

COMMUNITY HEALTHCHOICES AGREEMENT

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- C CHC-MCO Requirements for Provider Terminations
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- E Specific Federal Regulatory Cites for Managed Care Agreements
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AGREEMENT and RFP ACRONYMS

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

ACA — Affordable Care Act.
ADA — Americans with Disabilities Act.
ADL – Activities of Daily Living
APS – Adult Protective Services
BH — Behavioral Health.
BHA — Bureau of Hearings and Appeals.
BH-MCO — Behavioral Health Managed Care Organization.
BLE – Benefit Limit Exception
BPI – Bureau of Program Integrity
CAHPS — Consumer Assessment of Healthcare Providers and Systems.
CAO — County Assistance Office.
CDC — Centers for Disease Control and Prevention.
CHC – Community HealthChoices.
CHC-MCO – Community HealthChoices MCO.
CHS — Contract Health Services.
CIS — Client Information System.
CLIA — Clinical Laboratory Improvement Amendment.
CMN — Certificate of Medical Necessity.
CMS — Centers for Medicare & Medicaid Services.
COB — Coordination of Benefits.
CRNP — Certified Registered Nurse Practitioner.
DEA — Drug Enforcement Agency.
DESI — Drug Efficacy Study Implementation.
DME — Durable Medical Equipment.
DOH — Department of Health (of the Commonwealth of Pennsylvania).
D-SNP – Dual Eligible Special Needs Plan
DHS — Department of Human Services.
DRG — Diagnosis Related Group.
DUR — Drug Utilization Review.
ED – Emergency Department
EOB — Explanation of Benefits.
EQR — External Quality Review.
EQRO — External Quality Review Organization.
EVS — Eligibility Verification System.
ERISA — Employees Retirement Income Security Act of 1974.
FDA — Food and Drug Administration.
FFS — Fee-for-Service.
FMS – Financial Management Services
FQHC — Federally Qualified Health Center.
FTP — File Transfer Protocol.
HBP — Healthy Beginnings Plus.
HCAC — Healthcare-Acquired Condition.

HCBS – Home and Community Based Services
 HCRP — High Cost Risk Pool.
 HEDIS — Healthcare Effectiveness Data and Information Set.
 HIPAA — Health Insurance Portability and Accountability Act.
 HIPP — Health Insurance Premium Payment.
 HMO — Health Maintenance Organization.
 IADL --- Instrumental Activities of Daily Living
 ID --- Intellectual Disability
 IEE – Independent Enrollment Entity.
 IHS — Indian Health Service.
 IRM — Information Resource Management.
 LEP – Limited English Proficiency
 I/T/U — Indian Tribe, Tribal Organization, or Urban Indian Organization.
 LTC – Long Term Care
 LTSS – Long-Term Services and Supports.
 JCAHO — Joint Commission for the Accreditation of Healthcare Organizations.
 LIFE—Living Independence for the Elderly.
 MA --- Medical Assistance
 MAAC — Medical Assistance Advisory Committee.
 MATP — Medical Assistance Transportation Program.
 MCO — Managed Care Organization.
 MIPPA - Medicare Improvements for Patients and Providers Act of 2008.
 MIS — Management Information System.
 MPI — Master Provider Index.
 NCPDP — National Council for Prescription Drug Programs.
 NCQA — National Committee for Quality Assurance.
 NF – Nursing Facility.
 NFCE --- Nursing Facility Clinically Eligible
 NFI --- Nursing Facility Ineligible
 NHT – Nursing Home Transition.
 NPDB — National Practitioner Data Bank.
 NPI — National Provider Identifier.
 OAPS – Older Adult Protective Services.
 OBRA — Omnibus Budget Reconciliation Act.
 OIP — Other Insurance Paid.
 OLTL – Office of Long-Term Living.
 OMAP — Office of Medical Assistance Programs.
 ORC — Other Related Conditions.
 OTC — Over-the-Counter.
 OVR- Department of Labor & Industry Office of Vocational Rehabilitation
 P&T — Pharmacy & Therapeutics.
 PAC – Participant Advisory Committee
 PARP — Prior Authorization Review Panel.
 PBM — Pharmacy Benefit Manager.
 PCP — Primary Care Practitioner.
 PCSP – Person-Centered Service Plan.

PCPT – Person-Centered Planning Team
PDA — Pennsylvania Department of Aging.
PDL — Preferred Drug List.
PH --- Physical Health
PID — Pennsylvania Insurance Department.
PIP — Physician Incentive Plan.
PMPM — Per Member, Per Month.
POSNet — Pennsylvania Open Systems Network.
PPC — Provider Preventable Condition.
PROMISe™ — Provider Reimbursement (and) Operations Management Information System.
QA — Quality Assurance.
QARI — Quality Assurance Reform Initiative.
QM — Quality Management.
QMC — Quality Management Committee.
QM/QI – Quality Management/Quality Improvement
RBC – Risk Based Capital
RHC — Rural Health Clinic.
RN – Registered Nurse
SAP — Statutory Accounting Principles.
SMI – Serious Mental Illness.
SSA — Social Security Act.
SSI — Supplemental Security Income.
SUD – Substance Use Disorder
TANF — Temporary Assistance for Needy Families.
TPL — Third Party Liability.
TPR – Third Party Resources
TTY — Text Telephone Typewriter.
UM — Utilization Management.
URCAP — Utilization Review Criteria Assessment Process.
US DHHS — United States Department of Health and Human Services.
WIC — Women's, Infants' and Children Program.

SECTION I: INCORPORATION OF DOCUMENTS

A. Operative Documents

1. This Agreement is comprised of the following documents, which are listed in the order of precedence in the event of a conflict between documents:
2. This document consisting of its Recitals and Sections I-XVI of the document and its Appendices 3-4 and its Exhibits A – GG.
3. RFP Number 12-15 attached as Appendix 1.
4. CHC-MCOs Proposal, attached as Appendix 2.

B. Operational Updates and Department Communications

1. CHC Operations Memos (CHC OPS Memos)

The Department will issue CHC OPS Memos via the CHC Intranet to provide clarifications to requirements pertaining to CHC and copies of required templates referenced in the Agreement. CHC-MCOs must routinely check the CHC Intranet site.

C. Approval of CHC-MCO Policies, Procedures and Processes

The CHC-MCO must submit for Department review and approval any type of change to Department previously approved CHC-MCO policies, processes and procedures prior to the implementation of the change. Unless otherwise required by law, the CHC-MCO must continue to operate in accordance with the existing approved policy, process or procedure until the Department has approved the change.

SECTION II: DEFINITIONS

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

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

Activities of Daily Living – Basic personal everyday activities that include bathing, dressing, transferring (e.g. from bed to chair), toileting, mobility and

eating.

Actuarially Sound Rates Medical Assistance capitation rates are “actuarially sound” if, for the business for which the certification is being prepared and for the period covered by the certification, projected capitation rates and other revenue sources provide for all reasonable, appropriate, and attainable costs. For purposes of this definition, other revenue sources include, but are not limited to, expected reinsurance and governmental stop-loss cash flows, governmental risk adjustment cash flows, and investment income. For purposes of this definition, costs include, but are not limited to, expected health benefits, health benefit settlement expenses, administrative expenses, the cost of capital, and government-mandated assessments, fees, and taxes.

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

Advanced Healthcare Directive - A healthcare power of attorney, living will or a written combination of a healthcare power of attorney and living will.

Adverse Action – Any action taken by the CHC-MCO, whether in response to a request for approval or otherwise, to deny, reduce, terminate, delay or suspend a Covered Service which serves to: disapprove a request completely; or approve provision of the requested service, but for a lesser amount, scope or duration than requested; or disapprove provision of the requested services, but approves provision of an alternative service; or reduces, suspends or terminates a previously authorized service. An approval of a requested service which includes a requirement for a Concurrent Review by the CHC-MCO during the authorized period does not constitute a denial of service. Also includes any other acts or omissions of the CHC-MCO which impair the quality, timeliness or availability of such Covered Services.

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

trust.

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

Behavioral Health Services — Mental health and substance use disorder services.

Capitation Payment – A fee the Department pays per month to a CHC-MCO for each Participant enrolled in its managed care plan to provide coverage of all Covered Services, whether or not the Participant receives the services during the period covered by the fee.

Centers for Medicare & Medicaid Services — The federal agency within the US DHHS responsible for oversight of the Medicare and Medicaid Programs.

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

Certified Nurse Midwife — A licensed registered nurse licensed to practice midwifery in Pennsylvania.

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

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

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

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

Client Information System — The Department's database of Beneficiaries, including Participants, containing demographic and eligibility information for all Participants.

Clinical Eligibility Determination – A determination of an individual's clinical eligibility for LTSS.

