is/are severely compromised; and

5. Following referral, service must be recommended as the most clinically appropriate and least restrictive service available for the child, by the FBMHS treatment team. Parent(s)/guardian(s), and/or caretaker, as appropriate, case manager (when assigned) and the child must be involved in the planning process; and

6. Significant psychosocial stressors are affecting the child and the family as a whole, increase the risk that the child's functioning will decrease for his/her developmental level; or

7. Symptoms improve in response to comprehensive treatment at a higher level of care, but child needs FBMHS to sustain and reinforce stability while completing the transition back to home and community. AND

C. Behavior is assessed to be manageable in the home setting, and degree of risk is assessed to be responsive to, and effectively reduced by the implementation of the treatment plan, as a result of:
## Family Based Mental Health Services
(Must meet I/II and III)

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<tr>
<td>1.</td>
<td>the delivery of the therapy and casework services in the home, required to serve the child's specific treatment needs; and</td>
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<tr>
<td>2.</td>
<td>there is documented commitment by the family to the treatment plan and</td>
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<tr>
<td>3.</td>
<td>if endangerment/destruction is a relevant feature of the presenting problem, both child or adolescent (age 14+) and family member develop a <strong>safety plan</strong> which, the family member signs.</td>
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**AND**

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<tr>
<th>D.</th>
<th>The severity and expression of the child's symptoms are such that:</th>
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<tr>
<td>1.</td>
<td>continuation with a less intense level of care cannot offer either an expectation of improvement, or prevention of deterioration, as identified above; and</td>
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<tr>
<td>2.</td>
<td>on-site intervention in the home or community offers a more effective preventive to longer term consequences.</td>
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</table>

### III. SUPPORT CRITERIA

The on-site clinical expertise necessary must be available as appropriate to the **SEVERITY OF BEHAVIORS**. There must be family commitment to the treatment process of the child or adolescent. The treatment must support community integrative objectives including development of the child/adolescent's network of personal, family, and community support.
IV. CONTINUED CARE

Child must be reevaluated every 30 days for the purpose of updating the child's progress, progress toward developing community linkages, and the necessity for continuing Family Based Mental Health Services in the treatment plan.

A. The review of the child being served must:
   1. clarify the child's progress in treatment, within the family context, and toward developing community linkages; and
      a. clarify the goals in continuing FBMHS; and
      b. the need for continuing FBMHS, if continuation beyond 32 weeks is recommended; and
   2. whenever FBMHS service is considered for a term greater than 32 weeks:
      a. a psychiatrist, licensed psychologist, or physician must revise and/or update the diagnosis; and
      b. review includes consideration/evaluation of alternative Levels of Care, therapeutic approaches, informal approaches, and resources;

B. Treatment plan is updated to reflect the recommendation to continue care.

C. Treatment plan is updated to reflect the recommendation to continue care.

D. Child demonstrates:
   1. measured improvement and/or begins to demonstrate alternative/replacement behaviors (document indicators in the evaluation);
   or
   2. increased or continued behavioral or emotional disturbance with continued expectation for improvement (indicate rationale in the treatment plan);
V. DISCHARGE CRITERIA

A. Prescriber, with the participation of the interagency team, determines that:
   1. Up to 32 weeks of FBMHS services has been completed;
      and/or
   2. The service results in an expected level of stability and treatment goal attainment for the intervention such that the child meets:
      a. expected positive behavioral response; and/or
      b. FBMHS are no longer necessary in favor of a reduced level of support provided by other services;
      or
   3. FBMHS should be discontinued because it ceases to be effective, requiring reassessment of services and alternative planning prior to authorization of any further Family Based Mental Health Services;
      or
   4. the services provided create a service dependency interfering with the family-child development and the development of the child's progress toward his/her highest functional level; requiring reassessment of the treatment plan and careful analysis of the benefits derived in light of the potential for problems created;
      or

   AND

B. The parent/guardian or adolescent, 14 years old or older, requests reduction in service or termination of the service.
HEALTHCHOICES BEHAVIORAL HEALTH SERVICES
GUIDELINES for MENTAL HEALTH SERVICE NECESSITY CRITERIA

CHILD/ADOLESCENT
TARGETED CASE MANAGEMENT SERVICES

Admission (must meet criteria I and II):

An individual who meets the minimum staff requirements for an Intensive Case Manager or Resource Coordinator as defined by Mental Health Bulletin OMH-93-09 — Resource Coordination: Implementation; July, 30, 1993 or Intensive Case Management Services as defined by Chapter 5221, Mental Health Intensive Case Management and has received training on the use of the environmental matrix has conducted an evaluation and has determined that:

I. The child/adolescent meets either the eligibility criteria for Resource Coordination Services as defined by Mental Health Bulletin OMH-93-09 — Resource Coordination: Implementation; July, 30, 1993 or Intensive Case Management Services as defined by Chapter 5221, Mental Health Intensive Case Management.

A child or adolescent who needs to receive targeted case management services but who does not meet the requirements identified above may be eligible for targeted case management upon review and recommendation by the county administrator.

and

II. The child/adolescent is in need of Targeted Case Management Services as indicated through utilization of the Targeted Case Management — Child/Adolescent Environmental Matrix and in conjunction with clinical information and the professional judgement of the reviewer

Continued Stay and/or Change of Level of Need (must meet criteria I and II):

The child/adolescent and his/her family and/or guardian, or caregiver/natural support must be reassessed at the point of concurrent review, but no less frequently than six month intervals, and when there are significant changes in the individual’s situation that warrants a change in level of TCM services.

I. The child/adolescent continues to meet at least 2 out of 3 Admission Criteria.

and
II. The child/adolescent is in need of Targeted Case Management Services as indicated through utilization of the Targeted Case Management — Child/Adolescent Environmental Matrix and in conjunction with clinical information and the professional judgement of the reviewer

**Discharge Indicators**

I. Targeted Case Management may be terminated when one of the following criteria is met:

A. The child/adolescent or family receiving the service determines that targeted case management is no longer needed or wanted and the child/adolescent no longer meets the continued stay criteria; or

B. Determination by the targeted case manager in consultation with his/her supervisor or the director of targeted case management, and with written concurrence by the county administrator that targeted case management is no longer necessary or appropriate for the child/adolescent receiving the service and the child/adolescent no longer meets the continued stay criteria; or

C. The child/adolescent or family receiving the service determines that targeted case management is no longer wanted, even though, the child/adolescent does meet continued stay criteria; or

D. the child/adolescent and family has moved outside of the current geographical service area (e.g., county, state, country).

**TCM ENVIRONMENTAL MATRIX — CHILDREN**

**INSTRUCTIONS**

The Environmental Matrix — Children is a scale that evaluates the functional and need levels of children and adolescents who are under the age of 18 years old or who are over 18 years of age but who are still attending a school program. *Note: Adolescents age 16 – 22 may be assessed on either the child/adolescent environmental matrix or the adult environmental matrix, depending on the adolescent’s current circumstances. The parent/guardian and adolescent, in discussion with the reviewer, should determine which Environmental Matrix will be used.* The child/adolescent and family and/or guardian or care giver/natural support must be assessed in a face to face interview assessment with the evaluator. Cultural competency will be recognized throughout the entire evaluation process and the entire document. Individuals should be reassessed as needed, but no less than every six months. There are ten (10) assessment areas identified in relationship to Targeted Case Management services:

1. Accessing Mental Health Services
2. Informal Support Network Building
3. Education/Vocation
4. Children and Youth System Involvement
5. Juvenile Justice/Criminal Justice System Involvement
6. Parent/Guardian and/or Other Family Members with Significant Family Needs.
7. Drug and Alcohol System Involvement
8. Mental Retardation System Involvement
9. Physical Health System Involvement
Appendix T - Part B (4)

10a. At Risk of Out-of-Home Placement

Or

10b. Currently in RTF, Other Out of Home Placements or Inpatient

Please note: Although items 10a. and 10b. both deal with residential placement, scoring is done for only one of the items, either item 10a. or item 10b., since only one of these items can be relevant to the child/adolescent’s current residential status.

The scale has a range from 0 to 5 with the following values for each activity:

<table>
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<tr>
<th>0: No assistance needed</th>
<th>1: Minimum of assistance needed</th>
<th>2: Needs moderate assistance in this area</th>
<th>3: Needs significant assistance in this area</th>
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All ten assessment areas are ranked on the above scale. The evaluator must complete the environmental matrix in a face-to-face, strengths-based assessment interview with the child/adolescent and his/her family and/or guardian, or care giver/natural support. Evaluators should incorporate in their assessment a recognition/determination of cultural strengths (i.e., extended family, resourcefulness and responsibility). The evaluator should consider the child’s/adolescent’s and parent’s/guardian’s (family) strengths and needs in the following life domains for each assessment area in order to produce a score that reflects the full dimension of need:

- Housing/living situation
- Income/benefits/financial management
- Socialization/support
- Activities of daily living
- Medical treatment

Each assessment area is defined at the “ 1 ”, “ 3 ”, and “ 5 ” levels (See attached Environmental Matrix) and the subtotal score is divided by 10 to obtain the EM Score (when scoring the individual, refer to the Environmental Matrix TCM Scoring Grid which identifies the expected frequency of TCM contact needed for the individual for that particular assessment area). Scoring levels may be gradated to the 0.5 level only; this allows for minor differentiation of the child’s/adolescent’s needs without compromising the integrity of the scale.

Looking at the behavior, inclusive of the lowest level of functioning, and situation of the child/adolescent during the last ninety (90) days, rate the child’s/adolescent’s need for TCM in each of the ten areas. Please note that the rating for each area should be made in whole numbers; in cases where there are extraordinary factors that make the assignment of whole numbers extremely difficult, if not impossible, 0.5 points may be added to or subtracted from the base scores. The sum of the ten (10) scores should then be taken and divided by 10 and the resulting subtotal score should be reviewed and compared to other known factors that may affect the consumer’s need for service. Note: If a particular assessment area does not apply to the individual being assessed, a score should not be given for that assessment area and the total score should be divided by the number of assessment areas scored. This should be noted on the scoring sheet. If after averaging the scores, the average is lower by at least 2 points than any one value given in any one assessment area (e.g., if a person’s average is 2 and he/she received a score of 4 in any one area), the evaluator must provide written justification for assignment to the level that corresponds to
the average, rather than the higher value. The Environmental Matrix score, your *professional judgement*, and other information (e.g., cultural factors, records of past treatment, etc.) that impacts on the child’s/adolescent’s level of need should then be considered and the recommended level of TCM service should be entered on the recommended level of TCM line of the scoring sheet. (These levels are consistent with minimum levels of contact as defined in Chapter 5221, Intensive Case Management regulations and bulletin OMH-93-09, Resource Coordination: Implementation.) If the recommended level of TCM services differs from the Environmental Matrix Score, the difference must be justified with professional judgement in the “Other Factors/Issues Affecting Score” section of the scoring sheet. **Note:** The level of service indicated by the assessment represents the individual’s needs at the time of the assessment. Service intensity could change as an individual’s needs and/or desires for service change.

Please note:

- Although a child/adolescent may not meet the eligibility criteria and/or the Environmental Matrix formulary, inclusive of professional judgement and other information that impacts on the individual’s need for the service, he/she may be authorized for Targeted Case Management Services upon the recommendation of the County Administrator and/or designee.

### ENVIRONMENTAL MATRIX — CHILD/ADOLESCENT TCM SERVICE SCORING GRID

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<th>MATRIX LEVEL</th>
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<tr>
<td>4.0 –5.0</td>
<td>ICM</td>
<td>At least 1 contact every 14 days (Face to face contact strongly recommended).</td>
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<tr>
<td>1.5 –3.9</td>
<td>RC</td>
<td>At least 1 contact every 30 days (Face to Face)</td>
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<td>0.0 - 1.4</td>
<td>NO TCM NEEDED</td>
<td>Alternative services may be needed and if necessary, referrals should be made.</td>
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*professional judgement:* opinion based on a thorough and ethical analysis of facts, data, history, and issues in accordance with one’s training and experience.
ACCESSING MENTAL HEALTH SERVICES

Child’s/adolescent’s mental health problems require mental health services and the family requires help to access them. The TCM should take into consideration that the behavioral health system may pose a number of barriers which serve as obstacles to assessing services (e.g., language, perceived/actual institutional racism/discrimination, the family may mistrust the behavioral health system, the family may lack the capability to access services, the family may lack information, be overwhelmed, poorly informed about the benefits of such services, or intimidated by the system). The TCM is instrumental in assuring that the child/adolescent receives the necessary services for therapy, medication monitoring, etc.

*The decision for level of TCM needed in this area must be determined in collaboration with family and/or guardian, or caregiver/natural support and child/adolescent.

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0= Parent/guardian and child/adolescent does not require/desire any assistance in this area.

1= Parent/guardian and child/adolescent requires/desires a minimal level of assistance, guidance and support to obtain mental health and other essential services to meet the child’s/adolescent’s multiple needs.

3= Parent/guardian and child/adolescent requires/desires a moderate level of assistance, guidance and support to obtain mental health and other essential services to meet the child’s/adolescent’s multiple needs.

5= Parent/guardian and child/adolescent requires/desires a significant level of assistance, guidance and support to obtain mental health and other essential services to meet the child’s/adolescent’s multiple needs.
INFORMAL SUPPORT NETWORK BUILDING

The child/adolescent and parent/guardian identifies, communicates, and interacts with family, friends, significant others, and community groups from whom the child/adolescent may gain informal support. Service system barriers and other factors, however, may impede the child/adolescent and parent/guardian from interacting with family, friends, significant others and community groups. The child/adolescent may need assistance to challenge and remove barriers so as to enhance the informal building of supports. The child/adolescent may need the assistance of the targeted case manager and/or others to identify, enhance and/or maintain existing relationships and the encouragement to develop new ones.

*The decision for level of TCM needed in this area must be determined in collaboration with family and/or guardian, or caregiver/natural support and child/adolescent.


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0= Parent/guardian and child/adolescent does not require/desire any assistance in this area.

1= Child/adolescent is able to identify and provide meaningful/accurate/relevant information about family, friends, significant others, and social/religious groups with whom he/she interacts and from whom the child/adolescent may gain informal support. The parent/guardian and child/adolescent requires and/or desires minimal assistance, to access and maintain positive relationships with these people and groups who provide personal social support and/or companionship.

3= Child/adolescent needs and/or requests moderate assistance in identifying and communicating with family, friends, significant others, and social/religious groups from whom the child/adolescent may gain informal support. The parent/guardian and child/adolescent requires and/or desires moderate assistance from others in order to enhance and/or maintain existing relationships and to develop new ones.

5= Child/adolescent is unable to identify nor interact with family, friends, significant others, and/or social/religious groups who may serve as personal supports. The child/adolescent has few, if any, personal or familial relationships and is unable/unwilling to interact positively, if at all, with these persons or groups. The parent/guardian and child/adolescent requires and/or desires significant assistance from others to elicit information and support on his/her behalf.
EDUCATION/VOCAATION

The need for additional or more appropriate educational and/or vocational services, based on the needs of the child/adolescent, including a more appropriate educational and/or vocational placement, may require school meetings, IEP meetings, meetings with the Office of Vocational Rehabilitation or other vocational planning or service groups (e.g., vocational service providers), advocacy for the child’s/adolescent’s needs and providing information to the parent/guardian regarding their rights in determining the appropriate education/vocational setting for their child/adolescent. The child/adolescent should have everything that is necessary to be successful in an educational and/or vocational environment, including access to the family’s primary language for all meetings. TCM assists the parent/guardian in accessing educational and/or vocational advocacy and obtaining the appropriate education and/or vocational training for the child/adolescent and offers support in conflicts between the school and parent/guardian concerning the child/adolescent’s needs and services to be provided.

*The decision for level of TCM needed in this area must be determined in collaboration with family and/or guardian, or caregiver/natural support and child/adolescent.

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1= Parent/guardian and child/adolescent requires/desires a minimal level of assistance, guidance and advocacy to obtain support for and to maintain appropriate educational services.

3= Parent/guardian and child/adolescent requires/desires a moderate level of assistance, guidance and advocacy to obtain support for and to maintain appropriate educational services.

5= Parent/guardian and child/adolescent requires/desires a significant level of assistance, guidance and advocacy to obtain support for and to maintain appropriate educational services.

Commonwealth of Pennsylvania
HealthChoices Behavioral Health
## CHILDREN AND YOUTH SYSTEM INVOLVEMENT

TCM may assist family in working with CYS and meeting CYS requirements for the parent/guardian or care giver/natural support and their child/adolescent with serious emotional disturbances. TCM assists the family in responding to the CYS family services plan. TCM may be needed to assure collaboration between the Children and Youth and Mental Health systems and a need for collaboration among multiple providers from these two systems. TCM may also participate in court processes for the family and the child/adolescent.

*The decision for level of TCM needed in this area must be determined in collaboration with family and/or guardian, or care giver/natural support and child/adolescent.

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<td>1= Parent/guardian and child/adolescent requires/desires a minimal level of assistance, guidance and support from TCM to carry out the goals of CYS plan, maintain a safe and healthy environment and assure child’s/adolescent’s participation in mental health services.</td>
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<td>3= Parent/guardian and child/adolescent requires/desires a moderate level of assistance, guidance and support from TCM to carry out the goals of CYS plan, maintain a safe and healthy environment and assure child’s/adolescent’s participation in mental health services.</td>
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<td>5= Parent/guardian and child/adolescent requires/desires a significant level of assistance, guidance and support from TCM to carry out the goals of CYS plan, maintain a safe and healthy environment and assure child’s/adolescent’s participation in mental health services.</td>
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**JUVENILE JUSTICE/CRIMINAL JUSTICE SYSTEM INVOLVEMENT**

A child or adolescent with a serious emotional disturbance who demonstrates delinquent behavior and/or is not compliant with probation and mental health service needs may require TCM support in addition to probation services. TCM uses his/her ongoing relationship with the child/adolescent and family to encourage compliance with the probation plan and participation in mental health services. TCM may be needed to assure collaboration between the Juvenile Justice/Criminal Justice and Mental Health systems. The TCM may also participate in court processes with family/juvenile.

*The decision for level of TCM needed in this area must be determined in collaboration with family and/or guardian, or caregiver/natural support and child/adolescent.

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N/A = Parent/Guardian and child/adolescent does not need/have involvement with the Juvenile Justice/Criminal Justice System.

