## EXHIBIT E

# PRIOR AUTHORIZATION GUIDELINES FOR THE CHC-MCO

## A. GENERAL REQUIREMENT

The CHC-MCOs must submit to the Department all written policies and procedures for the Prior Authorization of services. Prior authorization is not required for Family Planning services (V.A.6), Emergency Services (see V.A.8), or services for which Medicare is the primary payor except where Medicare has denied the service. The CHC-MCO may require Prior Authorization for any services that require Prior Authorization in the Medical Assistance Fee-for-Service (FFS) Program. The CHC-MCO must notify the Department of the FFS authorized services they will continue to prior authorize and the basis for determining if the service is Medically Necessary. The CHC-MCO must receive advance written approval from the Department to require the Prior Authorization of any services not currently required to be Prior Authorized under the FFS Program. For each service to be Prior Authorized, the CHC-MCO must submit for the Department's review and approval the written policies and procedures in accordance with the guidelines described below. The policies and procedures must:

- Be submitted in writing, for all new and revised criteria, prior to implementation;
- Be approved by the Department in writing prior to implementation;
- Adhere to specifications of the CHC RFP, this Agreement, the CHC 1915(c) Waiver, federal regulations, and Department regulations, including 55 Pa. Code Chapter 1101;
- Ensure that Covered Services are Medically Necessary and provided in an appropriate, effective, timely, and cost-efficient manner;
- Adhere to the applicable requirements of Centers for Medicare and Medicaid Services (CMS) Guidelines for Internal Quality Assurance Programs of Health Maintenance Organizations (HMOs), Health Insuring Organizations, 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;
- Specify that Person-Centered Service Plans serve as Prior Authorization for the services outlined therein.

Future changes in State and Federal statutes, regulations, or court cases may require

re-evaluation of any previously approved Prior Authorization proposal. Any deviation from the policies and procedures approved by the Department, including time frames for decisions, is considered to be a change and requires a new request for approval. Failure of the CHC-MCO to comply may result in sanctions and/or penalties by the Department.

The Department defines Prior Authorization as a determination made by a CHC-MCO to approve or deny payment for a Provider's request to provide a service or course of treatment of a specific duration and scope to a Participant prior to the Provider's initiation or continuation of the requested service.

The Department's Prior Authorization Review Panel (PARP) has the sole responsibility to review and approve all Prior Authorization proposals from the CHC-MCOs.

## B. GUIDELINES FOR REVIEW

1. Basic Requirements:

   a. The CHC-MCO must identify individual service(s), medical item(s), and/or therapeutic categories of drugs to be Prior Authorized.

   b. If the Prior Authorization is limited to specific populations, the CHC-MCO must identify all populations who will be affected by the proposal for Prior Authorization.

2. Medically Necessary Requirements:

   a. The CHC-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 CHC-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 CHC Agreement definition for a service or benefit that is Medically Necessary. All criteria must be submitted to the Department for evaluation and approval under Utilization Review Criteria Assessment Process (URCAP).

   c. For CHC-MCOs, if the criteria being used are:

      - Purchased and licensed, the CHC-MCO must identify the vendor;
      - Developed/recommended/endorsed by a national or state Provider association or society, the CHC-MCO must identify the association or society;
      - Based on national best practice guidelines, the CHC-MCO must identify the source of those guidelines;

- Based on the medical training, qualifications, and experience of the CHC-MCO's Medical Director, Dental Director, or other qualified and trained practitioners, the CHC-MCO must identify the individuals who will determine if the service or benefit is Medically Necessary.

d. CHC-MCO guidelines to determine medical necessity of all drugs that require Prior Authorization must be posted for public view on the CHC-MCO's website. This includes, but is not limited to, guidelines to determine medical necessity of both specific drugs and entire classes of drugs that require Prior Authorization for health and safety reasons, non-formulary designations, appropriate utilization, quantity limits, or mandatory generic substitution. The guidelines must specify all of the conditions that the CHC-MCO reviewers will consider when determining medical necessity, including requirements for step therapy.

e. The CHC-MCO must identify the qualification of staff that will determine if the service is Medically Necessary.

   Requests for service will not be denied for lack of Medical Necessity unless a physician or other healthcare professional with appropriate clinical expertise in treating the Participant'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.

f. The CHC-MCO must outline how the Service Planning process with PCPT approach will ensure that Medically Necessary services specified in the Person-Centered Service Plan are authorized by virtue of inclusion in the Person-Centered Service Plan and processed into all appropriate systems.

g. In accordance with Section V.I., the CHC-MCO must outline which PCSP changes during the period covered by the PCSP may be made by the Participant and Service Coordinator without PCPT involvement and which must be made by the CHC-MCO in accordance with the CHC-MCO Prior Authorization plan and must outline the timeframes specified in V.B.2.

h. For LTSS in home and community-based settings, Covered Services will be authorized in accordance with the requirements of the CHC 1915(c) Waiver.

3. Administrative Requirements

a. The CHC-MCO's written policies and procedures must identify the time frames for review and decisions and the CHC-MCO must demonstrate that the time frames are consistent with the requirements specified in V.B.2 and Exhibit D for drug services.

b. The CHC-MCO's written policies and procedures must demonstrate how the CHC-MCO will ensure adequate care management and overall continuity of care among all levels and specialty areas.

c. The CHC-MCO's written policies and procedures must explain how Prior Authorization data will be incorporated into the CHC-MCO's overall Quality Management plan.

4. Notification, Grievance, and DHS Fair Hearing Requirements

The CHC-MCO must demonstrate how written policies and procedures for requests for Prior Authorization comply and are integrated with the Participant and Provider notification requirements and Participant Grievance and DHS Fair Hearing requirements of the RFP and Agreement.

5. Requirements for Care Management/Care Coordination of Non Prior Authorized Service(s)/Items(s)

For purposes of tracking care management/identification of certain diagnoses or conditions, and with advance written approval from the Department, the CHC-MCO may choose to establish a process or protocol requiring notification prior to service delivery. This process must not involve any approvals/denials or delays in receiving the service. The CHC-MCO must notify Providers of this notification requirement. This process may not be administratively cumbersome to Providers and Participants. These situations need not comply with the other Prior Authorization requirements contained in this Exhibit.