Complaint — A dispute or objection regarding a participating Provider or the coverage, operations, or management policies of a CHC-MCO, which has not been resolved by the CHC-MCO and has been filed with the CHC-MCO or with the DOH or the PID, including but not limited to:

- a denial because the requested service or item is not a Covered Service;
- a failure of the CHC-MCO to meet the required time frames for providing a service or item; or
- a failure of the CHC-MCO to decide a Complaint or Grievance within the specified time frames;
- a denial of payment by the CHC-MCO after a service has been delivered because the service or item was provided without authorization by a Provider not enrolled in the Pennsylvania MA Program; or
- a denial of payment by the CHC-MCO after a service or item has been delivered because the service or item provided is not a Covered Service for the Participant.

The term does not include a Grievance.

Comprehensive Medical and Service Record – A record kept by the CHC-MCO and available to the Participant and relevant Providers that contains, at a minimum, documentation of care and services rendered to the Participant by Providers.

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

Consumer Assessment of Healthcare Providers and Systems – A comprehensive and evolving family of survey instruments to evaluate Participant experience and quality of care on various aspects of services.

County Assistance Office — The county offices of the Department that determine eligibility for all benefit programs, including MA, on the local level.

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

- Is approved by the FDA.
 - Is distributed by a manufacturer that entered into a Federal Drug Rebate Program agreement with the CMS.
 - Is compensable under the MA Program.
 - May be dispensed only upon prescription in the MA Program.
 - Has been prescribed or ordered by a licensed prescriber within the scope of the prescriber's practice.
 - Is dispensed or administered in an outpatient setting.
- The term includes biological products and insulin.

Covered Services - Services which CHC-MCOs are required to offer to Participants under CHC as specified in Exhibit EE Covered Services.

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

Daily Participant File — An electronic file in a HIPAA compliant 834 format using data from CIS that is transmitted to the CHC-MCO on state work days. This 834 Daily File includes TPL information and is transmitted via the Department's MIS contractor.

Day — Indicates a calendar day unless specified otherwise.

Deliverables — Documents, records and reports required to be furnished to the Department for review and approval pursuant to the terms of this agreement.

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

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

Disability Competency – The demonstration that an entity or individual has the capacity to understand the diverse nature of disabilities and the impact that different disabilities can have on a Participant, access to services, and experience of care.

Disease Management — An integrated treatment approach that includes the collaboration and coordination of patient care delivery systems and that focuses on measurably improving clinical outcomes for a particular medical condition through the use of appropriate clinical resources such as preventive care, treatment guidelines, patient counseling, education, and outpatient care; and that includes evaluation of the appropriateness of the scope, setting, and

level of care in relation to clinical outcomes and cost of a particular condition.

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

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

Dual Eligible — An individual who is enrolled in both Medicare and MA.

Dual Eligible Special Needs Plan – A Medicare Advantage Plan that primarily or exclusively enrolls individuals who are entitled to both Medicare and MA.

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

Eligibility Verification System — An automated system available to Providers and other specified organizations for automated verification of MA eligibility, CHC-MCO Enrollment, PCP assignment, TPR, and scope of benefits.

Emergency Medical Condition — A medical condition manifesting itself by acute symptoms of sufficient severity, including severe pain such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in: (a) placing the health of the individual or with respect to a pregnant woman, the health of the woman or her unborn child in serious jeopardy, (b) serious impairment to bodily functions, or (c) serious dysfunction of any bodily organ or part.

Emergency Participant Issue — A problem of a CHC-MCO Participant, including problems related to whether an individual is a Participant, the resolution of which should occur immediately or before the beginning of the next business day in order to prevent a denial or significant delay in care to the Participant that could precipitate an Emergency Medical Condition or need for urgent care.

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

Encounter — Any covered healthcare service provided to a CHC-MCO Participant, regardless of whether it has an associated Claim.

Encounter Data — A record of any Covered Service provided to a Participant and includes Encounters reimbursed through Capitation, FFS, or other methods of compensation regardless of whether payment is due or made.

Enrollment — The process by which a Participant is enrolled in a CHC-MCO.

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

External Quality Review — An annual independent, external review by an EQRO of the quality of services furnished by a CHC-MCO including the evaluation of quality outcomes, timeliness and access to services.

External Quality Review Organization - An independent organization that meets the competence and independence requirements set forth in 42 CFR §438.354, and performs EQR as well as other EQR-related activities as set forth in 42 CFR §438.358, or both.

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

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

Fee-for-Service — Payment to Providers on a per-service basis for healthcare services provided to Beneficiaries.

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

Fraud — Any type of intentional deception or misrepresentation made by an entity or person with the knowledge that the deception could result in some unauthorized benefit to the entity, him/herself, or some other person in a managed care setting. The Fraud can be committed by many entities, including the CHC-MCO, a subcontractor, a Provider, a State employee, or a Participant.

Full Dual Eligible - An individual, who is (i) entitled to Medicare Part A, enrolled in or eligible for Medicare Part B, and enrolled in or eligible to enroll

in Part D and (ii) full Medicaid eligible.

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

Healthcare-Acquired Condition — A condition occurring in any inpatient hospital setting, identified as a HAC by the US DHHS Secretary under §1886(d)(4)(D)(iv) of the SSA for purposes of the Medicare program as identified in the State plan as described in §1886(d)(4)(D)(ii) of the SSA; other than Deep Vein Thrombosis/Pulmonary Embolism as related to total knee replacement or hip replacement surgery in pediatric and obstetric patients.

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

- occurs in a patient in a healthcare setting.
- was not present or incubating at the time of admission, unless the infection was related to a previous admission to the same setting.
- if occurring in a hospital setting, meets the criteria for a specific infection site as defined by the CDC its National Healthcare Safety Network.

Healthcare Provider — A licensed hospital or healthcare facility, medical equipment supplier or person who is licensed, certified or otherwise regulated to provide healthcare services under the laws of the Commonwealth or states in which the entity or person provides services, including a physician, podiatrist, optometrist, psychologist, physical therapist, CRNP, RN, clinical nurse specialist, certified registered nurse anesthetist, certified nurse midwife, physician's assistant, chiropractor, dentist, dental hygienist, pharmacist or an individual accredited or certified to provide behavioral health services.

Healthcare Effectiveness Data and Information Set —The set of managed care performance measures maintained by the NCQA.

Health Maintenance Organization — A Commonwealth licensed risk-bearing entity which combines delivery and financing of healthcare and which provides basic health services to enrolled Participants for fixed, prepaid fees.

Home and Community-Based Services — A range of services and supports

provided to Participants in their homes and communities including assistance with ADLs and IADLs, which promote the ability for older adults and adults with disabilities to live independently to the greatest degree and remain in their homes for the longest time as is possible.

Hospice - A coordinated program of home and inpatient care that provides non-curative medical and support services for persons certified by a physician to be terminally ill with a life expectancy of six (6) months or less including palliative and supportive care to Participants and their families.

Immediate Need — A situation in which, in the professional judgment of the dispensing registered pharmacist 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.

Independent Enrollment Entity — An independent and conflict-free entity is responsible for providing choice counseling and enrollment services to Potential Participants and Participants.

Individualized Back-Up Plan – An individualized plan that is developed as part of the PCSP development process, which identifies the strategies to be taken in the event that routine services are not able to be delivered to a Participant which, depending on the Participant's preferences and choice, may include, but are not limited to the use of family and friends of the Participant's choice, and/or agency staff.

Indian Healthcare Provider — A healthcare program, including CHS, operated by the IHS or by an Indian Tribe, Tribal Organization, or Urban Indian Organization as those terms are defined in section 4 of the Indian Healthcare Improvement Act (25 U.S.C. §1603).

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

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

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

Instrumental Activities of Daily Living - Activities related to independent living, including preparing meals, managing money, shopping for groceries or personal items, performing housework, and communication.

Linguistic competency – The demonstration that an entity or individual has the capacity to communicate effectively, and convey information in a manner that is easily understood by diverse audiences including persons of LEP, those who have low literacy skills or are not literate, and individuals with disabilities that require communication accommodations.

Living Independence for the Elderly - A comprehensive service delivery and financing program model in Pennsylvania (which is known nationally as the Program of All-Inclusive Care for the Elderly) that provides comprehensive healthcare services under dual capitation agreements with Medicare and the MA Program to individuals age 55 and over who are NFCE and reside in a LIFE service area.

Lock-In — The restriction of a Participant who is involved in fraudulent activities or who is identified as abusing MA services to one or more specific Providers to obtain all of his/her services in an attempt to appropriately manage care.