0 = Parent/guardian and child/adolescent does not require/desire any assistance in this area.

1 = Parent/guardian and child/adolescent requires/desires minimal level of assistance, guidance, advocacy, support and TCM involvement to assure child’s/adolescent’s cooperation with the probation plan.

3 = Parent/guardian and child/adolescent requires/desires moderate level of assistance, guidance, advocacy, support and TCM involvement to assure child’s/adolescent’s cooperation with the probation plan.

5 = Parent/guardian and child/adolescent requires/desires a significant level of assistance, guidance, advocacy, support and TCM involvement to assure child’s/adolescent’s cooperation with the probation plan.
PARENT/GUARDIAN AND/OR OTHER FAMILY MEMBERS WITH SIGNIFICANT FAMILY NEEDS

Other members of the family may have individual needs that have a serious impact on the child/adolescent’s ability to function at home and in the community. Other family members may have chronic mental illness, serious emotional disturbances, substance abuse problems, and/or physical illness that combine to compromise caretaker availability to the child. TCM provides culturally consistent and language appropriate service to the child/adolescent and family, assuring access and participation in services, including mental health services.

*The decision for level of TCM needed in this area must be determined in collaboration with family and/or guardian, or caregiver/natural support and child/adolescent.

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0= Parent/guardian and child/adolescent does not require/desire any assistance in this area.

1= Other family members may have mental illness, serious emotional disturbance, physical illness, or substance abuse problems and/or there are significant family needs which may require or the family may desire a minimal level of TCM services to support the family in meeting the child’s/adolescent’s basic living needs and emotional well-being.

3= Other family members may have mental illness, serious emotional disturbance, physical illness, or substance abuse problems and/or there are significant family needs which may require or the family may desire a moderate level of TCM services to support the family in meeting the child’s/adolescent’s basic living needs and emotional well-being.

5= Other family members may have a mental illness, serious emotional disturbance, physical illness, or substance abuse problems and/or there are significant family needs which may require or the family may desire a significant level of TCM services to support the family in meeting the child’s/adolescent’s basic living needs and emotional well-being.
Appendix T - Part B (4)

**DRUG AND ALCOHOL SYSTEM INVOLVEMENT**

TCM assists family in obtaining drug and alcohol treatment for a child/adolescent with serious emotional disturbances and co-occurring drug and alcohol problems and encouraging child/adolescent to accept and comply with these services. The TCM supports the child’s/adolescent’s participation in all phases of treatment, including aftercare. TCM assists the family in obtaining culturally competent, language appropriate services for the child/adolescent.

*The decision for level of TCM needed in this area must be determined in collaboration with family and/or guardian, or care giver/natural support and child/adolescent.

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<td>N/A= Parent/Guardian and child/adolescent does not need/have involvement with the Drug and Alcohol System.</td>
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<td>0= Parent/guardian and child/adolescent does not require/desire any assistance in this area.</td>
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<tr>
<td>1= Parent/guardian and child/adolescent requires/desires minimal level of assistance, guidance, advocacy, and support to obtain and maintain the child’s/adolescent’s participation in drug and alcohol services.</td>
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<td>3= Parent/guardian and child/adolescent requires/desires moderate level of assistance, guidance, advocacy, and support to maintain the child’s/adolescent’s participation in drug and alcohol services.</td>
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<td>5= Parent/guardian and child/adolescent requires/desires a significant level of assistance, guidance, advocacy, and support to obtain and maintain the child’s/adolescent’s participation in drug and alcohol services.</td>
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MENTAL RETARDATION SYSTEM INVOLVEMENT

TCM assists the family in obtaining and maintaining participation in mental retardation services for a child/adolescent with a serious emotional disturbance and a co-occurring diagnosis of mental retardation. The TCM supports the child’s/adolescent’s and parent’s/guardian’s participation in all phases of mental retardation services. TCM assists the family in obtaining culturally competent, language appropriate services for the child/adolescent.

*The decision for level of TCM needed in this area must be determined in collaboration with family and/or guardian, or caregiver/natural support and child/adolescent.

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N/A = Parent/Guardian and child/adolescent does not need/have involvement with the Mental Retardation System.

0  = Parent/guardian and child/adolescent does not require/desire any assistance in this area.

1  = Parent/guardian and child/adolescent requires/desires minimal level of assistance, guidance, advocacy, and support to obtain and maintain the child’s/adolescent’s participation in mental retardation services.

3  = Parent/guardian and child/adolescent requires/desires moderate level of assistance, guidance, advocacy, and support to maintain the child’s/adolescent’s participation in mental retardation services.

5  = Parent/guardian and child/adolescent requires/desires a significant level of assistance, guidance, advocacy, and support to obtain and maintain the child’s/adolescent’s participation in mental retardation services.
**PHYSICAL HEALTH SYSTEM INVOLVEMENT**

TCM assists family and child/adolescent with a serious emotional disturbance in attending to significant physical/medical needs by helping parent/guardian to access medical care, and to develop confidence in working with physical health care providers. TCM assists the family in obtaining culturally competent, language appropriate services for the child/adolescent.

*The decision for level of TCM needed in this area must be determined in collaboration with family and/or guardian, or care giver/natural support and child/adolescent.*

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<td>Parent/guardian and child/adolescent requires/desires minimal level of assistance, guidance, advocacy, and support to obtain medical services and to assure coordination between physical and behavioral health care services.</td>
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<td>Parent/guardian and child/adolescent requires/desires a significant level of assistance, guidance, advocacy, and support to obtain medical services and to assure coordination between physical and behavioral health care services.</td>
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CHILD/ADOLESCENT AT RISK OF OUT-OF-HOME PLACEMENT

The risk that a child/adolescent with a serious emotional disturbance will require an out-of-home placement may be reduced significantly through TCM services which assist parent/guardian in accessing needed child serving systems. TCM assistance may include information sharing with parent/guardian, advocacy with mental health service providers and other systems and support in working with multiple service providers. Every effort should be made to consider the child’s ethnicity, culture and religious background in any out-of-home placement. TCMs may need to provide assistance in the provision of cultural competence supports for children (e.g., grooming, leisure activities, etc.).

*The decision for level of TCM needed in this area must be determined in collaboration with family and/or guardian, or caregiver/natural support and child/adolescent.

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<td>0</td>
<td>Needs minimal assistance in this area</td>
<td>Needs moderate assistance in this area</td>
<td>Needs significant assistance in this area</td>
<td></td>
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<tr>
<td>1</td>
<td>Parent/guardian and child/adolescent does not require/desire any assistance in this area.</td>
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<tr>
<td>2</td>
<td>Child’s/adolescent’s ongoing emotional/behavioral issues place the child/adolescent at low risk of out-of-home placement.</td>
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<tr>
<td>3</td>
<td>Child’s/adolescent’s ongoing emotional/behavioral issues place the child/adolescent at moderate risk of out-of-home placement.</td>
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<tr>
<td>4</td>
<td>Child’s/adolescent’s ongoing emotional/behavioral issues place the child/adolescent at high risk of out-of-home placement.</td>
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</table>
CURRENTLY IN RTF, OTHER OUT-OF-HOME PLACEMENTS OR INPATIENT

Child/adolescent with a serious emotional disturbance is currently or has been receiving services in an RTF, other out-of-home placement or inpatient setting. The child/adolescent has been discharged within the past 30 days or discharge is anticipated within thirty 30 days. The child/adolescent may have been discharged for more than 30 days, however, TCM services are needed to assist with the discharge plan.

*The decision for level of TCM needed in this area must be determined in collaboration with family and/or guardian, or care giver/natural support and child/adolescent.

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<th>Needs minimal assistance in this area</th>
<th>Needs moderate assistance in this area</th>
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<tbody>
<tr>
<td>0</td>
<td>Parent/guardian and child/adolescent does not require/desire any assistance in this area.</td>
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<tr>
<td>1</td>
<td>Development and implementation of a multi-service-system plan for a child/adolescent discharged or anticipated to be discharged from RTF, other out-of-home placement or inpatient requires a minimal level of TCM service.</td>
<td></td>
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</tr>
<tr>
<td>3</td>
<td>Development and implementation of a multi-service-system plan for a child/adolescent discharged or anticipated to be discharged from RTF, other out-of-home placement or inpatient requires a moderate level of TCM service.</td>
<td></td>
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<tr>
<td>5</td>
<td>Development and implementation of a multi-service-system plan for a child/adolescent discharged or anticipated to be discharged from RTF, other out-of-home placement or inpatient requires a significant level of TCM service.</td>
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</table>
TARGETED CASE MANAGEMENT
ENVIRONMENTAL MATRIX - CHILD/ADOLESCENT

Agency

County

CHILD/ADOLESCENT INFORMATION:

Name :

(_Last) (First) (MI)

Parent/Guardian Name:

Identifying Number(s):

Date of Birth: / / (MM)/(DD)/(YYYY)

Social Security Number: - -

CIS/BSU/MCO Number:

PHMCO:

BHMCO:

Form Completed by:

Date Completed:

The purpose of this form is to assess what environmental and cultural factors help to determine an individual’s need for the various levels of case management services. Please complete this form utilizing the individual’s behavior and situation during the last ninety days as a basis for scoring each indicator. Please note that the decision for level of need in each of the areas must be determined in collaboration with family and/or guardian, or care giver/natural supports and child/adolescent. Please see the Scoring Sheet for additional information on determining the Environmental Matrix Score and its meaning for level of care assignments.
ENVIRONMENTAL MATRIX CHILD/ADOLESCENT SCORING SHEET

CHILD/ADOLESCENT NAME: __________________________________________________________

ID#(SOCIAL SECURITY/CIS/BSU): _____________________________________________________

SCORES:

1. Accessing Mental Health Services
2. Informal Support Network Building
3. Education
4. Children and Youth System Involvement
5. Juvenile Justice System Involvement
6. Parent/Guardian and/or Other Family Members
   With Significant Needs
7. Drug and Alcohol System Involvement
8. Mental Retardation System Involvement
9. Physical Health System Involvement
10a. At Risk of Out-of-Home Placement
10b. Currently in RTF, Other Out-of-Home Placements or Inpatient

SUBTOTAL ________________

ENVIRONMENTAL MATRIX SCORE = SUBTOTAL + BY ALL
APPLICABLE ASSESSMENT AREAS (AREAS SCORED “N/A” ARE NOT
USED IN DETERMINING OVERALL SCORE) ______________

OTHER FACTORS/ISSUES AFFECTING SCORE:

________________________________________________________________________

________________________________________________________________________

Commonwealth of Pennsylvania
HealthChoices Behavioral Health
**ENVIRONMENTAL MATRIX — CHILD/ADOLESCENT**  
**TCM SERVICE SCORING GRID**

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<tr>
<th>MATRIX LEVEL</th>
<th>NEED LEVEL</th>
<th>INTENSITY OF CARE</th>
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<tbody>
<tr>
<td>4.0 – 5.0</td>
<td>ICM</td>
<td>At least 1 contact every 14 days (Face to face contact strongly recommended)</td>
</tr>
<tr>
<td>1.5 – 3.9</td>
<td>RC</td>
<td>At least 1 contact every 30 days (Face to Face)</td>
</tr>
<tr>
<td>0.0 – 1.4</td>
<td>NO TCM NEEDED</td>
<td>Alternative services may be needed and if necessary, referrals should be made.</td>
</tr>
</tbody>
</table>

*professional judgement: opinion based on a thorough and ethical analysis of facts, data, history, and issues in accordance with one’s training and experience.*

**RECOMMENDED LEVEL OF TARGETED CASE MANAGEMENT SERVICE:**

CONSUMER (if age appropriate): ____________________ DATE: ________________

PARENT/GUARDIAN: ____________________ DATE: ________________

PERSON COMPLETING THE FORM: ____________________ DATE: ________________

**APPROVED LEVEL OF TARGETED CASE MANAGEMENT SERVICE:**

REVIEWER: ____________________ DATE: ________________

Click on link below:

http://www.portal.state.pa.us/portal/server.pt/community/enterprise_portal_information/212

Enter “Pennsylvania Client Placement Criteria” in search box.
Appendix T – Part D

AMERICAN SOCIETY OF ADDICTION MEDICINE
ASAM ADOLESCENT PLACEMENT CRITERIA
PPC-2R, Second Edition Revised

Can Be Purchased Through ASAM At The Address Below

ASAM PUBLICATIONS
P.O. BOX 101
ANNAPOLIS, MD 20701-0101

Phone: 1-800-844-8948
Fax: 301-206-9789
E-Mail: asampub@pmds.com
### Small Diverse Business (SDB) Commitment Worksheet

Offeror Name: _____________________________________________________

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<th></th>
<th>A</th>
<th>B</th>
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<tbody>
<tr>
<td>1</td>
<td><strong>% of Admin Dollars Committed to SDB</strong>*</td>
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</tbody>
</table>

* For the purposes of this submittal, assume that Administrative Dollars for this agreement will be $16,836,280 and does not include Gross Receipts Tax. Final Administrative Dollars will be determined at the time of the Agreement, and Offerors will be bound to the percentage committed to SDB applied to the Final Administrative Dollars less Gross Receipts Tax (GRT).

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<th>B</th>
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<tbody>
<tr>
<td>2</td>
<td>Name of SDB Business</td>
<td>% of Administrative Dollars</td>
</tr>
<tr>
<td>2a</td>
<td></td>
<td></td>
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<tr>
<td>2b</td>
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<td>2j</td>
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| 3 | Column B Total %* |

* The total in cell 3B should be equal to the sum of the percentages in Column B, 2a-2j and should equal the percentage in cell 1B, **% of Admin Dollars Committed to SDB**.

Use additional sheet if needed.

**This Worksheet should be attached to the Small Diverse Business Submittal. It only meets the requirements of Part II-8, B.2(a). Offerors also must complete, as a part of the SDB submittal, Part II-8, b.2(b) through b.2(g)**

Authorized Signature:_______________________________________ Date:__________
This document includes descriptions of policies supported by the Department's processes. In cases where the policy expressed in this document conflicts with another provision of the contract between the Primary Contractor and the Department (the Department Agreement), the Department contract will take precedence.

The Department will provide sufficient information to the Primary Contractor in order for it to reconcile Behavioral Health Managed Care Organization (BH-MCO) Membership data with amounts paid to and recovered from the Primary Contractor.

**Definitions:**

**BH-MCO Coverage Period** - A period of time during which a Recipient is eligible for Medical Assistance (MA) coverage and a BH-MCO coverage period exists on the Department’s Client Information System (CIS). Exceptions and Clarifications are identified in Sections D, E, F, G and H of this document.

**BH-MCO Member** - An MA Recipient who is enrolled with the BH-MCO under the HealthChoices Behavioral Health Program and for whom the BH-MCO is responsible to provide behavioral health services under the provisions of the HealthChoices Behavioral Health Program.

**BH-MCO Member Record** - A record contained on the Daily Membership File or the Monthly Membership File that contains information on MA eligibility, managed care coverage, and the category of assistance, which help establish the covered services for which a Recipient is eligible. **Child in Substitute Care** – A Child in Substitute Care is one who has been adjudicated dependent or delinquent and residing outside their own home. **Dependent** children and adolescents are living in the legal custody of a public child welfare agency, in any of the following settings:

- Shelter programs
- Foster family homes
- Group homes
- Supervised independent living
- Residential treatment facilities (RTF)
- Drug and alcohol treatment facilities
- Transitional living residence
- Mobile and outdoor programs
- Residential facilities
- Kinship homes

Children in Substitute Care classified as **delinquent** are adjudicated as such by the juvenile court and placed in temporary secure juvenile detention center (JDC), secure care or any of the settings...
listed above. They are under the supervision of the juvenile court and there is no transfer of legal custody to a public agency.

**Client Information System (CIS)** - The Department's automated file of previous, current and future MA Recipients and BH-MCO members.

**Daily Membership File** - An electronic file generated by the Department using CIS on a daily basis (exclusive of weekends and Department holidays), which is transmitted to the Primary Contractor. The Daily Membership File contains information on changes made to MA Recipient records on CIS, and may include retroactive, current or prospective MA eligibility, and BH-MCO coverage information.

**Drug and Alcohol Residential Facility** – Includes inpatient or non-hospital residential drug and alcohol services. Non-hospital residential includes residential detox, rehab and half-way house.

**Eligibility Verification System (EVS)** - An automated system available to MA Providers and other specified organizations for on-line verification of MA eligibility, prepaid capitation, PH-MCO or BH-MCO enrollment, third party resources, and the benefit package under the MA Fee-For-Service (FFS) Program.

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

**Monthly Membership File** - An electronic file generated by the Department using CIS on the next to the last Saturday of the month that is transmitted to the Primary Contractor. The Monthly Membership File lists retroactive, current and prospective BH-MCO Members, specifying for each BH-MCO Member the corresponding eligibility period, PH-MCO coverage and BH-MCO coverage. Recipients not included on this file with an indication of prospective coverage will not be the responsibility of the BH-MCO unless a subsequent Daily Membership File indicates otherwise. Those with an indication of future month coverage will not be the responsibility of the BH-MCO if a Daily Membership File received by the BH-MCO prior to the beginning of the future month indicates otherwise.

**Negation BH-MCO Member Record** - A BH-MCO Member Record used by the Department to advise the Primary Contractor that a certain related BH-MCO Member Record previously submitted by the Department to the Primary Contractor should be negated. A Negation BH-MCO Member Record can be recognized by its sequence of BH-MCO membership start and end dates with the end date preceding the start date.

**Open-ended** - A period of time that has a start date and does not have a definitive end date.

**PH-MCO Coverage Period** - A period of time during which a Recipient is eligible for MA coverage and a PH-MCO coverage period exists on CIS. Exceptions and clarifications are identified in sections D, E, F and G of this document.
PH-MCO Member - An MA Recipient who is enrolled with a specific PH-MCO and to whom the PH-MCO is responsible to provide physical health MA benefits under the provisions of the HealthChoices Physical Health Program.

Physical Health Managed Care Organization (PH-MCO) - A Commonwealth licensed risk-bearing entity, which has contracted with the Department to manage the purchase and provision of physical health services under the HealthChoices Physical Health Program.

Provider Agreement MCO - An MCO that has a Provider Agreement with DPW to operate a voluntary MA managed care program.

Recipient - A person eligible to receive medical and behavioral health services under the MA program of the Commonwealth of Pennsylvania.

System Date – The System Date is the date a change in coverage or eligibility is entered into the system. The effective date of the change may be different than the System Date.

A BH-MCO is responsible for a Recipient if coverage is determined by applying the general rules found in any of paragraphs A, B, or C below, subject to exceptions and clarifications found in paragraphs D, E, F, and G.

A. Unless otherwise specified, the BH-MCO is responsible to provide MA behavioral health benefits to BH-MCO Members in accordance with eligibility information included on the Monthly Membership File and/or the Daily Membership File, which is provided by DPW to each BH-MCO.

B. Monthly Membership Files containing information on Members are created on the next to the last Saturday of each month and are provided to the BH-MCO no later than the following Monday. Information on the file includes retroactive, current or prospective eligibility periods, PH-MCO coverage and BH-MCO coverage, and demographic data. For each BH-MCO member identified on the Monthly Membership File, the BH-MCO is responsible to provide behavioral health benefits from the beginning of the month or from the BH-MCO coverage start date, whichever is later. BH-MCO coverage will continue from the start date through the last day of the calendar month. BH-MCO coverage dates beyond the last date of the month in which a Monthly Membership File is created is preliminary information that is subject to change.

Daily Membership Files are provided to each BH-MCO with changes that have been applied to their enrolled population. In the example that follows, assume that the only information provided by DPW is on the Monthly Membership File created in October. If an eligibility period of October 21 through November 18 is provided, the BH-MCO is responsible from October 21 through November 30, assuming no subsequent daily file changes occur prior to November 1 to end coverage in October. If two eligibility periods

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Commonwealth of Pennsylvania
HealthChoices Behavioral Health
are provided, one from October 10 through October 25 and one from October 29 on with no end date, the BH-MCO is responsible from October 10 through at least November 30, subject to a daily file change prior to November 1. Coverage after October 31 is preliminary based on daily file changes.

If a Recipient is shown on the Department's Client Information System (CIS) as covered by a BH-MCO (coverage by a BH-MCO is indicated by an open MA eligibility record and a corresponding open BH-MCO record), the BH-MCO is responsible for the person from the first day of BH-MCO coverage through the last day of the month of the BH-MCO end date (if any). The Department will pay the BH-MCO from the first day of coverage in a month through the last calendar day of the month. Information on CIS for any future month should be viewed as preliminary. If a Recipient has eligibility in more than one county during the month, the BH-MCO with the earliest period of responsibility is responsible for providing services for the month.

Recipients who become ineligible for Medical Assistance will retain their PH-MCO selection for six months. These Members will become the responsibility of the same PH-MCO and BH-MCO if they regain MA eligibility during that six-month period and their category of assistance and geographic location remain valid. Upon regaining eligibility, their BH-MCO effective date will be their MA eligibility begin date or the date CIS is updated, whichever is later. EXCEPTION: Members may voluntarily disenroll from a PH-MCO during the ineligibility period.

C. DPW has established benefit packages based on category of assistance, program status code, age, and for some packages, the existence of Medicare coverage or a Deprivation Qualifying Code. In cases where the Recipient benefits are determined by the benefit package, the most comprehensive package is to be honored. For example, if a Recipient has the most comprehensive package on the first of the month but changes to a lesser level package during the month, they should receive the higher level of benefits for the entire month. If a Recipient has a lesser level benefit package at the beginning of the month but changes to a higher level during the month, they should receive the higher level benefits effective the first day of coverage under the higher level. The daily and monthly files can be used for determining increased benefits during a month.

D. Exceptions and Clarifications:

1. The BH-MCO will not be responsible and will not be paid when DPW sends the BH-MCO correspondence specifying member months for which they are not responsible. The Department will recover capitation payments made for Recipient for whom it had been determined the BH-MCO was not responsible to provide services.
2. If CIS shows Fee-For-Service (FFS) coverage that coincides with BH-MCO coverage, the Recipient may use either coverage and there will be no monetary adjustment between the Department and the BH-MCO. (This is subordinate to #8 below.)

3. If the BH-MCO has actual knowledge that a Recipient is deceased, and if such Recipient is shown on either the Monthly Membership File or the Daily Membership File as active, the BH-MCO is required to notify the County Assistance Office (CAO) and the Department. The Department will recover capitation payments made for deceased Recipients for up to eighteen (18) months after the service month in which the date of death occurred.

4. If it is determined that the member was not MA eligible on the begin date of coverage during a month, and the BH-MCO was paid, the Department will recover or adjust payments.

5. If a member is placed in a setting that results in the termination of coverage by the BH-MCO, the Department will recover capitation payments made for the member for up to twelve (12) months after the service month in which the termination of coverage occurred.

6. The BH-MCO retains responsibility for Members when placed outside the county, HealthChoices zone or state by the BH-MCO, juvenile court or county Children and Youth (C&Y) even if PH-MCO coverage information is not found on CIS, or on the daily or monthly files. The BH-MCO will continue to receive capitation payments.

If a member is placed in a facility by juvenile court or county Children and Youth authority for service(s) which the BH-MCO determines is not medically necessary, the cost of the service is the responsibility of the placing authority, not the BH-MCO. (See Section H for additional details).

7. Newborn babies are the responsibility of the BH-MCO that covered the mother on the date of birth. Where CIS does not reflect this, if the PH-MCO notifies the Department, the Department will coordinate adjustment of coverage. Limitations in Sections E-2 and E-3 applicable to the mother will apply to the newborn.

8. Movement out of a BH-MCO's service area, or lack of MA coverage or eligibility on a date of service for which the policies in this document otherwise hold a BH-MCO responsible for a Recipient do not negate a BH-MCO's responsibility to provide MA benefits. If a BH-MCO is aware that a Recipient is residing outside of its county, it is the BH-MCO’s responsibility to notify the County Assistance Office, within ten (10) days of the date of learning of the Recipient’s status.

9. If the rules to determine BH-MCO responsibility to provide benefits to MA
Members that are outlined in this document indicate that a BH-MCO is responsible to provide benefits to a MA Recipient on a certain date, a lack of MA eligibility indicated on CIS for that date does not negate this responsibility.

10. Errors in coverage must be reported to the Department within 45 days of receipt of the monthly eligibility file in order for retroactive changes to be considered. The BH-MCO will be responsible to cover Members, even when coverage assignment resulted from errors, if not reported to the Department within 45 days unless the error results in duplicate payment or coverage.

11. If CIS shows an exemption or facility/placement code that precludes BH-MCO coverage, the Recipient may not be enrolled in a BH-MCO.

E. When a Recipient has managed care coverage during part of an inpatient/residential stay, financial responsibility* is as follows: For purposes of this document, an inpatient/residential stay shall include those in the following facilities:

General Hospital
Rehabilitation Hospital
Acute Care Psychiatric Hospital
Extended Acute Care Psychiatric Hospital
Residential Treatment Facility (Accredited and Non-Accredited)
Hospital-Based Drug & Alcohol Detoxification and Rehabilitation Facility

*The covering plan will only be responsible for inpatient/residential services for continuous stays when the service is included as a covered service under its contract with the Department.

1. **Inpatient/residential Facilities Covered Under the Prospective Payment System for Diagnostic Related Groups.**

If a Recipient is in a facility covered by a DRG and is FFS on the admission date (or determined eligible through a proactive determination by the CAO) and the BH-MCO coverage begins while the Recipient is in the inpatient/residential facility, the FFS program is financially responsible for the entire initial stay. The BH-MCO will become financially responsible for the member upon discharge. Upon becoming aware of a new member currently in one of these facilities, the BH-MCO must coordinate with the Provider in determining an appropriate course of treatment as soon as possible, prior to discharge.

**EXAMPLE:** If a Recipient is determined to be covered by FFS on the admission date to an inpatient/residential facility, which is covered under the prospective payment system for Diagnostic Related Groups, on June 21, and the BH-MCO coverage begin date is July 1, and the individual is transferred/discharged on July 15, the FFS program will be financially responsible for the entire stay. The BH-MCO will be financially responsible for all covered services beginning July 15.
Upon becoming aware of a new member currently in a facility on July 1, the BH-MCO must become involved in discharge planning for the individual.

2. **Recipient Covered by FFS Becomes BH-MCO Covered While in Facility**

If a Recipient is covered by FFS on the admission date and the BH-MCO coverage begins while the Recipient is in an inpatient/residential facility not covered under the DRG Prospective Payment System, the FFS program is financially responsible for the stay until the BH-MCO begin date. Starting with the BH-MCO begin date, the BH-MCO is financially responsible for the remainder of the stay, as well as physician or other covered services not included in the inpatient/residential facility bill that would be their responsibility as the Recipient's BH-MCO. Upon assuming financial responsibility of a Recipient age 21 and over, the BH-MCO has the ability to conduct a concurrent review of the FFS authorized inpatient/residential facility stay to determine continued medical necessity.

**EXAMPLE:** If a Recipient covered by FFS is admitted to an inpatient/residential facility on June 21 and the BH-MCO coverage begin date is July 1, the BH-MCO will assume payment responsibility for the inpatient/residential facility stay on July 1. The FFS program will remain financially responsible for the stay through June 30. Anytime after June 30, the BH-MCO may conduct a concurrent review to determine medical necessity of the inpatient/residential facility stay if the member is an adult age 21 and over.

3. **Recipient Covered by BH-MCO Becomes FFS While in Facility**

If a Recipient is covered by a BH-MCO when admitted to an inpatient/residential facility and the Recipient loses BH-MCO coverage and assumes FFS coverage while still in the inpatient/residential facility, the BH-MCO is responsible for the stay except as indicated below.

**EXAMPLE #1:** If the Recipient is still in the inpatient/residential facility on the FFS coverage begin date, and the Recipient's FFS coverage begin date is the first day of the month, the BH-MCO will be financially responsible for the stay through the last day of that month. The FFS program will be financially responsible for the stay beginning on the first day of the next month. For example, if a Recipient covered by the BH-MCO is admitted to an inpatient/residential facility on June 21 and the FFS program coverage begin date is July 1, the FFS program will assume payment responsibility for the inpatient/residential facility stay on August 1. The BH-MCO will remain financially responsible for the stay through July 31.

**EXAMPLE #2:** If the Recipient is still in the inpatient/residential facility on the FFS program coverage begin date, and the Recipient's FFS program coverage
begin date is any day other than the first day of the month, the BH-MCO will be financially responsible for the stay through the last day of the FOLLOWING month. The FFS program will be financially responsible for the stay beginning on the first day of the NEXT month. For example, if a Recipient covered by a BH-MCO is admitted to an inpatient/residential facility on June 21 and the FFS program coverage begin date is July 15, the FFS program will assume payment responsibility for the inpatient/residential facility stay on September 1. The BH-MCO program will remain financially responsible for the stay through August 31.

4. Recipient Covered by BH-MCO Becomes Covered by Different BH-MCO While in Facility

If a Recipient is covered by a BH-MCO when admitted to an inpatient/residential facility and transfers to another BH-MCO while still in the inpatient/residential facility, the first BH-MCO is responsible for that stay except as indicated below.

**EXCEPTION #1:** If the Recipient is still in the inpatient/residential facility on the gaining BH-MCO coverage begin date, and the Recipient's gaining BH-MCO coverage begin date is the first day of the month, the first BH-MCO will be financially responsible for the stay through the last day of that month. The second BH-MCO will be financially responsible for the stay beginning on the first day of the next month. For example, if a Recipient is admitted to an inpatient/residential facility on June 21 and the second BH-MCO coverage begin date is July 1, the second BH-MCO will assume payment responsibility for the inpatient/residential facility stay on August 1. The first BH-MCO will remain financially responsible for the stay through July 31.

**EXCEPTION #2:** If the Recipient is still in the inpatient/residential facility on the second BH-MCO coverage begin date, and the Recipient's second BH-MCO coverage begin date is any day other than the first day of the month, the first BH-MCO will be financially responsible for the stay beginning on the first day of the NEXT month. The second BH-MCO will be financially responsible for the stay beginning on the first day of the following month. For example, if a Recipient is admitted to an inpatient/residential facility on June 21 and the second BH-MCO coverage begin date is July 15, the second BH-MCO will assume payment responsibility for the inpatient/residential facility stay on September 1. The first BH-MCO will remain financially responsible for the stay through August 31.
5. **Recipients Covered by a Provider Agreement MCO**

If a Recipient is covered by a Provider Agreement MCO that includes behavioral health services on the admission date and BH-MCO coverage begins while the Recipient is in the inpatient/residential facility, the Provider Agreement MCO is financially responsible for the stay except as indicated below. Starting with the BH-MCO begin date, the BH-MCO is financially responsible for physician and other covered services not included in the inpatient/residential facility bill that would be their responsibility as the Recipient's BH-MCO.

**EXCEPTION #1:** If the Recipient is still in the inpatient/residential facility on the BH-MCO coverage begin date, and the Recipient's BH-MCO coverage begin date is the first day of the month, the Provider Agreement MCO will be financially responsible for the stay through the last day of that month. The BH-MCO will be financially responsible for the stay beginning on the first day of the next month. For example, if a Provider Agreement MCO covered Recipient is admitted to an inpatient/residential facility on June 21 and the BH-MCO coverage begin date is July 1, the BH-MCO will assume payment responsibility for the inpatient/residential facility stay on August 1. The Provider Agreement MCO will remain financially responsible for the stay through July 31.

**EXCEPTION #2:** If the Recipient is still in the inpatient/residential facility on the BH-MCO coverage begin date, and the Recipient's BH-MCO coverage begin date is any day other than the first day of the month, the Provider Agreement MCO will be financially responsible for the stay through the last day of the FOLLOWING month. The BH-MCO will be financially responsible for the stay beginning on the first day of the NEXT month. For example, if a Recipient covered by the Provider Agreement MCO is admitted to an inpatient/residential facility on June 21 and the BH-MCO coverage begin date is July 15, the BH-MCO will assume payment responsibility for the inpatient/residential facility stay on September 1. The Provider Agreement MCO will remain financially responsible for the stay through August 31.

**F. Other Causes for Coverage Termination:**

1. **Nursing Facility** - BH-MCO Members are disenrolled after 30 consecutive days of placement in a nursing facility.

2. **Pennsylvania Department of Aging (PDA) Waiver** - BH-MCO Members are disenrolled 30 days after enrollment in the PDA Waiver.
3. Admission to a State Facility - BH-MCOs are not responsible for BH-MCO Members placed in a state facility. The Recipient will be disenrolled from the BH-MCO effective the day before placement in the facility and continued Medical Assistance eligibility will be determined by the County Assistance Office. The Department will recover capitation payments made for any months after the month of placement.

4. Admission to a Correctional Facility – A member who becomes an inmate of a penal facility or correctional institution (including work release), or a Member who is remanded to a Youth Development Center/Youth Forestry Camp will be disenrolled from the BH-MCO effective the day before placement in the facility. The Department will recover capitation payments made for any months after the month of placement.

5. Placement in a Juvenile Detention Center (JDC) – A member who is placed in a juvenile detention center is disenrolled from the BH-MCO after 35 days and covered through Medical Assistance Fee-For-Service. During the first 35 days of this JDC placement, the BH-MCO is responsible for all covered services that are provided to the member outside the JDC site; services provided inside the JDC are the responsibility of the FFS program.

6. Health Insurance Premium Payment Program (HIPP) - BH-MCO Members determined by the Department to be HIPP eligible (Employer Group Health Plan) will be disenrolled from the HC Program as of the date when the BH-MCO Member Record reflects such disenrollment. Additionally, HIPP eligible MA Members are prevented from enrolling in BH-MCOs.

7. A member enrolled in the LTCCAP (Long-Term Care Capitated Assistance Program, is disenrolled from the BH-MCO effective the day before the begin date of LTCCAP.

8. Residing in a PA Veterans Home – BH-MCO will not be responsible for a Member residing in a PA Veterans Home. The Member will be disenrolled from the BH-MCO the day before admission date and enrolled in the MA FFS program.

G. Other Facility Placement Coverage:

1. Intermediate Care Facility-Mental Retardation or Other Related Conditions (ICF-MR or ICF-ORC - Members placed in a private ICF-MR or ICF-ORC facility will continue to be covered by their BH-MCO for all medically necessary behavioral health services that are included in the scope of benefits provided by the contract with DPW.
2. Residential Facilities - BH-MCO Members placed by the BH-MCO in mental health and drug and alcohol residential treatment facilities will continue to be covered by their BH-MCO for all behavioral health services. The residential/treatment costs of Members placed by the BH-MCO in residential treatment facilities will be the responsibility of the BH-MCO. (See section H. 2 for exceptions for children in substitute care)

3. Extended Acute Care Psychiatric Hospital - BH-MCO Members admitted to an extended acute care psychiatric hospital will continue to be covered by their selected BH-MCO for all behavioral health services. The residential/treatment costs will be the responsibility of the BH-MCO.

H. Children and Adolescents In Substitute Care Issues:

When children have been adjudicated dependent or delinquent and are placed in substitute care, behavioral healthcare coverage is the responsibility of the BH-MCO. For purposes of this Section, terms “child” and “children” shall include “adolescents”. For a definition of Child in Substitute Care see “Definitions.”

1. Behavioral Health Services (includes MH and D&A)

If a child is placed in a substitute care setting, either in the same or different zone, the child is enrolled in the BH-MCO county of origin. The child remains enrolled in that BH-MCO which retains authorization and payment responsibility for BH-MCO approved behavioral health services, including both residential and non-residential services. For a child placed in a substitute care setting out of zone, effective August 1, 2009 the child remains enrolled in the BH-MCO which retains authorization and payment responsibility for BH-MCO approved behavioral health services, including both residential and non-residential services.

2. Placement in a Mental Health or Drug and Alcohol Residential Facility

a. Medically Necessary - Consistent with H.1 above, if a Child in Substitute Care is placed in a mental health or drug and alcohol residential treatment facility either in or out of state and the BH-MCO determines the placement is medically necessary, the behavioral health services are the responsibility of the BH-MCO.

b. Not Medically Necessary - If a Child in Substitute Care is placed in a mental health or drug and alcohol residential facility by a placement authority or juvenile court and the BH-MCO in which the child is enrolled determines the placement is not medically necessary, the BH-MCO is not responsible for payment for the placement. The child remains enrolled in the BH-MCO and the BH-MCO remains responsible for medically necessary Behavioral Health Services other than the mental health or drug and alcohol residential placement.
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January 1, 2012

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HealthChoices Behavioral Health

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3. **Placement in a C&Y or JPO non-Mental Health Placement**

   If a Child in Substitute Care is placed in a non-mental health or drug and alcohol placement such as:
   a. Shelter programs
   b. Diagnostic centers
   c. Foster family home, including kinship care homes
   d. Residential facilities
   the child remains enrolled in the BH-MCO from the original placing county.
   The child is enrolled in PHSS serving the zone in which the child is placed.
   Children placed out of state revert to FFS for physical health.