Long-Term Services and Supports – A broad range of services and supports designed to assist an individual with ADLs and IADLs which can be provided in a home and community-based setting, a nursing facility, or other residential setting. LTSS may include, but are not limited to: self-directed care; adult day health; personal emergency response systems; home modification and environmental accessibility options; home and personal care; home health; nursing services; specialized medical equipment and supplies; chore services; social work and counseling; nutritional consultation; home-delivered meals and alternative meal service; and nursing facility services.

Managed Care Organization — An entity which manages the purchase and provision of Physical Services and LTSS, under the CHC Program.

Market Share — The percentage of Participants enrolled with a particular CHC-MCO when compared to the total of Participants enrolled in all the CHC-MCOs within a CHC zone.

Marketing – Any communication from the CHC-MCO, or any of its agents or independent contractors, with a Potential Participant, who is not enrolled in the CHC-MCO that can reasonably be interpreted as intended to influence that individual to enroll in the CHC-MCO or remain enrolled in that particular CHC-MCO, or to disenroll from or not enroll in another CHC-MCO.

Marketing Materials – Any materials that are produced in any medium, by or on behalf of a CHC-MCO that can reasonably be interpreted as intended to be marketing to Potential Participants.

Master Provider Index — A component of PROMISe™ which is a central

repository of Provider profiles and demographic information that registers and identifies Providers uniquely within the DHS.

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

Medical Assistance Transportation Program — A non-emergency medical transportation service provided to eligible persons who need to make trips to or from any MA service for the purpose of receiving treatment, medical evaluation, or purchasing prescription drugs or medical equipment.

Medically Necessary (also referred to as Medical Necessity) — A Covered Service is Medically Necessary if it is compensable under the MA Program and if it meets any one of the following standards:

- The Covered Service will, or is reasonably expected to, prevent the onset of an illness, condition or disability.
- The Covered Service will, or is reasonably expected to, reduce or ameliorate the physical, mental or developmental effects of an illness, condition, injury or disability.
- The Covered Service will assist the Participant to achieve or maintain maximum functional capacity in performing daily activities, taking into account both the functional capacity of the Participant and those functional capacities that are appropriate for Participants of the same age.

MIPPA Agreement – An agreement required under the MIPPA of 2008 between a D-SNP and a State Medicaid Agency which documents entities' roles and responsibilities with regard to Dual Eligibles and describes the D-SNP's responsibility to integrate and coordinate Medicare and Medicaid benefits.

Monthly Participant File — An electronic file in a HIPAA compliant 834 format using data from CIS that is transmitted to the CHC-MCO on a monthly basis via the Department's MIS contractor.

Network — All contracted or employed Providers with the CHC-MCO who are providing Covered Services to Participants.

Network Provider — A MA enrolled Healthcare Provider who has a written Provider Agreement with and is credentialed by a CHC-MCO and who participates in the CHC-MCO's Network to serve CHC Participants.

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

Non-participating Provider — A Provider, whether a person, firm, corporation or other entity, either not enrolled in the Pennsylvania MA Program or not participating in the CHC-MCO's Network.

Nursing Facility — A general, county or hospital-based nursing facility, which is licensed by the DOH and enrolled in the MA Program.

Nursing Facility Clinically Eligible – Having clinical needs that require the level of care provided in a Nursing Facility.

Nursing Facility Ineligible – Having clinical needs that do not require the level of care provided in a Nursing Facility.

Ongoing Medication — A medication that has been previously dispensed to the Participant for the treatment of an illness that is chronic in nature or for an illness for which the medication is required for a length of time to complete a course of treatment, until the medication is no longer considered necessary by the physician/prescriber, and that has been used by the Participant without a gap in treatment.

Other Related Conditions — A physical disability such as cerebral palsy, epilepsy, spina bifida or similar conditions which occur before the age of twenty-two (22), is likely to continue indefinitely and results in three (3) or more substantial functional limitations in the following areas: self-care, receptive and expressive language, learning, mobility, self-direction and capacity for independent living.

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

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

- An Emergency Medical Condition that occurs while outside the CHC zone.
- The health of the Participant would be endangered if the Participant returned to the CHC zone for needed services.
- The Participant is attending a college or university in a state other than Pennsylvania or a zone other than his or her zone of residence or who is travelling outside of the CHC zone but remains a resident of the Commonwealth and the CHC zone and requires Covered Services, as identified in his or her PCSP or otherwise.
- The Provider is located outside the CHC zone, but regularly provides Covered Services to Participants at the request of the CHC-MCO.
- The needed Covered Services are not available in the CHC zone.

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

Out-of-Plan Services — Services which are non-capitated and are not the responsibility of the CHC-MCO under the CHC Program Covered Services package.

Participant — An eligible individual who is enrolled with the CHC-MCO.

Participant-Directed Budget – An amount of waiver funds that is under the control and direction of the Participant who has chosen the Budget Authority Participant Direction option. The Participant-Directed Budget is sometimes called the individual budget.

Participant Self-Directed Service – A waiver service that the state specifies may be directed by the Participant using the Employer Authority, the Budget Authority or both.

Participant-Direction – The opportunity for a Participant to exercise choice and control in identifying, accessing, and managing LTSS Covered Services and other supports in accordance with his or her needs and personal preferences.

Participant Record — A record contained on the Daily Participant Enrollment File or the Monthly Participant Enrollment File that contains information on MA eligibility, managed care coverage, and the category of assistance, which help establish the Covered Services for which a Participant is eligible.

Participant Restriction Program – The program to Lock-In Participants for a period of time.

Pay for Performance - Compensation given to a CHC-MCO for increased productivity or results that exceed anticipated targets.

Penalty Period -- A Period of ineligibility for the payment of LTC services, including LTC Facility and HCBS, due to a transfer of assets for less than fair market value or excess home equity. Penalty Periods apply to LTC and HCBS.

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

Performance Improvement Project - Projects where a CHC-MCO assess its

organization and make changes to meet its goals through assessment, systematic gathering of information and making improvements in care or services.

Person-Centered Planning Team — A team of individuals that will participate in Person Centered Service Planning with and provide person-centered coordinated services to Participants.

Person-Centered Service Plan - A written description of Participant-specific healthcare, LTSS, and wellness goals to be achieved, and the amount, duration, frequency and scope of the Covered Services to be provided to a Participant in order to achieve such goals, which is based on the comprehensive needs assessment of the Participant's healthcare, LTSS and wellness needs.

Person-Centered Service Planning – The process of developing an individualized PCSP based on an assessment of needs and preferences of the Participant.

Physician Incentive Plan — A compensation arrangement between a CHC-MCO and a physician or physician group that may directly or indirectly have the effect of reducing or limiting services furnished to Participants.

Plan Transfer - The processes by which a Participant changes CHC-MCOs.

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

Potential Participant — An individual who either 1) is an Eligible Individual or is not yet an Eligible Individual but may become an Eligible Individual in the foreseeable future.

Preadmission Screening and Resident Review – A Federally mandated process to determine whether individuals who have a Mental Illness, ID, or ORC require NF Services and if they also require Specialized Services to treat their conditions, based on the criteria established by CMS. The screening process applies to all individuals seeking admission to any MA-certified NF, regardless of payment source (private pay, third party insurance and/or MA). The PASRR process must be completed prior to admission and no later than the day of admission.

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

Committee.

Primary Care - Healthcare services and laboratory services customarily furnished by or through a general practitioner, family physician, internal medicine physician, or obstetrician/gynecologist acting within the scope of his/her licensure.

Primary Care Practitioner— A specific physician, physician group or a CRNP operating under the scope of his or her licensure, who is responsible for supervising, prescribing, and providing Primary Care services; locating, coordinating and monitoring other medical care and rehabilitative services, and maintaining continuity of care on behalf of a Participant.

Primary Care Practitioner Site — The location or office of a PCP where Participant care is delivered.

Prior Authorization — A determination made by the CHC-MCO to approve or deny payment for a Provider's request to provide a Covered 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.

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

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

Provider — A licensed hospital or healthcare facility, medical equipment supplier, person, firm, corporation, or other entity who is licensed, certified or otherwise authorized to provide healthcare services under the laws of the Commonwealth or other states. The term includes but is not be limited to the following: physician, podiatrist, optometrist, psychologist, physical therapist, CRNP, RN, clinical nurse specialist, certified registered nurse anesthetist, certified nurse midwife, physician's assistant, chiropractor, dentist, dental hygienist, pharmacist, home care agency, durable medical equipment supplier, LTSS provider, or behavioral health service provider.

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

Provider Appeal — A request from a Provider for reversal of a determination by the CHC-MCO of:

- A Provider credentialing denial.

- Claims denied by the CHC-MCO for Network Providers.
- Provider Agreement termination.

Provider Dispute — A written communication to a CHC-MCO, made by a Provider, expressing dissatisfaction with a CHC-MCO decision that directly impacts the Provider, excluding decisions concerning Medical Necessity.

Provider-Preventable Condition — A condition that meets the definition of a HCAC or other provider-preventable condition as defined in 42 CFR§ 447.26(b).

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

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

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

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

Related Parties — An entity that is an Affiliate of the CHC-MCO or subcontracting CHC-MCO and (1) performs some of the CHC-MCO or subcontracting CHC-MCO's management functions under contract or delegation; or (2) furnishes services to Participants under a written agreement; or (3) leases real property or sells materials to the CHC-MCO or subcontracting CHC-MCO at a cost of more than \$2,500.00 during any year of a CHC agreement with the Department.

Restraint—A Restraint can be physical or chemical.

- A physical restraint includes any apparatus, appliance, device or garment applied to or adjacent to a resident's body, which restricts or diminishes the resident's level of independence or freedom.
- A chemical restraint includes psychopharmacologic drugs that are used for discipline or convenience and not required to treat medical symptoms.

A device used to provide support for functional body position or proper balance and a device used for medical treatment, such as sand bags to limit movement after medical treatment, a wheelchair belt that is used for body positioning and support or a helmet for prevention of injury during seizure activity, are not

considered mechanical restraints.

Retrospective Review — A review conducted by the CHC-MCO to determine whether services were delivered as prescribed and consistent with the CHC-MCO's payment policies and procedures.

Routine Care — Care for conditions that generally do not need immediate attention and minor episodic illnesses that are not deemed urgent. Examples of preventive and routine care include immunizations, screenings and physical exams.

Seclusion – The involuntary confinement of an individual alone in a room or an area from which the individual is physically prevented from having contact with others or leaving.

Service Coordination – Activities to identify, coordinate and assist Participants to gain access to needed Covered Services and non-Covered Services such as social, housing, educational and other services and supports.

Service Coordinator - An appropriately qualified professional who is the CHC-MCO's designated accountable point of contact for each Participant's PCSP and Service Coordination.

Services My Way – The Budget Authority model of service, which provides Participants with a broader range of opportunities for Participant Self-Direction under which Participants have the opportunity to hire and manage staff that perform personal assistance type services, manage a flexible spending plan, and purchase allowable goods and services through their spending plan.

Sexual Abuse of a Participant - Intentionally, knowingly or recklessly causing or attempting to cause the rape of, involuntary deviate sexual intercourse with, sexual assault of, statutory sexual assault of, aggravated indecent assault of, indecent assault of, or incest of a Participant.

Special Needs Plan - Medicare Advantage Plans that primarily or exclusively enroll Special Needs Individuals.

Start Date — The first date on which a CHC-MCO is operationally responsible and financially liable for the provision of Medically Necessary Covered Services to Participants.

Step Therapy — A form of Prior Authorization whereby one or more prerequisite medications, which may or may not be in the same drug class, must be tried first before a Step Therapy medication will be approved.

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

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

Subcontract — A contract between the CHC-MCO and an individual, business, university, governmental entity, or nonprofit organization to perform part or all of the CHC-MCO's responsibilities under this agreement. Exempt from this definition are salaried employees, utility agreements and Provider Agreements.

Sustained Improvement — Improvement in performance documented through continued measurement of quality indicators after the performance project/study/quality initiative is completed.

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

Third Party Liability — The financial responsibility for all or part of a Participant's healthcare or LTSS expenses of an individual entity or program (e.g., Medicare) other than the CHC-MCO.

Third Party Resource — An individual, entity or program that is liable to pay all or part of the medical or service cost of injury, disease or disability of a Participant. Examples of TPR include government insurance programs such as Medicare or CHAMPUS; private health insurance companies, or carriers; liability or casualty insurance; and court-ordered medical support.

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

Urgent Medical Condition — An illness, injury or severe condition which under reasonable standards of medical practice should be diagnosed and treated within a twenty-four (24) hour period and if left untreated, could rapidly become a crisis or Emergency Medical Condition. The term also includes situations where a person's discharge from a hospital will be delayed until

services are approved or a person's ability to avoid hospitalization depends upon prompt approval of services.

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

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

Vital documents — Documents which contain information that is critical for accessing or understanding CHC-MCO benefits and services such as provider directories, Participant handbooks, appeal and grievance notices and other notices that are critical to obtaining services.

Waiver – One of many options available to states to allow the provision of long- term services and supports in home and community-based settings under the MA Program.

SECTION III: RELATIONSHIP OF PARTIES

A. Term of Agreement

The term of this Agreement will commence on January 1, 20xx and will have an initial term of X years, provided that no court order, administrative decision, or action by the federal or state government is outstanding which prevents the commencement of the Agreement. The Department has the option to extend this Agreement for an additional X year period upon the same terms and conditions. DHS will notify the CHC-MCO of its election to exercise the renewal option in writing at least one hundred twenty (120) days prior to the expiration of the then current term provided, however, that the Department's right to exercise any such renewal option shall not expire unless and until the CHC-MCO has given the Department written notice of the Department's failure to timely exercise its renewal option and has provided a ten (10) day opportunity from the Department's receipt of the notice to cure the failure. If the Department exercises its option, it will promptly commence rate discussions with the CHC-MCO.

If the Department has exercised its option to extend and the CHC-MCO and the Department are unable to agree upon terms for the extension, the Agreement will continue on the same terms and conditions for a period of one hundred twenty (120) days after the expiration of the Initial Term unless the Agreement has been terminated in accordance with Exhibit D Standard Terms and Conditions for Services.

B. Nature of Agreement

The CHC-MCO must provide for all Covered Services and related services to Participants through qualified Providers in accordance with this Agreement.

SECTION IV: APPLICABLE LAWS AND REGULATIONS

A. Certification, Licensing and Accreditation

The CHC-MCO must require its Network Providers to comply with all certification and licensing laws and regulations applicable to the profession or entity. The CHC-MCO may not employ or enter into a relationship with a Provider who is precluded from participation in the MA Program or other federally funded health care program. The CHC-MCO must screen all Providers at the time of hire or contracting; and thereafter, on an ongoing monthly basis to determine if they have been excluded from participation in federally funded health care programs.

CHC-MCOs must use the streamlined credentialing process that the Department develops, in conjunction with that of the CHC-MCOs.

1. National Accreditation

The CHC-MCO must be accredited by NCQA or by a national accreditation body and obtain accreditation within the accreditation body's specified timelines. A CHC-MCO applying for accreditation must select an accreditation option and notify the accrediting body of the accreditation option chosen. Accreditation obtained under the NCQA Full Accreditation Survey or Multiple Product Survey options will be accepted by the Department. The Department will accept the use of the NCQA Corporate Survey process, to the extent deemed allowable by NCQA, in the NCQA accreditation of the CHC-MCO.

If the CHC-MCO is accredited as of the Start Date, the CHC-MCO shall maintain accreditation throughout the term of this Agreement. If the CHC-MCO is not accredited as of the Start Date, the CHC-MCO shall obtain accreditation no later than the end of the second full calendar year of operation and shall maintain accreditation for the term of this Agreement.

The Department will consider the CHC-MCO's failure to obtain accreditation and failure to maintain accreditation a material breach of this Agreement. A CHC-MCO with provisional accreditation status must submit a corrective action plan within thirty (30) days of receipt of notification from the accreditation body and may be subject to termination of this Agreement.

The CHC-MCO must submit the final hard copy Accreditation Report for each accreditation cycle within ten (10) days of receipt of the report. The CHC-MCO must submit to the Department updates of accreditation status, based on annual HEDIS scores within ten (10) days of receipt.

B. Specific to Medical Assistance Program

The CHC-MCO must participate in the MA Program, and arrange for the provision of Covered Services essential to the health and support of its Participants, and comply with all federal and Pennsylvania laws generally and specifically governing participation in the MA Program. The CHC-MCO must provide services in the manner prescribed by 42 U.S.C. §300e(b), and warrants that the organization and operation of the CHC-MCO is in compliance with 42 U.S.C. §300e(c). The CHC-MCO must comply with all applicable rules, regulations, and Bulletins promulgated under such laws including, but not limited to, 42 U.S.C. §§1396 et seq.; 62 P.S. §§101 et. seq.; 42 C.F.R. Parts 431 through 481 and 45 C.F.R Parts 74, 80, and 84, and the Department regulations except as specified in Exhibit A, Managed Long Term Services and Supports Regulatory Compliance Guidelines.

C. Specific to Medicare

The CHC-MCO must be an Affiliate of a CMS approved D-SNP for the as

provided in this Agreement. For the SW Zone, the CHC-MCO must be in process in January 2017 to have a D-SNP operating and must have a CMS-approved D-SNP operating by January 1, 2018. For other zones, the CHC-MCO must have a D-SNP operating at the time of implementation for the zone.