4. The BH-MCO will be required to pay for Out-of-Network medically necessary behavioral health care services for up to ten days for a child enrolled in its plan who is placed in substitute care if the CCYA cannot identify the child nor verify MA coverage. However, this Out-of-Network coverage will only be required in certain circumstances, such as emergency placement as determined by county child welfare or juvenile probation, or where the CCYA has had no contact with the child prior to the placement. All efforts must be made by the CCYA to identify the child and to determine MA coverage responsibility in the most expedient manner possible.

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

6. Children whose adoptions have been finalized by the court and for whom there is an adoption assistance agreement in place, enroll in the BH-MCO of the county
where the adoptive family resides. If the family has moved to a permanent residence outside the Commonwealth of Pennsylvania and the family retains Pennsylvania Medicaid for the adopted child, the child will revert to Fee for Service for behavioral health services.
BEHAVIORAL HEALTH AUDIT CLAUSE

AUDITS

Annual Contract Audits

The Primary Contractor shall cause, and bear the costs of, an annual contract audit to be performed by an independent, licensed Certified Public Accountant. The contract audit shall be completed using guidelines provided by the Commonwealth. Such audit shall be made in accordance with generally accepted government auditing standards. The contract audit shall be submitted to the Commonwealth no later than the 15th day of the fifth month after the contract period is ended.

If circumstances arise in which the Commonwealth or the Primary Contractor invoke the contractual termination clause or determine the contract will cease, the contract audit for the period ending with the termination date or the last date the contractor is responsible to provide medical assistance benefits to HealthChoices recipients shall be submitted to the Commonwealth no later than the end of the fifth (5th) month after the contract termination date or the last date the contractor is responsible to provide medical assistance benefits.

The Primary Contractor shall ensure that audit working papers and audit reports are retained by the Primary Contractor’s auditor for a minimum of five (5) years from the date of final payment under the contract, unless the Primary Contractor’s auditor is notified in writing by the Commonwealth to extend the retention period. Audit working papers shall be made available, upon request, to authorized representatives of the Commonwealth or Federal agencies. Copies of working papers deemed necessary shall be provided by the Primary Contractor’s auditor.

Distribution shall be as follows:

Three (3) copies to: Pennsylvania Office of the Budget
Public Health and Human Services Comptroller Office
1010 North 7th Street
Eastgate Building, Suite 316
Harrisburg, PA 17102-1410
Two (2) copies to:

Regular Mail:  
Department of Public Welfare  
Office of Mental Health and Substance Abuse Services  
Bureau of Financial Management and Administration  
Division of Medicaid and Financial Review  
P.O. Box 2675  
Harrisburg, PA 17105-2675

Overnight Courier:  
Department of Public Welfare  
Office of Mental Health and Substance Abuse Services  
Bureau of Financial Management and Administration  
Division of Medicaid and Financial Review  
DGS Annex Complex  
Shamrock Hall, Bldg. #31, Room #116  
112 East Azalea Drive  
Harrisburg, PA 17110-3594

Annual Entity-Wide Financial Audits

The Primary Contractor and its Prime Subcontractor shall provide to the Commonwealth a copy of its annual entity-wide financial audit, performed by an independent, licensed Certified Public Accountant. Such audit shall be made in accordance with generally accepted auditing standards. If the Primary Contractor is a county government, the report on such audit shall be submitted within nine months after the end of the county’s fiscal year. If the Primary Contractor or Prime Subcontractor is not a county government, such audit shall be submitted to the Commonwealth within 180 days after the entity’s fiscal year end. If the Primary Contractor or Prime Subcontractor is a Commonwealth-licensed, risk-bearing entity, the annual audit prepared and submitted to the Pennsylvania Insurance Department, is acceptable for submission to the Department of Public Welfare.

Distribution shall be as follows:

One (1) copy to:  
Pennsylvania Office of the Budget  
Public Health and Human Services Comptroller Office  
Assistant Comptroller for Medical Assistance  
P.O. Box 2675  
Harrisburg, PA 17105-2675
Other Financial and Performance Audits

The Commonwealth reserves the right for federal and state agencies or their authorized representatives to perform additional financial or performance audits of the Primary Contractor, its Prime Subcontractors or providers. Any such additional audit work will rely on work already performed by the Contractor’s auditor to the extent possible. The costs incurred by the federal or state agencies for such additional work will be borne by those agencies.

Audits of the Primary Contractor, its Prime Subcontractors or providers may be performed by the Commonwealth or its designated representatives and include, but are not limited to:

- Financial and compliance audits of operations and activities for the purpose of determining the compliance with financial and programmatic record keeping and reporting requirements of this contract;

- Audits of automated data processing operations to verify that systems are in place to ensure that financial and programmatic data being submitted to the Commonwealth is properly safeguarded, accurate, timely, complete, reliable, and in accordance with contract terms and conditions; and

- Program audits and reviews to measure the economy, efficiency and effectiveness of program operations under this contract.

Audits performed by the Commonwealth shall be in addition to any federally-required audits or any monitoring or review efforts. Commonwealth audits of the Primary Contractor’s or its Prime Subcontractor’s operations will generally be performed on an annual basis. However, the Commonwealth reserves the right to audit more frequently, to vary the audit period, and to determine the type and duration of these audits. Audits of Prime Subcontractors or providers will be performed at the Commonwealth’s discretion.

The following provisions apply to the Primary Contractor, its Prime Subcontractors and providers:

- Except in cases where advance notice is not possible or advance notice may render the audit less useful, the Commonwealth will give the Primary Contractor, its Prime Subcontractors or providers (Entity) at least three weeks advance written notice of the start date, expected staffing, and estimated duration
of the audit. While the audit team is on-site, the Entity shall provide the team with adequate workspace; access to a telephone, photocopier and facsimile machine; electrical outlets; and privacy for conferences. The Primary Contractor shall also provide, at its own expense, necessary systems and staff support to timely extract and/or download information stored in electronic format, gather requested documents or information, complete forms or questionnaires, and respond to auditor inquiries. The Entity shall cooperate fully with the audit team in furnishing, either in advance or during the course of the audit, any policies, procedures, job descriptions, contracts or other documents or information requested by the audit team.

- Upon issuance of the final report to the Entity, the Entity shall prepare and submit, within 30 calendar days after issuance of the report, a Corrective Action Plan for each observation or finding contained therein. The Corrective Action Plan shall include a brief description of the finding, the specific steps to be taken to correct the situation or specific reasons why corrective action is not necessary, a timetable for performance of the corrective action steps, and a description of the monitoring to be performed to ensure that the steps are taken.

**Record Availability, Retention and Access**

The Primary Contractor shall, at its own expense, make all records available for audit, review or evaluation by the Commonwealth, its designated representatives or federal agencies. Access shall be provided either on-site, during normal business hours, or through the mail. During the contract and record retention period, these records shall be available at the Primary Contractor’s chosen location, subject to approval of the Commonwealth. All records to be sent by mail shall be sent to the requesting entity within 15 calendar days of such request and at no expense to the requesting entity. Such requests made by the Commonwealth shall not be unreasonable.

The Primary Contractor shall maintain books, records, documents, and other evidence pertaining to all revenues, expenditures and other financial activity pursuant to this agreement as well as all required programmatic activity and data pursuant to this agreement. Records other than medical records may be kept in an original paper state or preserved on micro media or electronic format. Medical records shall be maintained in a format acceptable by the Department. These books, records, documents and other evidence shall be available for review, audit or evaluation by authorized Commonwealth personnel or their representatives during the contract period and five (5) years thereafter, except if an audit is in progress or audit findings are yet unresolved, in which case records shall be kept until all tasks are completed.

**Audits of Subcontractors**

The Primary Contractor shall include in Prime subcontract agreements clauses, which reflect the above provisions relative to “Annual Contract Audits”, “Annual Entity-
Wide Financial Audits”, “Other Financial and Performance Audits” and “Record Availability, Retention, and Access”.

The Primary Contractor shall include in all contract agreements with other subcontractors or providers clauses, which reflect the above provisions relative to "Other Financial and Performance Audits" and "Record Availability, Retention, and Access".
HEALTHCHOICES BEHAVIORAL HEALTH PROGRAM
Program Standards and Requirements

Appendix X
HealthChoices Category/Program
Status Coverage Chart

Updated Coverage Chart at:
http://dpwintra.dpw.state.pa.us/HealthChoices/custom/program/recipcover/hcbp_mc_cat.asp

Attachment: PROMISe Managed Care Payment System Table for HealthChoices. Access at:
http://dpwintra.dpw.state.pa.us/HEALTHCHOICES/custom/program/cappay/cappay.asp
(Overviews/General Information)
HEALTHCHOICES BEHAVIORAL HEALTH
PROGRAM
Program Standards and Requirements

Appendix Y

HealthChoices Behavioral Health Services
Reporting Classification Chart (BHSRCC)

“To access the current version of the HealthChoices BHSRCC, visit Intranet site):
http://dpwintra.dpw.state.pa.us/OMHSAS/news/sysnews.asp
Scroll down and click on HealthChoices BHSRCC”.
HealthChoices Supplemental Services and Out-of Network Provider Enrollment for Providers, Counties and Behavioral Health Managed Care Organizations

1. The HealthChoices enrollment process for supplemental service providers begins when a county or Behavioral Health Managed Care Organization (BH-MCO) identifies a service need and credentials and contracts with a provider. The following steps are included in this process:

   A. The county/BH-MCO identifies the need for a supplemental service(s) and an appropriate provider (or providers) to deliver the supplemental service(s).

   B. The county/BH-MCO works directly with the Provider(s) to make application for supplemental services or for an out-of-network Provider.

   C. The Provider(s), with assistance from the county/BH-MCO, completes an enrollment application. The enrollment application includes:

      - HealthChoices Supplemental Services Provider Enrollment Application;
      - Provider Agreement for Outpatient Providers;
      - Ownership or Control Interest Form;
      - Document Generated by the Federal IRS listing name and FEIN or SSN;
      - Supplemental Service Description (where applicable);
      - BH-MCO Attestation Form;
      - OMHSAS Field Office Attestation Form (where applicable);

   D. There are two categories of Supplemental Services which require a supplemental service description (SSD) tailored to describe the provider-specific information. They are “standard” and “newly proposed.”

      The “standard” HealthChoices Supplemental Services which require the submission of a Supplemental Service Description (SSD) with the provider enrollment application include:

      - BSU Diagnostic Assessment
      - Drug and Alcohol Intervention
      - Drug and Alcohol Intensive Case Management
      - Drug and Alcohol Resource Coordination
      - Drug and Alcohol Level of Care Assessment

      A “newly proposed” HealthChoices Supplemental Service should fall into one of the 3 categories listed below:

      - Community Treatment Team
      - Community Mental Health Services, Other
      - Drug and Alcohol Services, Other

Commonwealth of Pennsylvania
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OMHSAS reviewers will ensure the SSD is consistent with the service requirements, and completed to describe the service as it is proposed to be delivered by the provider. Service descriptions that are incomplete or do not reflect provider-specific information will be returned to the County/BH-MCO.

A Service Description must be completed for each requested supplemental service. The Enrollment Form identifies standard (i.e., existing Supplemental Services). Whether the county/BH-MCO is requesting one of these standard services or a brand new service not included on the form, a Service Description Form must be completed. The county/BH-MCO needs to review the Office of Mental Health and Substance Abuse Services’ (OMHSAS) list of Supplemental Services service descriptions, which have standard descriptions, staff qualifications, expected outcomes, and other information to determine if the particular service being considered is included.

If the supplemental service is not on the standard supplemental services list, the county/BH-MCO assists the provider to develop a new supplemental service description.

- **Date of Submission** - list the date the County Contractor/BH-MCO submitted the service description for review and approval;
- **Provider’s Name** - Enter the name of the provider who will be providing this service;
- **Service Name** – Enter the name of the proposed service;
- **County/BH-MCO Name** – enter the name of the County Contractor/BH-MCO who is requesting this new service;
- **Description of Service** - complete this section;
- **Coding for Billing and/or Reporting of Services Rendered** – complete this section;
- **Anticipated Units of Services per Person** - complete this section;
- **Targeted Length of Service** - complete this section;
- **Information About Populations to be Served** - complete the table indicating the population, age ranges, projected numbers, and characteristics;
- **Program Philosophy, Goals, and Objectives** - complete this section;
- **Expected Outcomes** - complete this section;
- **Clinical Staffing Patterns** – complete this section;
- **Cost-Benefit Analysis** - complete this section.

E. The county/BH-MCO reviews the enrollment application for accuracy and completeness and completes the actions to credential the provider.

F. If the original or modified enrollment application is accepted and is complete, the Appropriate entity signs the Attestation Form and forwards the enrollment application to the OMHSAS Field Office – when applicable.

G. OMHSAS Field Office (when applicable) - will review the enrollment application for completeness and for determination of the desire to include the supplemental services provider and submit the new service description for review and approval through the Service System Review Committee (SSRC). After approval is received, the Field Office
representative signs the Field Office Attestation Form and secures it to the front of the enrolment application.

H. OMHSAS has delegated the approval of OON providers to the County/BH-MCO. It is the BH-MCO’s responsibility to enter into a written agreement with an OON provider, and to report person level encounters for the usage of OON providers. Out-of-network providers are not entered into the PROMISE™ system. Consideration should be given to bringing frequently-used OON providers into the BH-MCO’s network to ensure inclusion in the BH-MCO’s quality management review.
HealthChoices Supplemental Services and Out-of Network Provider Enrollment for Providers, Counties and Behavioral Health Managed Care Organizations

2. The HealthChoices enrollment process for supplemental service providers begins when a county or Behavioral Health Managed Care Organization (BH-MCO) identifies a service need and credentials and contracts with a provider. The following steps are included in this process:

I. The county/BH-MCO identifies the need for a supplemental service(s) and an appropriate provider (or providers) to deliver the supplemental service(s).

J. The county/BH-MCO works directly with the Provider(s) to make application for supplemental services or for an out-of-network Provider.

K. The Provider(s), with assistance from the county/BH-MCO, completes an enrollment application. The enrollment application includes:
   - HealthChoices Supplemental Services Provider Enrollment Application;
   - Provider Agreement for Outpatient Providers;
   - Ownership or Control Interest Form;
   - Document Generated by the Federal IRS listing name and FEIN or SSN;
   - Supplemental Service Description (where applicable);
   - BH-MCO Attestation Form;
   - OMHSAS Field Office Attestation Form (where applicable);

L. There are two categories of Supplemental Services which require a supplemental service description (SSD) tailored to describe the provider-specific information. They are “standard” and “newly proposed.”

The “standard” HealthChoices Supplemental Services which require the submission of a Supplemental Service Description (SSD) with the provider enrollment application include:

- BSU Diagnostic Assessment
- Drug and Alcohol Intervention
- Drug and Alcohol Intensive Case Management
- Drug and Alcohol Resource Coordination
- Drug and Alcohol Level of Care Assessment

A “newly proposed” HealthChoices Supplemental Service should fall into one of the 3 categories listed below:

- Community Treatment Team
- Community Mental Health Services, Other
- Drug and Alcohol Services, Other
OMHSAS reviewers will ensure the SSD is consistent with the service requirements, and completed to describe the service as it is proposed to be delivered by the provider. Service descriptions that are incomplete or do not reflect provider-specific information will be returned to the County/BH-MCO.

A Service Description must be completed for each requested supplemental service. The Enrollment Form identifies standard (i.e., existing Supplemental Services). Whether the county/BH-MCO is requesting one of these standard services or a brand new service not included on the form, a Service Description Form must be completed. The county/BH-MCO needs to review the Office of Mental Health and Substance Abuse Services’ (OMHSAS) list of Supplemental Services service descriptions, which have standard descriptions, staff qualifications, expected outcomes, and other information to determine if the particular service being considered is included.

If the supplemental service is not on the standard supplemental services list, the county/BH-MCO assists the provider to develop a new supplemental service description.

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- **Provider's Name** - Enter the name of the provider who will be providing this service;
- **Service Name** – Enter the name of the proposed service;
- **County/BH-MCO Name** – enter the name of the County Contractor/BH-MCO who is requesting this new service;
- **Description of Service** - complete this section;
- **Coding for Billing and/or Reporting of Services Rendered** – complete this section;
- **Anticipated Units of Services per Person** - complete this section;
- **Targeted Length of Service** - complete this section;
- **Information About Populations to be Served** - complete the table indicating the population, age ranges, projected numbers, and characteristics;
- **Program Philosophy, Goals, and Objectives** - complete this section;
- **Expected Outcomes** - complete this section;
- **Clinical Staffing Patterns** – complete this section;
- **Cost-Benefit Analysis** - complete this section.

M. The county/BH-MCO reviews the enrollment application for accuracy and completeness and completes the actions to credential the provider.

N. If the original or modified enrollment application is accepted and is complete, the Appropriate entity signs the Attestation Form and forwards the enrollment application to the OMHSAS Field Office – when applicable.
O. OMHSAS Field Office (when applicable) - will review the enrollment application for completeness and for determination of the desire to include the supplemental services provider and submit the new service description for review and approval through the Service System Review Committee (SSRC). After approval is received, the Field Office representative signs the Field Office Attestation Form and secures it to the front of the enrollment application.

P. OMHSAS has delegated the approval of OON providers to the County/BH-MCO. It is the BH-MCO’s responsibility to enter into a written agreement with an OON provider, and to report person level encounters for the usage of OON providers. Out-of-network providers are not entered into the PROMISe™ system. Consideration should be given to bringing frequently-used OON providers into the BH-MCO’s network to ensure inclusion in the BH-MCO’s quality management review.
PRIOR AUTHORIZATION REQUIREMENTS
FOR PARTICIPATING BEHAVIORAL HEALTH MANAGED CARE
ORGANIZATIONS
IN THE HEALTHCHOICES PROGRAM

A. GENERAL REQUIREMENT

The HealthChoices Behavioral Health Managed Care Organizations (BH-MCO) must submit to the Department a written description of their policies and procedures for the prior authorization of services. The BH-MCO may require prior authorization for any services which require prior authorization in the Medical Assistance Fee-for-Service (FFS) Program. The BH-MCO must notify the Department of the FFS authorized services they will continue to prior authorize and the basis for their determinations of medical necessity. The BH-MCO must request the Department’s approval to require the prior authorization of any services not currently required to be prior authorized under the FFS Program. For each service to be prior authorized, the BH-MCO must submit for the Department’s review and approval the written policies and procedures in accordance with the guidelines described below.

The policies and procedures must:

- be approved by the Department in writing prior to implementation;
- adhere to specifications of the HealthChoices (HC) contract, including applicable policy in Medical Assistance General Regulations, Chapter 1101, the Request For Proposal (RFP) and DPW regulations;
- ensure that physical or behavioral health care is medically necessary and provided in an appropriate, effective, timely, and cost efficient manner;
- adhere to the applicable requirements of The Centers for Medicaid and Medicare Services (CMS) Guidelines for Internal Quality Assurance Programs of Health Maintenance Organizations (HMOs), Health Insuring Organizations (HIOs), and Prepaid Health Plans (PHPs), contracting with Medicaid/Quality Assurance Reform Initiative (QARI);
- include an expedited review process to address those situations when an item or service must be provided on an urgent basis.

Future changes in state and federal law, state and federal regulations, and court cases may require re-evaluation of any previously approved prior authorization proposal. Any deviation from the Department’s approved policies and procedures, including time frames for decisions, is considered to be a change and requires a new request for approval. Failure of the BH-MCO to comply may result in sanctions/or penalties by the Department.

The Department defines prior authorization as any review of a service or request for a service, which must be conducted as a condition of the service being delivered. The term prior authorization is understood to include but is not limited to:

- pre-certification;
- concurrent;
- predetermination;
- any other review for the purpose of authorizing services.

The OMHSAS Prior Authorization Review Panel has the sole responsibility to review and approve all prior authorization proposals from the BH-MCOs.
B. GUIDELINES FOR REVIEW

1. Basic Requirements:
a. If the prior authorization is limited to specific populations, the BH-MCO must identify all populations who will be affected by the proposal for prior authorization.

2. Medical Necessity Requirements:
a. The BH-MCO must describe the process to validate medical necessity for:
   - covered care and services
   - procedures and level of care
   - medical or therapeutic items

b. The BH-MCO must identify the source of the criteria used to review the request for prior authorization of services. The criteria must be consistent with the HC RFP definition of medical necessity.

c. Medical necessity criteria used by BH-MCOs must conform to Appendix T of the HC BH RFP.

For BH-MCOs, if the criteria being used are:
   - purchased and licensed, the BH-MCO must identify the vendor;
   - developed/recommended/endorsed by a national or state health care provider association or society, the BH-MCO must identify the association or society;
   - based on national best practice guidelines, the BH-MCO must identify the source of those guidelines;
   - based on the medical training, qualifications, and experience of the BH-MCO’s Medical Director or other qualified and trained practitioners, the BH-MCO must identify the individuals who will make the medical necessity determinations.

d. The BH-MCO must identify the qualifications of staff who will determine medical necessity. Medical necessity determinations must be made by qualified and trained practitioners with appropriate clinical experience or expertise in treating the member’s condition or disease in accordance with CMS Guidelines, the HC RFPs, and applicable legal settlements.

For children under the age of 21, requests for service will not be denied for lack of medical necessity unless a physician or other health care professional with appropriate clinical experience or expertise in treating the member’s condition or disease determines:
   - that the prescriber did not make a good faith effort to submit a complete request, or
   - that the service or item is not medically necessary, after making a reasonable effort to consult with the prescriber. The reasonable effort to consult must be documented in writing.

3. Administrative Requirements
a. The BH-MCO’s written policies and procedure must demonstrate how the MCO will ensure adequate care management and overall continuity of care among all levels and specialty areas.

b. The BH-MCO’s written policies and procedures must explain how prior authorization data will be incorporated into the BH-MCO’s overall Quality Management Plan.

4. Notification, Grievance, and Appeal Requirements
The MCO must demonstrate how written policies and procedures for requests for prior authorization comply and are integrated with the member...
notification requirements and member grievance and appeal requirements of the HC RFPs.

5. Requirements for Care Management/Care Coordination of Non Prior Authorized Service(s)/Items(s)
For purposes of tracking/care management/identification of certain diagnoses or conditions, and with advance written approval from the Department, the BH-MCO may choose to establish a process or protocol requiring notification prior to service delivery. If this process does not involve any approvals/denials or delays in receiving the service, the BH-MCO must notify providers of this notification requirement. This process may not be administratively cumbersome to providers and members. These situations need not comply with the other prior authorization requirements contained in this Appendix

C. Prior Authorization Review and Decision Process:

1. Timeframes for Notice of Decisions
   a. The Contractor is required to process each request for Prior Authorization (prospective utilization review) of a service and ensure that the member is notified of the decision as expeditiously as the member’s health condition requires, at least verbally within two (2) business days of receiving the request, unless additional information is needed. If no additional information is needed, the BH-MCO must mail written notice of the decision to the Member, the Member’s PCP, and the prescribing Provider within two business days after the decision is made.

   b. If additional information is needed to make the decision, the BH-MCO must request the additional information from the provider within 48 hours of receipt of the request and allow up to 14 days for the provider to submit the additional information.

   c. The BH-MCO must provide written notice to the member that additional information has been requested; on the date the additional information was requested, using the template supplied by the Department as Attachment 1.

   d. If the requested information is provided within 14 days, the BH-MCO must make the determination to approve or deny the service and notify the member orally, within 2 business days of receipt of the additional information. The BH-MCO must mail written notice of the decision to the Member, the Member’s PCP, and the prescribing Provider within two business days after the decision is made. If the additional information is not received within 14 days, the decision to approve or deny the service must be made based upon the available information and the member notified orally within 2 business days after the additional information was to have been received. The BH-MCO must mail written notice of the decision to the Member, the Member’s PCP, and the prescribing Provider within two business days after the decision is made.

   e. In all cases, if the member does not receive written notification of the decision to approve or deny a covered service within twenty-one (21) days from the date the BH-MCO received the request, the service is automatically approved. To satisfy the twenty-one (21) day time period, the Contractor may mail written notice to the Member, the Member’s PCP, and the prescribing Provider on or before the eighteenth (18th) day from the date the request is received. If the notice is not mailed by the eighteenth (18th) day after the request is received, then the BH-MCO must hand deliver the notice to the Member, or the request is automatically authorized (i.e., deemed approved).
f. If the member is currently receiving a requested service, the written notice of denial must be mailed to the member at least ten (10) days prior to the effective date of the denial of authorization for continued services. If probable recipient fraud has been verified, the period of advance notice is shortened to five (5) days. For inpatient services, the effective date on a denial of a continuation of services must be at least one day after the date of the notice. If the member wishes to have services continued as previously approved, the member must file a grievance or request a DPW Fair Hearing before the effective date of the denial as indicated on the denial notice.

g. Advance notice is not required when the agency has factual information confirming the death of a recipient; the agency receives a clear written statement signed by a recipient that s/he no longer wishes to receive services or gives information that requires termination or reduction of services and indicates that s/he understands that termination or reduction must be the result of supplying that information; the recipient has been admitted to an institution where s/he is ineligible under the Contract for further services; the recipient’s whereabouts are unknown and the post office returns agency mail directed to the recipient indicating no forwarding address; the recipient has been accepted for Medicaid services by another State; or a change in the level of medical care is prescribed by the recipient’s physician.

2. Denial of Authorization for Service:

A determination made by a BH-MCO in response to a provider’s or member’s request for authorization for a service of a specific amount, duration and scope which:

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

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

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

3. Authorization Decisions:

A behavioral health denial decision based on medical necessity may be made only by a licensed physician or by a licensed psychologist if the requested service is within the
psychologist’s scope of practice. A licensed psychologist may not determine the medical necessity of requested inpatient services or prescribed medication. For substance abuse services, a decision based on medical necessity must be made by a licensed physician. Any representative of the BH-MCO who determines the medical necessity of a requested service must, in addition to being appropriately licensed, be appropriately experienced to render such a decision.

4. Denial Notice:

A written denial notice must be issued to the member using the notice template provided by the Department as Attachment 2 of this Appendix when a service is denied as defined in Section C.2. of this Appendix.
APPENDIX AA
ATTACHMENT 1
Notice of Request for Additional Information

[Date additional information was requested from Provider]

Member Name
Address
City, State Zip

Member ID: ********

Subject: Request for Additional Information from your Provider

Dear [Member Name]:

[MCO Name] received a request for [describe specific services] from [provider name] on [date received].

In order to decide if this service is medically necessary for you, [MCO Name] has requested the following additional information from your provider by [date]:

[list specific information requested]

[MCO Name] will make a decision on the requested services within 2 business days after receiving the additional information from your provider. [MCO Name] will notify you in writing within 2 business days after making its decision.

If we do not receive the additional information within 14 days, the decision to approve or deny the service will be made, based on the available information. [MCO Name] will notify you in writing within 2 business days after we should have received the additional information.

If you have any questions, please contact Member Services at [phone #].

Sincerely,

[MCO Name]

cc: Prescribing Provider

[The following statement must appear in English, Russian, Cambodian, Vietnamese, Spanish, Chinese, and any other language as required by the contract:]
The information in this notice is available in other languages and formats by calling [Plan’s Member Service’s phone #].
STANDARD DENIAL NOTICE

[DATE] [This MUST be the date the notice is mailed]

RE: [Member's name and DOB]

Dear [Member Name]:

[MCO Name] has reviewed the request for [identify SPECIFIC service] submitted by [prescriber’s name] on behalf of [patient name] on [date]. After physician review, the request for service is:

Denied completely because: [explain in detail every reason for denial in addition to explanation for decision, include specific references to approved criteria, rules or protocols on which decision is based; if denied because of insufficient information, identify all additional information needed to render decision].

This decision will take effect on [date].

To continue getting services
If you have been receiving the service that is being reduced, changed, or denied and you file a complaint, grievance, or request for a fair hearing (see instructions below) that is postmarked or hand-delivered within 10 days of the date on this notice, the service will continue until a decision is made.

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

1) Request Criteria

You may request a copy of the medical necessity criteria or other rules on which the decision was based by sending a written request to:

MCO address
2) File a Complaint or Grievance

You may file a complaint or grievance with [MCO Name] within 45 days from the date you get this notice. Your complaint or grievance will be decided no later than [#] days [MCO: Insert 30 unless plan will be using a shorter timeframe] from when we receive it.

To file a complaint or grievance:

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

  MCO address for filing complaint or grievance

To ask for an early decision

If your doctor or psychologist believes that waiting [#] days [MCO: Insert 30 unless plan will be using a shorter timeframe] to get a decision could harm your health, you may ask that your complaint or grievance be decided more quickly. To do this:

- Call [MCO Name] at [phone #]
- Your doctor or psychologist must fax a letter to [MCO fax #] explaining why taking [#] days [MCO: Insert 30 unless plan will be using a shorter timeframe] to decide your complaint or grievance could harm your health.

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

3) Request a Fair Hearing

You may ask for a fair hearing from the Department of Public Welfare. Your request for a fair hearing must be in writing and must be postmarked within 30 days from the date on this notice. Your request should include the following information:

- Your (the member’s) name, social security number, and date of birth;
- A telephone number where you can be reached during the day;
- Whether you want to have a hearing in person or by telephone;
- A copy of this notice.
Your request for a fair hearing must be sent to the following address:

Department of Public Welfare  
Office of Mental Health and Substance Abuse Services  
Division of Grievances and Appeals  
Beechmont Building # 32  
P.O. Box 2675  
Harrisburg, PA 17105-2675

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

**To ask for an early decision**

If your doctor or psychologist believes that the usual time frame for deciding your request for a fair hearing could harm your health, you may ask that the fair hearing take place more quickly. To do this:

- Call the Department at 1-877-356-5355, or fax your request to 1-717-772-7827;
- Your doctor or psychologist must fax a letter to [1-717-772-7827] explaining why taking the usual amount of time to decide your request for a fair hearing could harm your health. If your doctor or psychologist does not send a letter, your doctor or psychologist must testify at the fair hearing to explain why taking the usual amount of time to decide your request for a fair hearing could harm your health.

The Department will schedule a telephone hearing and notify you of its decision within three business days from when it receives your request.

You have the right to be present either in person or by telephone at the complaint review, grievance review, or fair hearing and to bring a family member, friend, lawyer or other person to help you. If you file a complaint, grievance, or request for a fair hearing, you may request all documents relevant to this decision by sending a written request for the information to the following address:

**Address for records information**

4) **Get a second opinion**

You may get a second opinion from a provider in the [MCO Name] network. Call your PCP or [MCO Name] at [phone #] to get a referral for a second opinion. Asking for a second opinion will not extend the time for filing a complaint, grievance, or request for a fair hearing, and it will not continue any service that you have been receiving.

If you have any questions or need help filing a complaint, grievance or request for a fair hearing, you may call us at [MCO phone #], the legal aid office at 1-800-322-7572
cc: Prescribing Provider

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

The information in this notice is available in other languages and formats by calling [MCO Name] at [phone #].
APPENDIX AA
ATTACHMENT 2b

STANDARD DENIAL NOTICE

[DATE] [This MUST be the date the notice is mailed]

RE: [Member’s name and DOB]

Dear [Member Name]:

[MCO Name] has reviewed the request for [identify SPECIFIC service] submitted by [prescriber's name] on behalf of [patient name] on [date]. After physician review, the request for service is:

Approved other than as requested as follows:  [Describe the level, frequency, and duration of service approved and the level, frequency, and duration of service denied].

The service is not approved as requested because:  [explain in detail every reason for denial in addition to explanation for decision, include specific references to approved criteria, rules or protocols on which decision is based; if denied because of insufficient information, identify all additional information needed to render decision]

This decision will take effect on [date].

To continue getting services
If you have been receiving the service that is being reduced, changed, or denied and you file a complaint, grievance, or request for a fair hearing (see instructions below) that is postmarked or hand-delivered within 10 days of the date on this notice, the service will continue until a decision is made.

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

1) Request Criteria

You may request a copy of the medical necessity criteria or other rules on which the decision was based by sending a written request to:

MCO address

Commonwealth of Pennsylvania
HealthChoices Behavioral Health
2) File a Complaint or Grievance

You may file a complaint or grievance with [MCO Name] within 45 days from the date you get this notice. Your complaint or grievance will be decided no later than [#] days [MCO: Insert 30 unless plan will be using a shorter timeframe] from when we receive it.

To file a complaint or grievance:

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

  MCO address for filing complaint or grievance

To ask for an early decision

If your doctor or psychologist believes that waiting [#] days [MCO: Insert 30 unless plan will be using a shorter timeframe] to get a decision could harm your health, you may ask that your complaint or grievance be decided more quickly. To do this:

- Call [MCO Name] at [phone #]
- Your doctor or psychologist must fax a letter to [MCO fax #] explaining why taking [#] days [MCO: Insert 30 unless plan will be using a shorter timeframe] to decide your complaint or grievance could harm your health.

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

3) Request a Fair Hearing

You may ask for a fair hearing from the Department of Public Welfare. Your request for a fair hearing must be in writing and must be postmarked within 30 days from the date on this notice. Your request should include the following information:

- Your (the member’s) name, social security number, and date of birth;
- A telephone number where you can be reached during the day;
- Whether you want to have a hearing in person or by telephone;
- A copy of this notice.
Your request for a fair hearing must be sent to the following address:

Department of Public Welfare  
Office of Mental Health and Substance Abuse Services  
Division of Grievances and Appeals  
Beechmont Building # 32  
P.O. Box 2675  
Harrisburg, PA 17105-2675

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

**To ask for an early decision**

If your doctor or psychologist believes that the usual time frame for deciding your request for a fair hearing could harm your health, you may ask that the fair hearing take place more quickly. To do this:

- Call the Department at 1-877-356-5355, or fax your request to 1-717-772-7827
- Your doctor or psychologist must fax a letter to [1-717-772-7827] explaining why taking the usual amount of time to decide your request for a fair hearing could harm your health. If your doctor or psychologist does not send a letter, your doctor or psychologist must testify at the fair hearing to explain why taking the usual amount of time to decide your request for a fair hearing could harm your health.

The Department will schedule a telephone hearing and notify you of its decision within three business days from when it receives your request.

You have the right to be present either in person or by telephone at the complaint review, grievance review, or fair hearing and to bring a family member, friend, lawyer or other person to help you.

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

**Address for records information**

4) Get a second opinion

You may get a second opinion from a provider in the [MCO Name] network. Call your PCP or [MCO Name] at [phone #] to get a referral for a second opinion. Asking for a second opinion will not extend the time for filing a complaint, grievance, or request for a fair hearing, and it will not continue any service or item that you have been receiving.

If you have questions or need help filing a complaint, grievance or request for a fair hearing, you may call us at [MCO Phone #], the legal aid office at 1-800-322-7572.
Appendix AA

(www.palegalservices.org), or the Pennsylvania Health Law project at 1-800-274-3258 (www.phlp.org).

cc: Prescribing Provider

[MCO, the following statement must appear in English, Russian, Cambodian, Vietnamese, Spanish, Chinese, and any other language as required by the contract:]

The information contained in this notice is available in other languages and formats by calling [MCO Name] at [phone #].
ATTACHMENT 2c

STANDARD DENIAL NOTICE

[DATE] [This MUST be the date the notice is mailed]

RE: [Member’s name and DOB]

Dear [Member Name]:

[MO Name] has reviewed the request for [identify SPECIFIC service] submitted by [prescriber’s name] on behalf of [patient name] on [date]. After physician review, the request for service is:

Denied as requested, but the following service is approved: [describe the specific service approved, including the level, frequency, and duration of service].

A different service is approved because: [explain in detail every reason for denial in addition to explanation for decision, include specific references to approved criteria, rules or protocols on which decision is based; if denied because of insufficient information, identify all additional information needed to render decision].

This decision will take effect on [date].

To continue getting services
If you have been receiving the service that is being reduced, changed, or denied and you file a complaint, grievance, or request for a fair hearing (see instructions below) that is postmarked or hand-delivered within 10 days of the date on this notice, the service will continue until a decision is made.