D. General Laws and Regulations

1. The CHC-MCO must comply with Titles VI and VII of the Civil Rights Act of 1964, 42 U.S.C. §§2000d et seq. and 2000e et seq.; Title IX of the Education Amendments of 1972, 20 U.S.C. §§1681 et seq.; Section 504 of the Rehabilitation Act of 1973, 29 U.S.C. §§701 et seq.; the Age Discrimination Act of 1975, 42 U.S.C. §§6101 et seq.; the Americans with Disabilities Act, 42 U.S.C. §§12101 et seq.; the Health Insurance Portability and Accountability Act of 1996 (HIPAA); the Pennsylvania Human Relations Act of 1955, 71 P.S. §§941 et seq.; and Article XXI of the Insurance Company Law of 1921, as amended, 40 P.S. §§991.2102 et seq.; and Drug and Alcohol Use and Dependency Coverage Act 106 of 1989, 40 P.S. §§908-1 et seq.
2. The CHC-MCO must comply with all applicable laws, regulations, and policies of the DOH and PID.

The CHC-MCO must comply with applicable Federal and State laws that pertain to Participant rights and protections.

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

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

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

The CHC-MCO must provide this information to Potential Participants before and during Enrollment and to Participants within thirty (30) days after adopting such a policy.

4. Nothing in this Agreement shall be construed to permit or require the Department to pay for any services or items which are not or cease to be

compensable under the laws, rules and regulations governing the MA Program at the time such services are provided.

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

E. Limitation on the Department's Obligations

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

F. Health Care Legislation, Regulations, Policies and Procedures

The CHC-MCO must comply with future changes in federal and state law, federal and state regulations, and Department requirements and procedures related to changes in the MA Program including any changes to 1915(b) or (c) Waivers and changes to MIPPA Agreements.

SECTION V: PROGRAM REQUIREMENTS

A. Covered Services

The CHC-MCO must provide Medically Necessary PH services and LTSS provided in home and community-based settings in accordance with the requirements of the CHC 1915(c) Waiver. The CHC-MCO must require that determinations of Medically Necessary Covered Services be documented in writing and that they be based on medical information provided by a Participant, the Participant's family or caretaker and PCP, as well as other Providers, programs or agencies that have evaluated the Participant. A determination of Medically Necessary services must be made by qualified and trained Providers with clinical expertise comparable to the prescribing Provider.

1. Amount, Duration and Scope

At a minimum, the CHC-MCO must provide Covered Services in Exhibit EE Covered Services in the amount, duration and scope available in the MA FFS Program and CHC 1915(c) Waiver. The CHC-MCO must provide services that are sufficient in amount, duration, or scope to reasonably be expected to achieve the purpose for which the services are furnished. If services are added to the Pennsylvania MA Program or the CHC Program, or if Covered Services are expanded or eliminated, the CHC-MCO must implement on the same day as the Department, unless the CHC-MCO is notified by the Department of an alternative implementation date.

The CHC-MCO shall not arbitrarily deny or reduce the scope of services

based on a Participant's diagnosis, disability, or type of illness/condition

2. Home and Community-Based Services

The CHC-MCO must provide Home and Community Based LTSS as Covered Services. The CHC-MCO must make home and community-based LTSS services available 7 days per week, 24 hours a day at any hour of the day and for any number or combination of hours, as dictated by Participants' needs and outlined in their approved PCSPs.

For Participants who are living in the community at the time of implementation of CHC in the zone and who choose to remain in the community, the CHC-MCO must support that choice and support the Participants in the community.

3. Program Exceptions

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

4. Expanded or Value-Added Services

The CHC-MCO may provide Expanded or Value-Added services subject to advance written approval by the Department. These services must be services, items, or positive incentives that are generally considered to have a direct relationship to the maintenance or enhancement of a Participant's health or functional status or that the CHC-MCO believes will promote healthy lifestyles and improved health outcomes. The Department does not consider best practice approaches to delivering Covered Services to be Expanded or Value-Added Services.

The CHC-MC may include various seminars and educational programs promoting healthy living or illness prevention, memberships in health clubs and facilities promoting physical fitness and expanded eyeglass or eye care benefits as Expanded or Value-Added Services.

If provided, the CHC-MCO must offer Expanded or Value-Added Services to all Participants for whom the services are appropriate and must provide them at no cost to the Department. These services must be made available by appropriate Network Providers. The CHC-MCO may not link these services

to specific Participant performance; however, the Department may grant exceptions. Once approved, the CHC-MCO must continue to offer Expanded or Value-Added services unless the CHC-MCO is notified, in writing, by the Department, to discontinue the services.

In order for information about Expanded or Value-Added Services to be included in Participant information provided by the CHC-MCO, the CHC-MCO must make services available for a minimum of one full year or until the Participant information is revised, whichever is later. Upon sixty (60) days advance notice to the Department, the CHC-MCO may modify or eliminate any expanded service. The CHC-MCO must send written notice to Participants and affected Providers at least thirty (30) days prior to the effective date of the change and must simultaneously amend all written materials describing its Expanded or Value-Added Services.

The CHC-MCO is permitted and encouraged to offer LTSS Services to Participants who are not yet NFCE. These services will not be reimbursed by the Department.

The CHC-MCOs may provide one-time, unique, or individually-tailored supportive items or services in addition to the required Covered Services where determined by the CHC-MCO through the PCSP process to be appropriate for supporting a specific Participant in remaining in his or her home or community based setting. The CHC-MCO must report these individually tailored service or item authorizations to the Department but does not need pre-approval.

5. Referrals

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

6. Self-Referral/Direct Access

A Participant may self-refer for vision, dental care, Indian Healthcare Providers, obstetrical and gynecological (OB/GYN) services, providing the Participant obtains the services within Network. A Participant may access chiropractic services in accordance with the process set forth in Medical Assistance Bulletin 15-07-01, and physical therapy services in accordance with the amended Physical Therapy Act (63 P.S. §§1301 et seq.). The CHC-MCO may request Department approval to allow other Covered Services to be directly available without referral.

The CHC-MCO may not use either the referral process or Prior Authorization

to manage the utilization of Family Planning Services. The CHC-MCO may not restrict the right of a Participant to choose a Healthcare Provider for Family Planning Services and must make such services available without regard to marital status, age, sex or parenthood. Participants may access, at a minimum, health education and counseling necessary to make an informed choice about contraceptive methods, pregnancy testing and counseling, breast cancer screening services, basic contraceptive supplies such as oral birth control pills, diaphragms, foams, creams, jellies, condoms (male and female), Norplant, injectables, intrauterine devices, and family planning procedures as described in Exhibit F, Family Planning Services Procedures. The CHC-MCO must pay for Out-of-Network Family Planning Services.

The CHC-MCO must permit Participants to select a Network Provider, including Certified Nurse Midwives, to obtain OB/GYN Services without prior approval from a PCP, including selecting a Network Provider to provide an annual well-woman gynecological visit, primary and preventive gynecology care, including PAP smears and referrals for diagnostic testing related to maternity and gynecological care, and Medically Necessary follow-up care.

In situations where a newly enrolled Participant is pregnant and already receiving care from an Out-of-Network OB-GYN specialist at the time of Enrollment, the Participant may continue to receive services from that specialist throughout the pregnancy and postpartum care related to the delivery.

7. Behavioral Health Services

The CHC MCO will be responsible for the BH services included in the 1915(c) Waiver. Except for those BH Services in the 1915(c) Waiver, BH-MCOs will provide BH services to Participants who need Medicaid State Plan BH services. The CHC-MCO must coordinate with the BH-MCOs as necessary to so that Participants receive all Medically Necessary BH Services.

8. Outpatient Drug (Pharmacy) Services

The CHC-MCO must provide coverage of prescriptions and OTCs medicines for Full Dual Eligibles that are not otherwise covered by the Dual Eligible's Part D prescription drug plan. The CHC-MCO must provide pharmacy services for all other Participants. The CHC-MCO must coordinate pharmacy services across Medicare Part D, and other third-party pharmacy coverages so that the Participant receives the pharmacy services outlined in the Participant's PCSP. The CHC-MCO must offer assistance to Full Dual Eligible Participants in selecting a Medicare Part D plan including advising on the benefit of enrolling in a Medicare Part D plan with a zero co-pay.

The CHC-MCO must comply with the requirements described in Exhibit CC, Outpatient Drug Services.

9. Emergency Services

The CHC-MCO is responsible for Emergency Services including those categorized as mental health or drug and alcohol services, except for emergency department evaluations for voluntary and involuntary commitments pursuant to 50 P.S. §§7101 et seq.