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

1) Request Criteria

You may request a copy of the medical necessity criteria or other rules on which the decision was based by sending a written request to:

MCO address
2) File a Complaint or Grievance

You may file a complaint or grievance with [MCO Name] within 45 days from the date you get this notice. Your complaint or grievance will be decided no later than [#] days [MCO: Insert 30 unless plan will be using a shorter timeframe] from when we receive it.

To file a complaint or grievance:

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

  MCO address for filing complaint or grievance

To ask for an early decision

If your doctor or psychologist believes that waiting [#] days [MCO: Insert 30 unless plan will be using a shorter timeframe] to get a decision could harm your health, you may ask that your complaint or grievance be decided more quickly. To do this:

- Call [MCO Name] at [phone #];
- Your doctor or psychologist must fax a letter to [MCO fax #] explaining why taking [#] days [MCO: Insert 30 unless plan will be using a shorter timeframe] to decide your complaint or grievance could harm your health.

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

3) Request a Fair Hearing

You may ask for a fair hearing from the Department of Public Welfare. Your request for a fair hearing must be in writing and must be postmarked within 30 days from the date on this notice. Your request should include the following information:

- Your (the member’s) name, social security number and date of birth;
- A telephone number where you can be reached during the day;
- Whether you want to have a hearing in person or by telephone;
- A copy of this notice.
Your request for a fair hearing must be sent to the following address:

Department of Public Welfare  
Office of Mental Health and Substance Abuse Services  
Division of Grievances and Appeals  
Beechmont Building # 32  
P.O. Box 2675  
Harrisburg, PA 17105-2675

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

**To ask for an early decision**

If your doctor or psychologist believes that the usual time frame for deciding your request for a fair hearing could harm your health, you may ask that the fair hearing take place more quickly. To do this:

- Call the Department at 1-877-356-5355, or fax your request to 1-717-772-7827
- Your doctor or psychologist must fax a letter to 1-717-772-7827 explaining why taking the usual amount of time to decide your request for a fair hearing could harm your health. If your doctor or psychologist does not send a letter, your doctor or psychologist must testify at the fair hearing to explain why taking the usual amount of time to decide your request for a fair hearing could harm your health.

The Department will schedule a telephone hearing and notify you of its decision within three business days from when it receives your request.

You have the right to be present either in person or by telephone at the complaint review, grievance review, or fair hearing and to bring a family member, friend, lawyer or other person to help you.

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

**Address for records information**
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4) Get a second opinion

You may get a second opinion from a provider in the [MCO Name] network. Call your PCP or [MCO Name] at [phone #] to get a referral for a second opinion. Asking for a second opinion will not extend the time for filing a complaint, grievance, or request for a fair hearing, and it will not continue any service that you have been receiving.

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

cc: Prescribing Provider

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

The information contained in this notice is available in other languages and formats by calling [MCO Name] at [phone #].
Appendix BB

REGULATIONS AND POLICIES NOT APPLICABLE TO
HEALTHCHOICES BEHAVIORAL HEALTH PROGRAM

Regulations and policies not applicable to HealthChoices Behavioral Health:

DEPARTMENT OF PUBLIC WELFARE, OFFICE OF MENTAL HEALTH AND
SUBSTANCE ABUSE SERVICES REGULATIONS:

Chapter 4300 County Mental Health and Mental Retardation Fiscal Manual
4300.11
4300.22, 4300.23
4300.25 through 4300.28
4300.41 through 4300.69
4300.81 through 4300.108
4300.111 through 4300.118
4300.131 through 4300.160

Chapter 5221 Mental Health Intensive Case Management
5221.42 (b)(c)(e)(f)(g)
5221.42 (h) ...100% of the approved expenditures for...

OFFICE OF MENTAL HEALTH AND SUBSTANCE ABUSE SERVICES BULLETINS:

OMH-91-19 Transmittal of General Family-Based Mental Health Services
Program Issues
P.2, #7
P.8, #40
P.9, #46,47
P.11,#56,57
P.12,#62
P.13,#67,70
P.14,#72-75
P.16 #1

OMH-92-16 Mental Health Crisis Intervention Services: Implementation
Attachment (A),(B)
Attachment (C) - Payment
Subsections (A-E) - Payment Conditions

OMH-93-10 Mental Health Crisis Intervention Services Guidelines
Issues (1),(2),(3),(4),(8),(9)

00-88-14 Fee Schedule Revisions and Transportation Requirements.
Appendix BB

4000-95-01 Room and Board Payments for Mental Health Only Children in Residential Facilities Which Are Not JCAHO Accredited.

OMH-94-07 180 Day Exception Requests and Invoice Submission Time Frames.

OMH-95-01 Maximum Allowable Rates of Reimbursement for Psychiatric Physicians

OMH-93-09 Resource Coordination: Implementation.
Attachment (A),(B)
Attachment C,- Service Description "The implementation of Resource Coordination services is optional at this time."
Payment

00-88-03 Appropriate Billing for Psychiatric Partial Hospitalization Services and Psychiatric Outpatient Clinic Providers.

OMH-96-04 Procedures for Claiming Federal Reimbursement on Administrative Costs for Medicaid Funded MH Services

OMH-94-09 180 Day Exception Requests of MA Invoices.

OMHSAS-99-02 Maximum Allowable Rates of Reimbursement for Psychiatric Physicians.

OMHSAS-05-01 Cost Settlement Policy and Procedures for Community-Based Medicaid Initiatives.

OMH-96-05 Mental Health Crisis Intervention (MHCI) Fee Schedule.

Administrative Bulletin 7021-03-03 Maximum Rates of State Participation for the County Mental Health/Mental Retardation Programs.

OFFICE OF MENTAL HEALTH AND SUBSTANCE ABUSE SERVICES CONTRACT ADDENDUM:

Chapter 5260 Family Based Mental Health Services for Children and Adolescents
5260.12 (b)(c)(d)
5260.22 (b) (1-7)
5260.45 (e)(f)(g)(i)(j)(k)
5260.46
Note: The above exceptions also apply to the Family-Based Mental Health Services Contract Addendum.
OFFICE OF MEDICAL ASSISTANCE REGULATIONS:

§1151 Inpatient Psychiatric Services
1151.2 Definition of benefit period
1151.21(b) "...for up to 60 days."
1151.34
1151.41(b)(c)(1-2)(d)(i)&(j)
1151.42(a)(c)(d)
1151.43(a)(b)
1151.45(2)(3)
1151.46
1151.48(a)(2-6)(9-16)(18-20)
1151.52
1151.53
1151.54

§1153 Outpatient Psychiatric Services
1153.2 Definitions - Psychiatric Partial Hospitalization:"... a maximum of six hours in a 24 hour period"
1153.14 (2)(3)(9)
1153.52(a)(2) "separate billings for these additional services are not compensable"
1153.53 Limitations on Payment
1153.53a Requests for Waiver of Hour Limits

§1163 Inpatient Drug and Alcohol Services
1163.59
1163.455

§1223 Outpatient Drug and Alcohol Clinic Services
1223.12 Outpatient services "...fee for service."
1223.14 (3)(4)(8)(9)(14)
1223.52(2)(3)(b,4,c)
Separate billings for these interviews are not compensable."
1223.53 Limitations on Payment.

OFFICE OF MEDICAL ASSISTANCE BULLETINS:

01-93-04, 11-93-02, 13-93-02, 41-93-0201-93-04,11-93-02,13-93-02,41-93-02 (a.k.a.,
1165-93-01, 53-93-02)
Payment for Mental Health Services Provided in a Residential Treatment Facility for Eligible Individuals Under 21 Years of Age (applies to JCAHO accredited RTF's only)

Page 1, 1st paragraph
Page 3, Number 4
Section C. Payment for Service
Section D. Request for prior authorization
Section E. How to invoice
Appendix BB

Attachment 6 1150 Waiver request
Attachment 7 Plan of care summary
Attachment 8
Attachment 9

1157-95-01 Mental Health Services Provided in a Non-JCAHO Accredited Residential Facility for Children Under 21 Years of Age

Page 3, A(2)(c)  
A(4)  
Page 4, B, C, "To receive MA reimbursement"  
Page 5, D(1), (2), "Payment will be made only for services prior approved by OMAP"  
Pages 9-14, (A), (B)  
Attachment 2, 3(e), 4(b), 4(e)  
Attachments 5, 6, 7, 8, 9, 11

1165-95-01 Update, JCAHO-Accredited RTF Services

Page 3, The two paragraphs following item C  
Page 4, The last paragraph in item 2, "All admissions are subject..."  
(3. HIO and HMO)  
Page 5, Invoicing for RTF Services  
Page 7, (b and c)  
Page 10, Last sentence on the page

50-96-03 Summer Therapeutic Activities Program

p.3, 3rd paragraph - Reference to the maximum period of "five weeks per calendar year"

p.3, 4th paragraph - The required supporting documentation for the provision of this service does not apply except as required by the MCO of their provider network.

p.6, "Provider Requirements" - #1

pp.7-8, "Payment for Services"

Attachment 7

01-97-16 “Change in Procedure for Requesting and Billing Therapeutic Staff Support (TSS) Services.”

99-97-06 “Accurate Billing for Units of Service Based On Periods of Time.”

01-97-08 “Diagnostic and Psychological Evaluations.”
Appendix BB

Page 2 – “The Department limits these procedure codes to three per child, regardless of the combination of procedure codes…to end of paragraph.”

01-98-19 “Clozapine Support Services.”

Page 3: “Non-covered services” #1, #3, #4 and #5

Page 3: 2nd paragraph “The maximum time period for each order shall not exceed 6 consecutive calendar months.”

Page 5: the entire chart.

99-98-12 “Accurate Billing for Units of Service Based on Periods of Time.”

01-98-10 “Change in Billing Procedure for Behavioral Health Rehabilitation Services.”

Page 2: “Discussion:”

01-00-01 “Expansion of Special Pharmaceutical Benefits Clozaril Program.”

“Background:” 1st Paragraph: “Reimbursement for special pharmaceutical covered drugs is processed… to the end of the third paragraph.”

28-97-06 “Change in Billing Procedures for Psychotherapy.”

28-99-03 “Increased Fees for Outpatient Psychiatric Clinics, Psychiatric Partial Hospitalization Programs and Outpatient Drug and Alcohol Clinics.”

17-99-02 “Procedures for Licensed, Enrolled Mental Retardation Providers to Access and Submit Claims for Outpatient Behavioral Health Services for Individuals Under 21 Years of Age.”

Page 2: Procedures: #2, #3 and #4.

Page 3: Procedure: #5

Page 3: “Procedure for Handling TSS, MT and BSC Services Already Approved Through the 1150 Administrative Waiver Process” #s 1, 2 and 3

1153-95-01: Accessing Outpatient Wraparound Mental Health Services Not Currently Included in the Medical Assistance Program Fee Schedule for Eligible Children Under 21 Years of Age.”
Appendix BB

Page 5(c) (2): 3\textsuperscript{rd} paragraph “A Provider Type 50 …. MA Bulletin.”

Page 4 (d): # and #2

Page 6 (a): #1 (a)

Page 8: #3 (a-c), note, #4, #5(a), #5 (b-e):
- #3 (a-c): “Requesting Exception to the Fee Schedule Rate”
- #4 – Pg. 8: “Notification of decision to approve or reject exemption request – Request for prior approval”
- #5a – Pg. 9: “Decision to approve or reject”
- #5b – Pg. 9: “Written notification of decision”
- #5c – Pg. 9: “Parent/Legal Guardian notice/right to appeal”
- #5d – Pg. 9: “OMAP obtaining additional information within the 21 day period.
- #5e – Pg. 10: “Outpatient service authorization request (MA97)

Page 7-8: #6 (a-e)

Page 8-9: #7 (a-d)

Page 9: #8, #9, B: “Invoicing for Outpatient Wraparound MH Services.”

Attachment #4 “Subcontract Agreement Form.”

Attachment #8 “Request for Expedited Outpatient Behavioral Health Services.”

Attachment #5 “Outpatient Service Authorization Request.”

19-99-04 “Prescriptions Not Received by The Medical Assistance Recipient.”

50-97-03 “Training for EPSDT Expanded Services Providers (Provider Type 50) on Completing Medical Assistance Invoices.”

01-94-01, Outpatient Psychiatric Services for Children Under 21 Years of Age:

1) Page 2 - "Exceptions" - The entire section.

2) Page 3 - "Note" - The entire section.

3) Page 3 - "Reminder" - "...and must be requested from the Office of Medical Assistance through the 1150 waiver process."

4) Page 3, "Requirements and Procedures" - First two paragraphs and number 1.

5) Page 4, Number 6 (a-c).

Commonwealth of Pennsylvania
HealthChoices Behavioral Health
6) Page 5, The MA fee, type services and procedure code

7) Page 7, The MA fee, type services and procedure code

8) Page 9, The MA fee, type services and procedure code

9) Page 10, The MA fee, type services and procedure code

10) Page 12, The Limit, MA fee and "Limit of 3 per year of any combination of the procedure codes listed, type of service and procedure code.

11) Page 13, The Limit, MA fee and "Limit of three per year of any combination of the procedure codes listed above" do not apply, type of service and procedure code.

12) Page 15, Last paragraph - ".. by an 1150 Waiver Request (MA 325)."

THE DEPARTMENT OF HEALTH

Managed care plans are to adhere to all federal and state confidentiality regulations. Adherence must be to the most restrictive regulations.
COMMONWEALTH OF PENNSYLVANIA
DEPARTMENT OF PUBLIC WELFARE
OFFICE OF MENTAL HEALTH AND SUBSTANCE ABUSE SERVICES

Indicators of the Application of Cultural Competence Principles

Cultural Competence has long been an expectation of Pennsylvania's public mental health system. Included in the CASSP and CSP Principles from their inception, cultural competence has historically focused on the four traditionally under served populations of African Americans, Latinos, Asian Americans and Native Americans. More recently, the Office of Mental Health and Substance Abuse Services (OMHSAS) in collaboration with the OMHSAS Cultural Competence Advisory Committee, has taken a broader view of culture. Recognizing the diversity that makes up Pennsylvania's population, Cultural Competence is viewed as inclusive of rural and urban populations, deaf persons, the Amish, groups of recent refugees and clusters of various ethnic populations that are scattered across the Commonwealth, as well as the traditionally identified populations.

The Department in its issuance of the Request for Proposals for the HealthChoices Behavioral Health Program recommends the implementation of Cultural Competence Principles by the Primary Contractor, managed care organization (MCO), its subcontractors and any associated provider networks.

It is the expectation that the implementation of Cultural Competence Principles will result in a system that understands the implications of racial genetics for medication prescription, the differences in help seeking behaviors among various groups and populations and the basis of internal and external stigma related to mental illness, as well as many other barriers to a successful and effective system of care.

PRINCIPLES OF CULTURAL COMPETENCE

1. Principle of the Universality of Ethnicity and Culture. Each person is aging therefore has an age and an age cohort. Each person has: a gender, therefore a gender orientation; abilities, therefore limitations; resources deriving from social constructs, therefore a socioeconomic status; a family history and a legacy that precedes by many generations, therefore an ethnicity and a culture. Identification with others by all these means helps provide a sense of security, belonging and identity. It is this power that drives “Honk if you own a Volkswagen”, or “the wave” at ball parks to work so effectively. Each human encounter in so far as it crosses some boundary of age, belief or practice is, in a sense, a cross-cultural encounter, but we have many bridges to facilitate the crossing. Culture is more than just membership in one’s racial/ethnic group. Culture is a dominant force arising within us from our parental and community upbringing, serving to shape behavior, values, cognition and social institutions.

In the treatment setting, every consumer must be valued within his/her cultural context. Observed differences are to be appreciated as sources of strength and enrichment and resources of reconnection and reintegration. Within each individual’s thinking, personal history and family culture lay the defining attributes of his or her problems and the solutions. The wholeness of the individual is important for a complete evaluation and effective intervention.
2. Principle of Cultural Competence. Treatment, recovery and rehabilitation are more effective when consumers and families fully engage in services that are compatible with their cultural values and world-views. Services that are culturally competent are provided by individuals who have the skills to recognize and respect the behavior, ideas, attitudes, values, beliefs, customs, language, rituals, ceremonies and practices characteristic of a particular group of people (Child and Adolescents Services Systems Program Principles). These skills are used to determine consumer wellness/illness, establish individualized and consumer-driven plans and goals, and to create unique services that are community-based and that integrate natural supports. Cultural competence entails knowledge of consumers’ literacy level, native languages, levels of acculturation and assimilation, and cultural health care beliefs, customs and practices. This body of knowledge guides the service system to increase consumer access to services, and to better design, implement and evaluate services tailored to particular cultural groups. The principle entails vigorous integration of cultural competency principles and standards of practice throughout all levels of behavioral health and substance abuse planning, policy-making, research, evaluation, training and service delivery.

3. Principle of Social and Environmental Influences. Social conditions of poverty, unemployment, discrimination, class rank, immigration status, and isolation greatly impact all aspects of behavioral health care, and contribute deleterious effects and exacerbate symptomatology. Effective service outcomes and quality of life are achieved when the consequences of these social experiences are identified and incorporated into health care planning and service delivery. Services are designed and funded to assure these conditions are not barriers to health care. The service system assures that services do not merely reach the most motivated, educated and socially mobile consumer and family. Service evaluations entail assessing the prevalence of these social conditions in communities, and engaging consumers at the highest risk of illness. Planning processes recognize social conditions and their impact on health and interventions. Professionals avoid assigning fixed diagnoses and characteristics to consumers who are merely responding to stressful social conditions. Service systems adopt no-reject/no-eject standards of practice so that no consumer is rejected or ejected from services because of behavior that is necessary to survive and cope in their social conditions.

4. Principle of Consumer-Driven Services. Consumer-driven services include activities that individualize plans, assessments and services that focus on the priorities, values and goals of consumers and families. Whenever possible, self-help services are created and utilized. Consumer-driven services foster self-determination and choice. Cultural groups are fully engaged when they are actively involved in the design, implementation and evaluation of services that fit their unique worldview. For many cultural groups this entails services that heal the wounds of bias and discrimination. It entails the establishment of linguistically appropriate services, assuring the availability of culturally competent advocates, and educating consumers on the workings of the service system. Consumers, and their families and communities, fully participate in determining the kind of services that best achieve goals for achieving high quality and meaningful lives. Systems of care must have a goal of empowering consumers, during the course of treatment, to be self-determining in all domains of their lives.

5. Principle of a System of Care. Systems of care are consumer-driven, highly coordinated service responses to multiple needs of consumers and families. They require professional willingness to engage, interact and communicate in effective partnerships with culturally diverse populations, and to encourage and value consumers’ active role in the service planning process. In a system of care services focus on all domains of consumers’ lives (mental health, education, medical, housing, social rehabilitation, employment) and integrate health care needs into a single coordinated plan of services that is individualized and culturally relevant. Services are
community-based, involve natural supports, strength-based, and are least restrictive. Cultural and non-traditional ways of healing are integrated in case management and treatment/rehabilitation plans. All planning processes are consumer-driven and family-focused. Family and community members are engaged and invited into the planning and service delivery processes. This entails planning meetings that are community-based and are convenient to consumer availability. These strength-based, comprehensive plans are designed to enhance consumers achieving high quality and meaningful lives.

6. Principle of Access. Access occurs when cultural groups perceive that services are relevant to their life experience and world-view, and use them. Linguistic, geographic and cultural barriers to services are identified and removed. Service systems use culturally relevant media to inform and educate cultural groups, and the general public, about services and supports. Full access to services is determined by evaluating both the use of services by cultural groups as compared to the general population, and by evaluating the prevalence of concerns and problems in specific cultural communities. Increasing access results in less use of crisis and emergency services. Problems and concerns are identified early, and prevention and support services reduce the severity and prevalence of chronic illnesses. This principle entails identifying and overcoming transportation, poverty and community safety barriers to services. Whenever possible, services are community-based.

7. Principle of Quality of Life Outcomes. Consumers and families evaluate outcomes of services, and the service system, by their ability to enhance and improve quality of life. Quality of life is achieved when consumers reach and accomplish self-defined meaningful life goals. It involves having meaningful social roles within family and community. It involves consumer empowerment and self-determination to make decisions in all domains of their life. Case management and treatment/rehabilitation plans encompass all domains of consumers’ lives to foster growth and development of necessary personal, social, employment and interpersonal skills to achieve fulfillment and wellbeing. Holistic approaches to health care are essential to assure consumers have a high quality of life.

8. Principle of Managed and Integrated Health Care. Costs of public health care are best managed and contained by providing high quality, effective mental health and substance abuse services tailored to consumers and family culture that integrate and coordinate medical, mental health and substance abuse. In this way, consumer engagement may be maximized, and use of more costly emergency services reduced. Primary health care that engages consumers in preventative health care throughout life development reduces costs and improves the overall health of our communities. Integrating physical and emotional health in assessments, plans and services is essential. The service system emphasizes managing care, and not dollars, by assuring consumers are in least-restrictive treatment settings, and gain access to services early. Prevention is a key goal for managed and integrated systems of care. Prevention includes community education about mental illness, substance abuse, family support services, early identification programs and services, and social marketing campaigns to de-stigmatize mental illness. Prevention and early intervention necessitate behavioral health providers to link with physical health care providers and other community-based services. Assuring a high quality of life for consumers is considered an important aspect of prevention. Subsequently, increasing community employment and job skill training are examples of prevention activities.

9. Principle of Data/Evaluated Driven Systems of Care. Traditional ways of collecting information, and planning and evaluating services, do not reach isolated and high-risk populations. Many existing information systems and planning processes do not attain information about communities, and only focus on those currently and traditionally served.
Assuring services are culturally competent requires engaging communities to gather information about the prevalence of problems, stressful social conditions, substance abuse and mental illness. Data and findings are always interpreted in the context of each cultural community, and not merely compared to the general population as a normative standard. Individual, family and community outcomes are projected as an aspect of county planning processes. Storytelling, testimonials, and oral accounts of needs and satisfaction are considered data sources. In consumer-driven systems of care, feedback by consumers regarding service satisfaction and outcome are most important data for future planning and system re-design. Outcomes and effectiveness of services are evaluated based on the prevalence of illness and problems in the cultural community, and not merely by comparing rates to the general population. This principle assures professionals and community members avoid using the dominant culture as a normative standard of health. Rates of illness are impacted by cultural, social and historic differences among social groups. Behavior that seems aberrant to the general population may be healthy responses to social conditions. Services target the unique patterns of illness and problems in cultural communities, and develop unique community-based health standards by which to evaluate services.

10. Principle of Least Restrictive/Least Intrusive Services. Services occur in settings that are the most appropriate and natural for the consumer and family, and are the least restrictive and intrusive in impacting the right of self-determination by consumers, families and communities. (CASSP) This means community-based, in-home and natural support services being first utilized, unless there are assessed indications that other services are necessary to assure outcomes and quality of life. Justification for more restrictive and intrusive services occurs at all levels of planning: initial assessment through discharge. Consumer, family and community members are included in determining the least restrictive/intrusive setting and service. As minorities are over-represented in restrictive settings, and as recipients of behavioral controlling treatments, service systems regularly collect data and monitor these services. Plans of action are created and implemented when evaluation finds cultural groups are over-represented in restrictive treatments.
Guidelines for the Application of Cultural Competence Principles

Access and Services Authorization

Families and natural supports persons (self-defined family) have access to services in a respectful and welcoming manner. Services are provided in timely, convenient and easily accessible ways. Protocols exist to assure services are available to persons who are disinclined to accept treatment. Bilingual and bicultural providers, and trained interpreters, are available throughout the entire service system. Service availability and determination encompass a holistic rehabilitative approach that includes psychiatric, medical, social, vocational, behavioral, cultural, spiritual, familial and community supports.

Indicators of Guideline Application

1. Persons of diverse cultures and linguistic differences are served based on their preference and actual need.
2. Service systems utilize a variety of formats to disseminate culturally relevant information regarding mental health and addiction services, as well as non-traditional and self-help resources.
3. A written plan guides action that engages and encourages individuals in need of services but who are disinclined to accept treatment.
4. Service systems demonstrate timeliness in member access and authorization of services.
5. Service systems adopt flexible service hours to maximize the availability of services.
6. Service systems authorize cultural-based alternative and complementary treatment approaches that assure consumer engagement, retention and follow-up.
7. Service systems staff and Managed Care Organizations have culturally and linguistically competent staff available 24 hours a day, and 7 days a week.
8. Service agencies have a milieu and physical environment that reflects diversity and the surface cultures of consumers being served.

Measures of Guideline Application

9. Service utilization rates of traditionally under-served and over-represented persons are comparable to the prevalence of illness and problems that occur in the ethnic/cultural group. Cultural/ethnic community residents use behavioral healthcare providers as a community resource for all health concerns. In highly restrictive services, utilization rates are comparable to all other groups in the general population.
10. Service providers have a list available in each facility of culturally and linguistically accessible services.
11. Descriptions of culturally sensitive services and programs are available for consumers in their community and other natural gathering places. Providers develop ethnically/culturally relevant ways of disseminating information that make services widely known in ethnic/cultural communities.
12. Educational and information materials reflect the languages and cultures of persons served.
13. Service systems track the utilization rates of persons who are traditionally disinclined to accept treatment. These systems develop studies on the prevalence of illness and problems in ethnic/cultural communities, and identify the barriers they experience to seeking help. Service systems create correction plans, implements actions, and measure
improvements in help-seeking behavior. Indicators of positive impact include: decrease use of emergency rooms, decrease use of crisis services, increase number and use of advocacy groups, decrease arrest rates of persistently ill consumers, increase referral follow-through rates, and increase voluntary use of self-help and prevention services.

16. Service systems track the increase in availability of services. Availability is indicated by services occurring in settings that various ethnic/cultural groups define as comfortable, appropriate, consistent with their values and worldview, and complementary to their natural healing practices.

17. Service systems track the number and type of alternative and complimentary treatment approaches for various cultural groups. High performance is indicated by an integration of traditional healing practices and treatment approaches with professional models that capture the best of each.

18. Service systems determine consumer satisfaction and increase access because of flexible hours, and alternative and complimentary treatment.

19. Waiting area and offices display magazines, art, music, etc., reflective of the cultures and ethnic groups of consumers being served.

Case Management

Case management shall be central to the operation of the multidisciplinary team. It reflects an understanding and appreciation of the values, norms and beliefs of consumers’ cultures, and knowledge of resources in their communities. Case management recognizes the unique mental health/substance abuse issues associated with the consumer’s economic conditions, social class, and experience of bias, discrimination and racism. Case management recognizes the impact of these issues on behavioral health, and takes these into account in considering the cultural appropriateness of all services that are coordinated and managed. Case management advocates for the consumer, assures consumers are knowledgeable of service options, and assists consumers in making best choices. These activities are individualized to the diverse culture, race, ethnicity and language differences. Case management services participate in ongoing assessments of their service system to determine and assure that they are responsive to diverse consumer needs and experiences.

Indicators of Guideline Application

1. Consumers have access to a comprehensive array of services that are compatible with their culture.

2. Consumers receive culturally competent services that are coordinated within multiple domains, i.e., vocational, social, educational and residential settings.

3. Culturally competent services are continually created and adapted to meet the needs of consumers.

Measures of Guideline Application

1. Service utilization data and information are utilized to increase enrollment of underserved populations. Ethnic cultural group enrollment in less restrictive services (outpatient, self-help, social rehabilitation) increases to levels comparable to the general population. Enrollment in restrictive services (inpatient, involuntary commitments, jail treatment settings, court-ordered outpatient) decreases to levels comparable to the general population.

2. Service systems document culturally competent services and resources received by consumers. Individual and family definitions of culture, ethnicity and need guide the
development of indicators for high levels of performance. Merely providing culturally competent services to person of color, or persons who are perceived different than mainstream culture, is not an indicator of compliance.

3. Service systems document family and community contacts/visits, and visit locations. High levels of compliance are system-wide supports for family and community member advocacy and full participation in all aspects of case planning. Parent led support/advocacy groups naturally develop and influence decision-making throughout the delivery system. Merely having record of family member attendance at meetings is not an indicator of compliance.

4. Service systems document that consumers have improved relationships within family, and within social networks of their cultural group. High levels of compliance are indicated by fewer consumers estranged from their natural family, and high levels of family involvement in planning processes and support services.

5. Service systems document that consumers achieve the greatest degree of independence and self-determination. The use of restrictive services by ethnic/cultural groups is reviewed annually for use in comparison to the general population. Each provider implements a plan of correction until usage levels are comparable. Restrictive care includes the use of psychotropic treatment without complementary clinical/rehabilitative services.

6. Revised care plans and services demonstrate inclusion of ethnic, social and cultural factors.

7. Cultural competence training for all case managers is incorporated in reviews for regulation compliance. Training is designed for the ethnic/cultural groups that exist in the service community. Levels of training and competence are established.

8. Community resources and natural supports are included in all care plans.

Treatment/Rehabilitation Plan

All persons served receive a treatment/rehabilitation plan that is holistic, and incorporates the consumer’s choice of attainable goals, culturally compatible treatment modalities, and consumer driven alternative strategies of health care. These strategies include the use of family, community supports, spiritual leaders and folk healers. Plans are consumer driven, based on their individual strengths, and developed within the context of family and social networks so as to create a consumer-professional partnership. Plans are formulated and reviewed by culturally competent professionals and culturally competent consultants in full collaboration with consumers and families.

Indicators of Guideline Application

1. Identification and creation of culturally relevant goals.
2. Use of culturally compatible modalities and alternative strategies.
3. Consumers and families fully participate and share in the development of goals and wishes, and express satisfaction with their role and participation.

Measures of Guideline application

1. Plans document consumer wishes and goals. These may be related to employment, education, training, personal appearance, health, family relationships, social activities and social relationships. Plans specify ethnically/culturally relevant wishes and goals.
2. Service systems document consumer and family satisfaction with their participation in the treatment/rehabilitation planning process. Low levels of satisfaction trigger plans of correction, implementation of these plans, and re-evaluation.
3. Plans outline cultural relevant treatment and rehabilitation modalities and strategies.
4. Service systems document that professionals are trained in the development of culturally competent treatment and rehabilitation plans. Training, staff skills, and cultural competence will be greatly impacted by the kinds of ethnic/cultural groups in the service area. A high level of performance is indicated by professional standards for competence for each ethnic/cultural group, and not a generalized declaration of professional competence due to completion of a generalized cultural competence training program.

5. Service systems create all written planning materials and documents in plain and simple text that is readily comprehended by consumers and families.

Recovery and Self-Help

Recovery and self-help groups are readily available, and function as an integral part of a seamless continuum of care. Recovery and self-help groups are culturally diverse and culturally compatible, incorporating consumer-driven goals and objectives that are oriented toward rehabilitation and recovery outcomes. Culturally competent providers and consumers in recovery are enlisted as consultants and educators to assist in the creative development of alternative treatment services, models and supports that are compatible with the lifestyles, values and beliefs of various cultures.

Indicators of Guideline Application

1. Services are accessible and available in a variety of settings, including churches, neighborhood facilities, and consumer residences.
2. Service system creates more integrated, culturally and linguistically specific, recovery groups.
3. Services are readily accessible and available in a variety of settings.
4. Community groups, consumers in recovery and other natural supports groups are recruited in the development and design of recovery and self-help service models.

Measures of Guideline Application

1. Service systems document the increase use of recovery and self-help programs by consumers of various cultural groups. As families and communities are engaged in services, the number of ethnic/cultural self-help, advocacy and recovery groups increase. A high-level of self-determination which is emphasized while maintaining inclusion in the service system is a strong performance indicator.
2. Service systems document an increase in the variety of ethnically/culturally relevant recovery and self-help programs. The array of ethnic/cultural services increases as the service system better engages and empowers families and communities.
3. Providers make available to consumers a list of recovery and self-help services in locations that are readily accessible to consumers and their communities.

Cultural Assessment

A cultural assessment is conducted by competent staff for each consumer, and within the context of the consumer's culture, family and community. The assessment is individualized, multidimensional and strength-focused. The components of the assessment include functional, psychiatric, social status, cultural milieu, social and economic stresses, discrimination, and family supports.
Indicators of Guideline Application

1. A cultural assessment is the basis for a culturally relevant diagnosis, goals and rehabilitation/treatment plans.
2. A cultural assessment tool and guide exists to determine cultural factors that impact treatment/rehabilitation services.
3. On-going cultural assessment occurs at each phase of treatment and rehabilitation. Cultural assessment includes consumer preferences, and differentiates pathology from cultural factors.

Measures of Guideline Application

1. Bilingual staff is available to assess consumers in their language of preference.
2. Qualified cultural interpreters are utilized when bilingual staff is not available.
3. Psychological assessment and measurement tools are culturally valid and reliable, and administered, scored and interpreted by culturally competent providers.
4. All consumers receive an ethnic/cultural assessment. The rates of chronic, anti-social and other serious diagnoses for all ethnic/cultural groups are comparable to the general population. The use of restrictive treatments for all ethnic/cultural groups is comparable to the general population.
5. Providers document the inclusion of family members and significant community support persons in the initial and on-going assessment process. An indicator of high level performance is community-based, including community/family/consumer driven assessments and service planning.
6. The assessment includes cultural factors that are important to the treatment process. These factors include, but are not limited to, the following:
   a) Preferred language.
   b) History of indigenous/immigration/migration/generation behavior patterns.
   c) Degree of acculturation and adaptation.
   d) Cultural, social, economic and discrimination stresses and traumas.
   e) Learning and cognitive styles.
   f) Family organization and relational roles.
   g) Extent of family support.
   h) Social network composition.
   i) Ethnic identity
   j) Consumer’s perception/belief of presenting problems and explanations for symptoms.
   k) Consumer’s belief systems regarding mental illness/substance abuse.
   l) Sexual identity and sex role orientation in cultural group.
   m) Coping strategies utilized within the cultural group.
   n) Help-seeking behavior.
   o) Previous attempts at relieving, managing and treating symptoms. (Including healers, traditional medicine, etc.)

To protect the rights and confidentiality of consumers, family and friends are not to be used as language/communication interpreters. These persons are welcomed to participate in the treatment planning process.

Communication Style and Linguistic Support
Consumers, families and other support persons receive cross-cultural and communication-support, such as assistive devices and qualified language interpreters and professionals interpreters. These supports are available at each entry point to services, and continue throughout the consumer’s treatment and rehabilitation services. Staff is knowledgeable in the use of professional interpreters, and telephone interpreters are only utilized in emergencies. Orally presented information, and written materials and documents, are translated in the consumer’s preferred language. Examples include consumer rights information, orientation packets, consent forms and treatment plans.

**Indicators of Guideline Application**
1. Consumers and family members receive cross-cultural communication supports at each point of entry in the service system.
2. Consumers and family members report their level of satisfaction with communication supports.
3. Staff is knowledgeable in the use of communication supports.
4. Interpreters are qualified, competent, and demonstrate knowledge of consumers’ cultural experience; including deaf, hard of hearing, and deaf blind.
5. Communication supports demonstrate culturally accurate assessments, treatment/rehabilitation plans and service delivery.
6. Cross-cultural communication supports are available and comparable across all consumer cultural groups.

**Measures of Guideline Application**
1. Service systems increase the number of bicultural and bilingual staff, competent in the communication styles of the diverse cultures of consumers, as to minimize the use of interpreters.
2. A resource list of trained and qualified interpreters, updated annually, is maintained by facilities. Consumers and families are aware of the availability of interpreters through service advertisement efforts.
3. Certified qualified interpreters are available within 24-hour notice for routine situations, and within one hour for emergencies.
4. Service systems document consumer satisfaction of communication supports. A plan of correction and implemented action occur when consumer are not satisfied with communication supports.
5. Service systems document that staff receives training in the use of interpreters.
6. Service systems document that interpreters are certified (sign language interpreters), qualified and competent.
7. Service systems document that communication supports are comparable across consumer cultural groups.

**Continuum of Service/Discharge Planning**

Service and discharge planning begin at all points of entry along the continuum of services. It is provided by culturally competent providers in cooperation and collaboration with consumer, family, community support persons, and persons in consumer social networks. Service and discharge planning are done consistent with the values, norms and beliefs of consumers. These plans incorporate pertinent information from the cultural assessment, and include service/discharge factors that are culturally relevant and important to the consumer’s recovery.
Plans identify personal, family, social environment, social network and cultural resources necessary for treatment and rehabilitation services that assure consumer recovery.