The CHC-MCO must comply with the provisions of 42 U.S.C. §1396u-2(b)(2), 40 P.S. §991.2102 and §991.2116, and 28 Pa. Code §9.672 pertaining to coverage and payment of Medically Necessary Emergency Services.

The CHC-MCO may not:

- Limit what constitutes an Emergency Medical Condition based on lists of diagnoses or symptoms.
- Refuse to cover Emergency Services based on the ED, hospital, or fiscal agent not notifying the Participant's PCP, CHC-MCO, or applicable state entity of the Participant's screening and treatment within ten (10) calendar days of presentation for Emergency Services.
- Hold a Participant who has an Emergency Medical Condition liable for payment of subsequent screening and treatment needed to diagnose the specific condition or stabilize the patient.

The CHC-MCO may not require Prior Authorization of Emergency Services. A Healthcare Provider may initiate necessary intervention to stabilize an Emergency Medical Condition without seeking or receiving Prior Authorization. The treating Healthcare Provider determines when a Participant is sufficiently stabilized for transfer or discharge, and that determination is binding on the CHC-MCO.

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

The CHC-MCO may not deny payment for services when:

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

- organ or part; or,
- A representative of the CHC-MCO instructs the Participant to seek emergency services.

The CHC-MCO may not apply case management protocols when they would interfere with Emergency Services. In the case of a pregnant woman who is having contractions, the CHC-MCO may not use case management protocols unless adequate time exists to affect a safe transfer before delivery or the transfer would not pose a threat to the health and safety of the patient and the unborn child. When a transfer occurs, the CHC-MCO must have and maintain documentation that its case management protocols did not interfere with the transferring hospital's obligation to:

- Restrict transfer until a patient is stabilized;
- Affect an appropriate transfer or provide medical treatment within its capacity to minimize the risk of transfer;
- Require a supervised transfer;
- Provide a Participant with the opportunity to make an informed decision to consent to or refuse transfer along with documentation of the associated risks and benefits and;
- Not divert a Participant being transported by emergency vehicle on the basis of insurance coverage.

A CHC-MCO may:

- track, trend and profile emergency department utilization;
- retrospectively review and where appropriate, deny payment for inappropriate ED use;
- use appropriate methods to encourage Participants to use PCPs rather than EDs for symptoms that do not qualify as an Emergency Medical Condition; or
- use a Participant Lock-In methodology for Participants with a history of significant inappropriate ED usage as referenced in Section V.X. Administration.

The CHC-MCO must have a process to have PCPs promptly see Participants who presented to an ED but did not require or receive services for those symptoms prompting the ED visit.

10. Post-Stabilization Services

The CHC-MCO must cover Post-Stabilization Services, as defined in 42 CFR §438.114.

The CHC-MCO must limit charges to Participants for Post-Stabilization Services to an amount no greater than what the CHC-MCO would charge

the Participant if he or she had obtained the services through the Network.

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

- a. The Post-Stabilization Services were administered to maintain the Participant's stabilized condition within one hour of Provider's request to the CHC-MCO for pre-approval of further Post-Stabilization Services.
- b. The Post-Stabilization Services were not pre-approved by the CHC-MCO because the CHC-MCO did not respond to the Provider's request for pre-approval of these Post-Stabilization Services within one (1) hour of the request.
- c. The Post-Stabilization Services were not pre-approved by the CHC-MCO because the Provider could not reach the CHC-MCO to request pre-approval.
- d. The CHC-MCO and the treating physician could not reach an agreement concerning the Participant's care and a CHC-MCO physician is not available for consultation. In this situation, the CHC-MCO must give the treating physician the opportunity to consult with a CHC-MCO physician and the treating physician may continue with the care of the patient until a CHC-MCO physician is reached or one of the criteria applicable to termination of a CHC-MCO's financial responsibility described below is met.

The CHC-MCO's financial responsibility for Post-Stabilization Services that the CHC-MCO has not pre-approved ends when:

- a. A Network Provider with privileges at the treating hospital assumes responsibility for the Participant's care;
- b. A CHC-MCO physician assumes responsibility for the Participant's care through transfer;
- c. The CHC-MCO and the treating physician reach an agreement concerning the Participant's care;
- d. The Participant is discharged.

11. Examinations to Determine Abuse or Neglect

- a. The CHC-MCO must provide Participants under evaluation as possible victims of abuse or neglect and who present for physical examinations for

determination of abuse or neglect, with such services.

- b. The CHC-MCO must inform Network Providers they are mandatory reporters and must require all Network Providers to know the procedures for reporting suspected abuse and neglect. This requirement must be included in all applicable Provider Agreements. The CHC-MCO must have a sufficient number of Network Providers qualified to conduct the specialty evaluations necessary for investigating alleged physical and/or sexual abuse.
- c. Should a Network PCP determine that a mental health assessment is needed, the PCP must inform the Participant or the APS or OAPS representative on how to access mental health services and coordinate access to these services, when necessary.

12. Hospice Services

The CHC-MCO must provide hospice care and use certified Hospice Providers in accordance with 42 C.F.R. Subpart G. CHC-MCOs must coordinate with Hospice Providers for Dual Eligible Participants who are receiving hospice services through their Medicare coverage. Hospice services provided to Participants by Medicare approved hospice Providers are directly reimbursed by Medicare.

13. Organ Transplants

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

14. Transportation

The CHC-MCO must provide all Participants with Medically Necessary emergency ambulance transportation and Medically Necessary non-emergency ambulance transportation. The CHC-MCO must provide all NFCE Participants with non-medical transportation. The CHC-MCO may provide non-medical transportation to other Participants at its own discretion and own cost. Non-medical transportation includes transportation to community activities, grocery shopping, religious services, Adult Daily Living centers, employment and volunteering, and other activities or LTSS services as specified in the Participant's PCSP.

The CHC-MCO must provide non-emergency medical transportation for NF residents. The CHC-MCO must also provide any specialized non-emergency medical transportation for Participants including transportation for Participants who are stretcher-bound. The Service Coordinator will coordinate these services.

Transportation for Participants to and from Medicare and/or CHC Covered Medical Services must be arranged through the MATP. The CHC-MCO must arrange and coordinate transportation with the MATP providers so Participants receive the MATP services outlined in their PCSP. The CHC-MCO will comply with the responsibilities set forth in Exhibit J, Medical Assistance Transportation Program.

15. Healthy Beginnings Plus Program

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

The CHC-MCO's prenatal program must have the majority of its pregnant Participants seen face-to-face in a community setting. Majority is defined as greater than fifty percent (50%) of unique pregnant women that have an initial care management assessment as reported. This will be accomplished by relationships within the CHC-MCO's Network, CHC-MCO employees, or delegated vendor relationship.

The CHC-MCO program must provide for the adequate treatment of high risk pregnant women SUD. The CHC-MCO will contract with high volume obstetrical hospitals and health systems that perform more than 900 MA deliveries to establish highly coordinated health homes for pregnant Participants with SUD. These health homes will be focused on identifying, initiating treatment, and referring pregnant Participants for comprehensive drug and alcohol counseling services. If the CHC-MCO is unsuccessful in contracting with any of the high volume obstetrical hospitals or health systems, it must document its efforts to negotiate with these providers for review by the Department.

16. Nursing Facility Services

The CHC-MCO is responsible for payment for Medically Necessary NF

services, including bed hold days and up to fifteen (15) days per hospitalization and up to thirty (30) Therapeutic Leave Days per year if a Participant is admitted to a NF or resides in a NF at the time of Enrollment.

The CHC-MCO must, in coordination with the Department, monitor for completion of all NF related processes, including but not limited to: PASRR process, specialized service delivery, Participant's rights, patient pay liability, personal care accounts or other identified processes.

17. Participant Self-Directed Services

In addition to the traditional agency model, CHC-MCOs must offer Participants who are eligible for HCBS the opportunity to self-direct Personal Assistance Services and Respite through one of two models.

- Participants may elect to receive personal assistance services through a Participant-Directed Employer Authority model, in which the Participant employs his or her own personal assistance provider, who can be a family member, a friend, a neighbor or any other qualified personal assistance worker; or
- Participants may elect the Budget Authority model called Services My Way, in which the PCSP is converted to a budget and the Participant develops a spending plan to purchase needed goods and services. Participants in this model may elect to receive personal assistance through an agency and/or to employ their own personal assistance providers.

Personal assistance workers employed by Participants under either self-directed model become qualified and receive payment through a FMS vendor, which processes timesheets, makes payments, and manages all required tax withholdings, including FICA taxes. The CHC-MCO must establish relationships and cooperate with all of the Commonwealth-procured FMS entities in order that necessary FMS services can be provided to Participants. The CHC-MCO is responsible for paying the FMS provider:

- Reimbursement for payments the FMS provider makes on behalf of the Participant-employer for workers' wages and vendor goods and services
- A per-member per-month fee to perform the tasks outlined in the FMS service description
- A one-time start-up fee for new Participants, paid once in a lifetime per Participant.