**Indicators of Guideline application**

1. A culturally compatible continuum of service/discharge plan is developed for each consumer.
2. Plans include clear goals and recommendations for necessary services in the post-discharge continuum of care.
3. Plans use the resources of family and social networks.
4. Plans assure consumers remain connected to treatment/rehabilitation recovery services as needed.

**Measures of Guideline Application**

1. Service systems document service/discharge plans involve consumers, family members, community resources, and social supports. High levels of performance occur when family and community members are partnered with consumers and driving the planning process. Family and community members merely attending meetings is not an indicator of adequate performance.
2. Plan lists the resources and services utilized, and consumer accomplishments.
3. Consumer values, norms and beliefs are documented in the plan and drive the planning process.
4. Service systems document future treatment and rehabilitation goals.
5. Service systems document recommendations for the use of consumer, family, social networks and cultural resources in any subsequent treatment/rehabilitation setting.

**Quality of Life**

Quality of life is achieved through a holistic integration of symptom reduction, family and community support, and spirituality, which maximizes the consumer’s sense of personal meaning, fulfillment and well-being. Assuring consumers have a high quality of life enhances recovery. Quality of life is determined by an individual’s freedom to make choices and enjoy the benefits of those choices.

**Indicators of Guideline Application**

1. Service system develops ways of assessing the quality of life for all consumers.
2. Consumers report improved quality of life through services.
3. Consumers direct the recovery planning and treatment process.

**Measures of Guideline Application**

1. Assessments, treatment/rehabilitation plans and services incorporate the goals, preferences, hopes and wishes of consumers.
2. Service systems compile, collect and interpret quality of life measures.
3. Service systems utilize quality of life information and data to evaluate and improve service delivery, and to develop new services.

**Services Accommodations**
Programs respond to the needs of individuals and families from different cultures by ensuring the best *cultural fit* between persons’ beliefs, their cultural/behavioral styles and the services provided. Based on information derived from cultural assessments (re: family styles, gender roles, sexual orientation, spirituality/religion, worldview, traditions, work ethic, communication styles, leadership and organizational styles cognitive and learning styles) services, interventions, modalities, and strategies are adapted or developed in order to better promote program engagement, treatment/rehabilitation, and retention. Particular consideration is given to the visible presence of different cultures throughout the program’s physical environment. Culturally competent strategies are utilized to attract and recruit consumers and families. Varied induction methods that orient persons to types of services offered as well as how to utilize and participate in these services are available. Service outcome expectations as well as clarification of both staff and consumer roles and responsibilities are reviewed.

**Indicators of Guideline Application**

1. Program services interventions and modalities are modified and developed in order to enhance consumer engagement, treatment/rehabilitation, or retention.
2. Varied program induction methods are available.
3. Varied outreach and recruitment strategies are utilized.

**Measures of Guideline Application**

1. Information derived from cultural assessments is collated and summarized.
2. Programmatic needs to ensure responsiveness to persons from different cultures have been identified and prioritized.
3. Selected, prioritized services, interventions and modalities that have been modified are documented.
4. Examples of varied culturally compatible, program outreach and recruitment strategies are documented.
5. Examples of varied program induction methods utilized to engage consumers and families from different cultures are documented.
### Library/Internet Desk Reference Chart
#### HealthChoices Behavioral Health Program

<table>
<thead>
<tr>
<th>#</th>
<th>Document</th>
<th>Library</th>
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<tr>
<td><strong>Physical Health Request For Proposals: (RFPs)</strong></td>
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<td>HealthChoices Northeast Physical Health RFP #23-01</td>
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<td>HC Physical Health Agreement, Effective 7/1/05</td>
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**Program Standards and Requirements: (PS&Rs)**

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**Behavioral Health Data Books**

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**Library/Internet Desk Reference Chart**  
**HealthChoices Behavioral Health Program**

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| 2. | PA Code Title 55, Chapter 4210; Description of Services and Service Areas.  
   http://www.pacode.com/secure/data/055/chapter4210/chap4210toc.html | ✔️ | ✔️ |
| 3. | PA Code Title 55, Chapter 5200; Psychiatric Outpatient Clinic  
   http://www.pacode.com/secure/data/055/chapter5200/chap5200toc.html | ✔️ | ✔️ |
| 4. | Pa. Code Title 55, Chapter 20; Licensure of Approval of Facilities & Agencies  
   http://www.pacode.com/secure/data/055/chapter20/chap20toc.html | ✔️ | ✔️ |
| 5. | PA Code Title 55, Chapter 5210; Partial Hospitalization  
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| 6. | PA Code Title 55, Chapter 5221; Mental Health Intensive Case Management.  
   http://www.pacode.com/secure/data/055/chapter5221/chap5221toc.html | ✔️ | ✔️ |
| 7. | PA Code Title 55, Chapter 5310; Community Residential Rehabilitation Services for Mentally Ill.  
   http://www.pacode.com/secure/data/055/chapter5310/chap5310toc.html | ✔️ | ✔️ |
| 8. | PA Code Title 55, Chapter 5320; Long term Structured Residence  
   http://www.pacode.com/secure/data/055/chapter5320/chap5320toc.html | ✔️ | ✔️ |
| 9. | PA Code Title 55, Chapter 5240; Annex A, Proposed Crisis Intervention Services Regulations. | ✔ | |
| 10. | PA Code Title 55, Chapter 5260; Proposed Family-Based Mental Health Services. | ✔ | |
| 13. | Pennsylvania Child and Adolescent Service System Program | ✔ | CASSP Web |
| 14. | School-Based Mental Health Services Concept Paper (Draft) | ✔ | |
### Library/Internet Desk Reference Chart

#### HealthChoices Behavioral Health Program

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<td><a href="http://www.dsf.health.state.pa.us/health/lib/health/drugandalcohol/CMMumanual_03.pdf">http://www.dsf.health.state.pa.us/health/lib/health/drugandalcohol/CMMumanual_03.pdf</a></td>
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<td>Bulletin #02-96; Confidentiality and Case Management</td>
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<td>Medical Assistance Bulletin #1163-95-01; Revision of Utilization</td>
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### Library/Internet Desk Reference Chart
#### HealthChoices Behavioral Health Program

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<td>Guidelines for Inpatient Hospital Drug and Alcohol Services Under the Medical Assistance Program.</td>
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<td>Service Descriptions (Revised April 1999)</td>
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<td>“Attention Deficit Hyperactivity Disorder and Stimulant Medication”.</td>
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<td>Continuous Quality Improvement in Family-Based Mental Health Services.</td>
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<td>How to Think, Not What to Think (A Cognitive Approach to Prevention of Early High-Risk Behaviors in Children).</td>
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<td>Implementing Comprehensive Classroom-Based Programs for Students with Emotional and Behavioral Problems.</td>
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<td>h.</td>
<td>“A Mental Health Practitioner’s Guide to Positive Behavior Support for Children with Disabilities and Problem Behavior at School”.</td>
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<td>Mental Health Residential Treatment Facilities within the Continuum of Child and Adolescent Mental Health Services.</td>
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<td>A Model for Multi-System Service Planning Meeting.</td>
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<td>“Parent Participation in the Residential Treatment Process”.</td>
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<td>Pennsylvania’s Ideal Child Mental Health System Design (A CASSP Concept Paper).</td>
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<td>Preventing Mental Disorders in School-Age Children: A Review of the Effectiveness of Prevention Programs.</td>
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<td>Putting It Together: Providing Mental Health Services in Early Intervention.</td>
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<td>Residential Services (The Perspective of an African American parent).</td>
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<td>“Therapeutic Staff Support in Professional Practice”.</td>
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<td>To Walk In Troubling Shoes: Another Way to Think About the Challenging Behavior of Children and Adolescents.</td>
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<td>What Makes Wraparound Special: (Understanding and Creating a Unique Experience for Children and Their Families).</td>
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<td>PA Department of Health, Bureau of Drug and Alcohol; Pennsylvania Drug and Alcohol Facility and Services Directory, 2005.</td>
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<td>Child Protective Services Law</td>
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<td>Medical Assistance Transportation: (MATP) <a href="http://matp.pa.gov/">http://matp.pa.gov/</a></td>
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<td>MATP Instructions and Requirements Manual, 2004-2005</td>
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### 43A Sample Documents:

- S-1: Member Handbook (Sample)  
- S-2: Southeast/Southwest Behavioral Health Contracts by County  
- S-3: Southwest Behavioral Health Year 2 Contract Amendments  
- S-4: HealthChoices 96 Performance Outcome Measurement System (POMS Draft)  
- S-6: HealthChoices NE Expansion Model Contract (11/8/05)  

### 43B Sample Documents:

- S-1: Southeast/Southwest County/BH-MCO Letters of Agreement  
- S-2: Changes to BHRS Delivery System, June 2001  
- S-3: HealthChoices SW PH/BH Letter Of Agreement Template  
- S-4: Cross Systems Reference Charts for Children and Adolescents  
- S-6: Benefits and Rights for Older Pennsylvania’s (Booklet, 2000)  

### 43C Most Current Behavioral Health Services Reporting Classification Chart (BHSRCC), July, 22, 2006.  

### 44 Cultural Competency:

A: The Pennsylvania Office of Mental Health and Substance Abuse Services Strategic Plan for Cultural Competence.  

B: Recommended Clinical/Rehabilitation Standards of Practice for Culturally Competent Services in Pennsylvania.  

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**Miscellaneous Information:**

- a. Act 68 – Managed Care Consumer Protection Act (1/1/99)
- b. Provider Type 80 Enrollment
- c. Statewide Mandatory Medicaid Managed Care Summary (October 1997)
- d. HealthChoices “Next Steps” Paper; Top Comment Areas
- e. North Central Zone Discussion Paper (January 2001)
- f. Protocol to Review Formularies
- g. Pro-Children Act of 1994 (Smoking in Children’s Facilities Prohibition)
- h. HealthChoices Behavioral Health Services: Overview, Oversight, Eligible Recipients, Enrollment, Services provided, County Mental Health System, and Drug and Alcohol Service.
- i. POSNet OIS Circuit Ordering & Billing Authorization Form
- j. [OMHSAS QUIC Facts 2010](http://www.PArecovery.org)

| 46 | Department of Health HIV Guidelines for Drug and Alcohol Abuse Treatment Programs in Pennsylvania (1998) |         | ✓ |

**Psychiatric Rehabilitation Services for Adults:**

**Guidelines for the Implementation of Psychiatric Rehabilitation in HealthChoices:**

- a. Medical Necessity Criteria and Standards
- b. US Psychiatric Rehabilitation Association Core Principles and Values. ([USPRA](http://www.PArecovery.org))
- c. Guidelines for requests for Admission, Continued Stay and Discharge (2nd Edition)
- d. Psychiatric Rehabilitation Functional Assessment Tool (2nd Edition)
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<td>Early Warning Care Management Report (Quarterly Monitoring Reports can be accessed and reviewed on the DPW Website: <a href="http://www.dpw.state.pa.us/publications/healthchoicesbehavioralhealthpublications/index.htm">http://www.dpw.state.pa.us/publications/healthchoicesbehavioralhealthpublications/index.htm</a>)</td>
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HEALTHCHOICES BEHAVIORAL HEALTH DEFINITIONS

ACCESS Plus - The Medical Assistance physical health care delivery system which is an Enhanced Primary Care Case Management and Disease Management Program providing services to eligible MA recipients.

Adjudicate - A determination to pay or reject a claim.

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

Agreement – The HealthChoices Behavioral Health Agreement.

Alternative Payment Arrangements (APA) – Refers to any of the various contractual agreements for reimbursement that are not based on a traditional fee-for-service model. Types of arrangements include, but are not limited to the following: Retainer Payments; Case Rate; and Capitation.

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

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

Behavioral Health Residential Treatment Facility – An In-Plan Services mental health or drug and alcohol residential treatment facility.

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

**Behavioral Health (BH) Services Provider** - A Provider, practitioner, or vendor/supplier which contracts with a BH-MCO to provide Behavioral Health Services under the HealthChoices Behavioral Health Program.

**Capitation** - A fee the Department pays periodically to a Primary Contractor for each Member enrolled under an agreement for the provision of covered In-Plan Services, whether or not the Member received the services during the period covered by the fee.

**Care Management/Manager** - see Service Management/Manager.

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

**Clean Claim** – A claim that can be processed without obtaining additional information from the Provider of the service or from a third party. It includes a claim with errors originating in the Primary Contractor’s claims processing computer system, and those originating from human errors. It does not include a claim under review for medical necessity, or a claim that is from a Provider who is under investigation by a governmental agency or the Primary Contractor for fraud or abuse.

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

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

**Complaint** – A dispute or objection filed with the BH-MCO regarding a participating health care Provider or the coverage, operations, or management policies of a BH-MCO, including, but not limited to, 1) a denial because the requested service is not a covered benefit; 2) failure of the BH-MCO to meet the required timeframes for providing a service; 3) failure of the BH-MCO to decide a Complaint or Grievance within the specified timeframes; 4) a denial of payment after a service(s) has been delivered because the service was provided without authorization by a Provider not enrolled in the Pennsylvania Medical Assistance Program; 5) a denial of payment after a service(s) has been delivered because the service is not a covered benefit. The term does not include a Grievance.

**Concurrent Review** - A review conducted by the BH-MCO during a course of treatment to determine whether services should continue as prescribed or should be terminated, changed or altered.
**County Assistance Office** - The county offices of the Department which administer the Medical Assistance program at the local level. Department staff in these offices perform necessary Medical Assistance functions such as determining recipient eligibility.

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

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

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

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

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

**Department/DPW** - The Pennsylvania Department of Public Welfare.

**Department of Public Welfare Fair Hearing** - A hearing conducted by the Department of Public Welfare, Bureau of Hearings and Appeals in response to an appeal by a Member.

**Discretionary Funds (Profit)** - Capitation payments and investment income that are not expended for purchase of services for plan Members (in-plan, supplemental, or cost/effective alternatives), administrative costs, risk and contingency, equity requirements or reinvestment.

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

**Eligibility Verification System (EVS)** - An automated system available to MA Providers and other specified organizations for on-line verification of MA eligibility, MCO enrollment, third party resources, and scope of benefits.
Emergency Medical Condition - A medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in:

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

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

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

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

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

Fee-for-Service (FFS) - Payment by the Department to Providers on a per-service basis for health care services provided to Medical Assistance recipients.

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

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

Gross Receipt Tax (GRT) – a state tax imposed upon the Medicaid revenues of DPW’s Medicaid managed care organizations pursuant to Act 48 of 2009, 72 P.S. §8101.
**Health Care Quality Unit (HCQU)** – Serves as the entity responsible to county mental retardation programs for the overall health status of individual screening services in county mental retardation programs.

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

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

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

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

**HealthChoices Library** - A collection of reference documents and materials, relevant to the HealthChoices program available for use by potential and current contractors.

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

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

**In-Plan Services** - Services which are included in the HC BH Capitation rate and are the payment responsibility of the Primary Contractor.

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

*Joinder* - Local authorities of any county who have joined with the local authorities of any other county to establish a county mental health and mental retardation program, subject to the provisions of the Mental Health and Mental Retardation Act of 1966 (50 P.S. § 4201 (2)), or a drug and alcohol program pursuant to the Pa. Drug and Alcohol Abuse Control Act (71 P.S. § 1690. 101 et. seq.).

*Juvenile Detention Center* - A publicly or privately administered, secure residential placement for:
- Children and adolescents alleged to have committed delinquent acts who are awaiting a court hearing;
- Children and adolescents who have been adjudicated delinquent and are awaiting disposition or awaiting placement; and
- Children and adolescents who have been returned from some other form of disposition and are awaiting a new disposition (e.g., court order regarding custody of child, placement of child, or services to be provided to the child upon discharge from the Juvenile Detention Center).

*Managed Care Organization (MCO)* - An entity which manages the purchase and provision of physical or Behavioral Health Services under the HC Program.

*Medical Necessity* - Clinical determinations to establish a service or benefit which will, or is reasonably expected to:
- prevent the onset of an illness, condition, or disability;
- reduce or ameliorate the physical, mental, behavioral, or developmental effects of an illness, condition, injury, or disability;
- assist the individual to achieve or maintain maximum functional capacity in performing daily activities, taking into account both the functional capacity of the individual and those functional capacities appropriate for individuals of the same age.

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

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

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

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

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

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

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

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

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

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

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

**Prepaid Inpatient Health Plan (PIHP)** - An entity that provides medical services to enrolled recipients, under contract with the Medicaid agency and on the basis of prepaid Capitation fees, but is not subject to requirements in Section 1903(m)(2)(A) of Title XIX of the Social Security Act.

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

**Primary Contractor** - A county, Multi-County Entity, or a BH-MCO which has a HealthChoices Agreement with the Department to manage the purchase and provision of Behavioral Health Services.
Primary Diagnosis - The condition established after study to be chiefly responsible for occasioning the visit for outpatient settings or admission for inpatient settings.

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

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

Priority Population(s) – A specific description of the group(s) is provided in Appendix Q. Generally, however, such populations include: Members with serious mental illness and/or addictive disease, and children and adolescent Members with or at risk of serious emotional disturbance and/or who abuse substances and who, in the absence of effective behavioral health treatment and rehabilitation services, care coordination and management are at risk of separation from their families through placement in long term treatment facilities, homelessness, or incarceration, and/or present a risk of serious harm to self or others. Drug and alcohol priority populations include child and adolescent substance abusers and persons with addictive diseases including pregnant women and women with dependent children, intravenous drug users and persons with HIV/AIDS who abuse substances.

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

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

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

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

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

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

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

1. Performs some of the Primary Contractor's management functions under contract or delegation; or

2. Furnishes services to Members under a written agreement; or

3. Leases real property or sells materials to the Primary Contractor at a cost of more than $2,500 during any year of a HealthChoices Behavioral Health Agreement with the Department.

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

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

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

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

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

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

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

**Subcontractor** – Any person or entity other than the Primary Contractor who enters into a Subcontract.

**Supplemental Services** – MA eligible mental health and drug and alcohol services purchased in lieu of or in addition to an In-Plan Service.
Appendix FF

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

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

Title XVIII (Medicare) - The federal health insurance program for people 65 years of age or older, certain younger people with disabilities, and people with end-stage Renal Disease (permanent kidney failure with dialysis or a transplant, sometimes called ESRD).

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

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

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

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

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<td>American Standard Code for Information Interchange</td>
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