18. Health and Wellness Education and Outreach for

Participants and Caregivers

The CHC-MCO must provide health and wellness opportunities for Participants, such as providing classes, support groups, and workshops, disseminating educational materials and resources, and providing website, email, or mobile application communications on topics including, but not limited to, heart attack and stroke prevention, asthma, living with chronic conditions, back care, stress management, healthy eating and weight management, oral hygiene, and osteoporosis. The CHC-MCO may also include annual or other preventive care reminders and caregiver resources. CHC-MCOs are also encouraged to identify regional community health education opportunities, improve outreach and communication with Participants and community-based organizations, and actively promote healthy lifestyles as well as disease prevention and health promotion.

19. Settings for LTSS

The CHC-MCO must provide services in the least restrictive, most integrated setting. The CHC-MCO shall only provide LTSS in settings that comply with federal regulations at 79 F.R. 2948 (January 16, 2014). NFCE Participants who are residing in Personal Care Homes as of the Zone Start Date will be permitted to remain in those settings while in CHC.

This service must be provided in accordance with 42 CFR §441.301(c) (4) and (5), which outlines allowable setting for home and community-based waiver services. Settings cannot be located on the grounds of a NF, Intermediate Care Facility, Institute for Mental Disease or Hospital, unless it meets the standards for the heightened scrutiny process established through the HCBS Final Rule and is included in the PCSP.

The CHC-MCO must submit documentation on a quarterly basis containing a list of settings that are non-compliant.

20. Service Delivery Innovation

The CHC-MCO must promote innovation in the CHC service delivery system, including innovation pursued by the CHC-MCO on its own initiative, as well as collaborative efforts involving the Department, CMS and local partners. Initial required target areas for CHC-MCO innovation are as follows.

- a. Housing innovation that includes, but is not limited to:
 - i. Pre-tenancy and tenancy supports that help Participants at risk of homelessness or institutionalization obtain and maintain homes in the community, including but not limited to: outreach to and engagement

- of Participants, housing search assistance, assistance and applying for housing and benefits, assistance with SSI eligibility processes, advocacy and negotiation with landlords and other tenants, moving assistance, eviction prevention, motivational interviewing, and incorporating social determinants of health into the person-centered planning process.
- ii. Participation in local and statewide housing collaboratives, which may include local and state housing agencies and social services organizations.
 - b. Employment innovation that supports Participants seek, find and maintain employment.
 - c. Workforce innovation that improves the recruitment, retention and skills of direct care workers, which may include but are not limited to incentives for education and training.
 - d. Technology innovation that supports Participants lead healthy and independent lives in the community, which may include but not be limited to home monitoring and telemedicine applications.

The CHC-MCO must participate in initiatives in these target innovation areas when requested by the Department. In addition, the CHC-MCO must submit a report to the Department annually that outlines the CHC-MCO's efforts in each of the four areas, lessons learned, and plans for the following year. The CHC-MCO must submit its first report by XXXX, 2017 and each subsequent report annually thereafter.

21. Exceptional Durable Medical Equipment

The CHC-MCO must provide Exceptional DME, as defined in Exhibit EE Covered Services. The CHC-MCO must operate a grant process to provide grants for Exceptional DME and Ventilators. The Department separately includes Exceptional DME from standard DME in its rate calculation. In the event of an Exceptional DME purchase, the equipment will belong to the Participant.

An Exceptional DME/Ventilator grant is an authorization permitting exceptional payments under specified terms to a NF, in addition to the NF's case-mix per diem rate, for NF services that are provided to a specified resident and that involve the use of certain exceptional DME and ventilator supplies. The amount of the additional payment authorized by a grant is based upon the necessary, reasonable and prudent cost of the Exceptional DME/Ventilators and the related services and items specified in the grant.

The CHC-MCO must provide an Exceptional DME/Ventilator grant where the Exceptional DME/Ventilator is Medically Necessary and it must be specially adapted for the Participant or is on the Exceptional List. The Department will publish the Exceptional DME List and annual notice in the PA Bulletin.

The CHC-MCO must provide a Ventilator grant where the ventilator equipment and supplies must be used for the unique Participant. The CHC-MCO must certify the ventilator units in the NF. The Department will publish the Ventilator Supply List and annual notice in the PA Bulletin.

B. Prior Authorization of Services

1. General Prior Authorization Requirements

The CHC-MCO may require Prior Authorization for services that require Prior Authorization in the FFS Program. If the CHC-MCO wishes to require Prior Authorization, the CHC-MCO must establish and maintain written policies and procedures which must have advance written approval from the Department. In addition, the CHC-MCO must submit a list and scope of services for referral and Prior Authorization for Department review and prior written approval as outlined in Exhibit G, Prior Authorization Guidelines for Participating Managed Care Organizations in the CHC Program, and Exhibit K(1), Quality Management and Utilization Management Program Requirements.

The Department will use its best efforts to review and provide feedback to the CHC-MCO on requests for written approval, corrective action plans, or denials, within sixty (60) days from the date the Department receives the request for review. For minor updates to existing approved Prior Authorization plans, the Department will use its best efforts to review updates within forty-five (45) days from the date the Department receives the request.

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

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

The CHC-MCO may not require prior authorization of Medicare services for Dual Eligible Participants. If coverage of the service is denied by Medicare, the CHC-MCO may require Prior Authorization if such authorization is required under the CHC-MCO's approved Prior Authorization policies and procedures. If the CHC-MCO does not require Prior Authorization of the services, the CHC-MCO will approve the service. Service Coordinators are required to work with the Participant's Medicare plan to obtain expeditious decision-making and communication of decisions.

2. Time Frames for Notice of Decisions

- a. The CHC-MCO must process each request for Prior Authorization and notify the Participant of the decision as expeditiously as the Participant's health condition requires, or at least orally, within two (2) business days of receiving the request, unless additional information is needed. If no additional information is needed, the CHC-MCO must mail written notice of the decision to the Participant, the Participant's PCP, and the prescribing Provider within two (2) business days after the decision is made. The CHC-MCO may make notification of coverage approvals via electronic notices as permitted under 28 Pa. Code §9.753(b). If additional information is needed to make a decision, the CHC-MCO must request such information from the appropriate Provider within forty-eight (48) hours of receiving the request and allow fourteen (14) days for the Provider to submit the additional information. If the CHC-MCO requests additional information, the CHC-MCO must notify the Participant on the date the additional information is requested, using the template N(7) Request for Additional Information Letter.
- b. If the requested information is provided within fourteen (14) days, the CHC-MCO must make the decision to approve or deny the service, and notify the Participant orally, within two (2) business days of receipt of the additional information. The CHC-MCO must mail written notice of the decision to the Participant, the Participant's PCP, and the prescribing Provider within two (2) business days after the decision is made.
- c. If the requested information is not received within fourteen (14) days, the CHC-MCO must make the decision to approve or deny the service based upon the available information and notify the Participant orally within two (2) business days after the additional information was to have been received. The CHC-MCO must mail written notice of the decision to the Participant, the Participant's PCP, and the prescribing Provider within two (2) business days after the decision is made.
- d. In all cases, the CHC-MCO must make the decision to approve or deny a covered service or item and the Participant must receive written notification of the decision no later than twenty-one (21) days from the

date the CHC-MCO received the request, or the service or item is automatically approved. To satisfy the twenty-one (21) day time period, the CHC-MCO may mail written notice to the Participant, the Participant's PCP, and the prescribing Provider on or before the eighteenth (18th) day from the date the request is received. If the notice is not mailed by the eighteenth (18th) day after the request is received, the CHC-MCO must hand deliver the notice to the Participant, or the request is automatically approved.

- e. If the Participant is currently receiving a requested service and the CHC-MCO decides to deny the Prior Authorization request, the CHC-MCO must mail the written notice of denial at least (10) days prior to the effective date of the denial of authorization for continued services. If probable Participant fraud has been verified, the period of advance notice is shortened to five (5) days. The CHC-MCO is not required to provide advance notice when it has factual information of the following:
 - confirmation of a Participant's death.
 - receipt of a clear written statement signed by a Participant that she or he no longer wishes the requested service or gives information that requires termination or reduction of services and indicates that she or he understands that termination will be the result of supplying that information.
 - the Participant has been admitted to an institution where she or he is ineligible under CHC for further services.
 - the Participant's whereabouts are unknown and the post office returns mail directed to him or her indicating no forwarding address.
 - the CHC-MCO established the fact that the Participant has been accepted for MA by another State.
 - a change in the level of medical care is prescribed by the Participant's physician.

3. Prior Authorization of Pharmacy Services

The CHC-MCO must comply with the requirements of Exhibit CC, Outpatient Drug (Pharmacy) Services, specific to Prior Authorization of Pharmacy Services.

C. Continuity of Care

The CHC-MCO must provide continuity of care to Participants upon transition into CHC as follows:

1. NF Residents. An individual who is a resident of a NF located in the CHC zone is eligible to receive NF services from the same NF if: (i) the individual is a resident of the NF on the Start Date of the CHC for the zone; and (ii) while a

resident of the NF, the individual is enrolled as a Participant and determined to be eligible for MA NF services. In order for the continuity of care period to apply, the Participant's stay in the NF must from the effective date of his or her eligibility for MA NF service through the first effective date of enrollment into CHC.

The continuity of care period under this section will begin on the Participant's first effective date of Enrollment into the CHC-MCO and end on the earliest date any of the following:

- a. The Participant chooses to return to his or her home or other home or community-based setting.
- b. The Participant chooses to transfer to a different NF.
- c. The Participant is disenrolled from CHC.
- d. The Participant's physician determines that he or she no longer needs NF services.
- e. The NF transfers or discharges the Participant in accordance with 42 CFR §483.12(a); provided that, if the Participant appeals his or her transfer or discharge, the continuity of care period will continue until the Participant's appeal is adjudicated by the BHA.
- f. The NF is no longer certified to participate as a provider in the MA Program.

A change in CHC-MCO, a temporary hospitalization or therapeutic leave does not interfere with or terminate this continuity of care period as long as the Participant remains a resident of the NF.

The CHC-MCO in which the Participant is enrolled must enter into an agreement or payment arrangement with the Participant's NF to make payments for the Participant's NF services during the continuity of care period, regardless of whether the NF is in the CHC-MCO Network. The CHC-MCOs may require nonparticipating NFs to meet the same requirements as participating NFs with the exception that a CHC-MCO may not require nonparticipating Healthcare Providers to undergo full credentialing.

Participants who are admitted to a NF after the Start Date for the CHC-MCO or who do not qualify for the continuity of care period in this section, will receive the continuity care period described in subsection 3 or 5 below.

2. Waiver Participants. For a Participant who is receiving LTSS on the CHC-MCO Start Date through an HCBS Waiver program on his or her Effective Date of Enrollment, the CHC-MCO must provide a continuity of care period for continuation of services provided under all existing HCBS Waiver service plans through all existing service Providers, including Service Coordination Entities that runs from the Participant's effective date of Enrollment for 180 days or until a comprehensive needs assessment has been completed and a PCSP has been developed and implemented, whichever date is later. If a

Participant chooses to transfer to a different CHC-MCO during the initial 180 day continuity of care period, the receiving CHC-MCO must continue to provide the previously authorized services for 1) the greater of 60 days or the remainder of the 180 days or 2) until a comprehensive needs assessment has been completed and a PCSP has been developed and implemented, whichever date is later. If a Participant chooses to transfer to a different CHC-MCO after the initial 180 day continuity of care period, the receiving CHC-MCO must continue to provide the previously authorized services for 60 days or until a comprehensive needs assessment has been completed and a PCSP has been developed and implemented, whichever date is later.

3. All Participants. For all Participants, the CHC-MCO must comply with continuity of care requirements for continuation of Healthcare Providers, services, and any ongoing course of treatment as governed by Section 2117 of Article XXI of the Insurance Company Law of 1921, 40 P.S. §991.2117, and 28 Pa. Code §9.684 and 31 Pa. Code §154.15. The CHC-MCO must comply with the procedures outlined in MA Bulletin 99-03-13, Continuity of Care for Recipients Transferring Between and Among Fee-for-Service and Managed Care Organizations.
4. PCSP Transition. The CHC-MCO must provide an electronic or hard paper copy of a Participant's existing Comprehensive Medical and Service Record, including PCSPs, to the CHC-MCO to which a Participant chooses to transfer. The CHC-MCO must expeditiously transfer the information, electronically if possible, not to exceed five (5) business days after notification of the transfer.
5. Other Care or Service Plan Transition. For Participants who are not receiving LTSS through an HCBS Waiver on the CHC-MCO Start Date at the time of his or her Enrollment, the CHC-MCO must coordinate initially and on an ongoing basis a Participant's transition into CHC with entities that are providing care or Service Coordination to Participants at the time of their CHC Enrollment. Entities might include, but are not limited to, the OPTIONS program or OMAP's Special Needs Unit.

D. Choice of Provider

The CHC-MCO must provide Participants with choice of Providers within its Network, including Service Coordinators. The CHC-MCO may not attempt to steer Participants to Affiliates who are Providers or interfere with the Participants' choice of Network Providers. Participants may choose a Provider from within the Network at any time, even during a continuity of care period.

E. Comprehensive Needs Assessments and Reassessments

The CHC-MCO must conduct a comprehensive needs assessment of every Participant who is determined NFCE. In addition, the CHC-MCO must conduct

a comprehensive assessment of a Participant who has not been determined NFCE when the Participant requests a comprehensive assessment or self-identifies as needing LTSS, or if either the CHC-MCO or the IEE determines that the Participant has unmet needs; service gaps; or a need for Service Coordination.

The CHC MCO will complete an in-person comprehensive needs assessment in accordance with the following time frames:

- For NCFE Participants but are not receiving LTSS at the time of Enrollment, the comprehensive needs assessment must be completed no later than five (5) business days from the effective date of Enrollment.
- For Dual Eligible Participants identified by the IEE as having a need for immediate services, the comprehensive needs assessment must be completed no later than five (5) business days from the effective date of Enrollment.
- For Participants who are identified as having unmet needs, service gaps, or a need for Service Coordination, the comprehensive needs assessment must be completed no later than fifteen (15) business days from the date the CHC-MCO is aware of the unmet needs, service gaps, or need for Service Coordination.
- For Participants with existing PCSPs in place at the time of Enrollment, the comprehensive needs assessment must be completed within 180 days of their effective date of Enrollment, except that Participants who are due for a level of care redetermination prior to the 180th day following this date must have a comprehensive needs assessment completed within five (5) business days of the level of care redetermination.
- When requested by a Participant or a Participant's designee or family member, the comprehensive needs assessment must be completed no later than fifteen (15) days from the request.

The CHC-MCO must conduct a comprehensive needs reassessment no more than 12 months following the most recent prior comprehensive needs assessment or comprehensive needs reassessment unless a trigger event occurs. The CHC-MCO must complete reassessments as expeditiously as possible in accordance with the circumstances and as clinically indicated by the Participant's health status and needs, but in no case more than 14 days after the occurrence of the following trigger events:

- A significant healthcare event to include but not be limited to a hospital admission, a transition between healthcare settings, or a hospital discharge.
- A change in functional status.
- A change in caregiver or informal support status if the change impacts one or more areas of health or functional status.
- A change in the home setting or environment if the change impacts one or more areas of health or functional status.

- A change in diagnosis that is not temporary or episodic and that impacts one or more area of health status or functioning.
- As requested by the Participant or designee, caregiver, Provider, or the PCPT or PCPT Participant, or the Department.

Through the comprehensive needs assessment and reassessment, the CHC-MCO must assess a Participant's physical health, behavioral health, social, psychosocial, environmental, caregiver, LTSS, and other needs as well as preferences, goals, housing, and informal supports. The comprehensive needs assessment and reassessment processes developed by the CHC-MCO must capture the following:

- Need for traditional comprehensive care management of chronic conditions and Disease Management.
- Functional limitations, including cognitive limitations, in performing ADL and IADLs and level of supports required by the Participant.
- Ability to manage and direct services and finances independently.
- Level of supervision required.
- Supports for unpaid caregivers.
- Identification of risks to the Participant's health and safety.
- Environmental challenges to independence and safety concerns.
- Availability of able and willing informal supports.
- Diagnoses and ongoing treatments.
- Medications.
- Use of adaptive devices.
- Preferences for community engagement.
- Employment and educational goals.

If, after conducting the comprehensive needs assessment, the CHC-MCO determines that a Participant who has not been determine NFCE has a need for LTSS, the CHC-MCO shall refer the Participant for a clinical eligibility determination. The CHC-MCO must abide by the clinical eligibility determination entity's decision as to the need for NF services.

The Department will designate a tool to be used for comprehensive needs assessments and reassessments. The CHC-MCO is permitted to gather additional information not included in the designated tool to supplement but not supplant the Department-designated tool.

F. Person-Centered Planning Team Approach Required

The CHC-MCO must develop a PCPT policy for PCSP development and implementation for Participants who require LTSS. The PCPT approach must be consistent with the person-centered service planning requirements of 42 C.F.R. §441.301(c)(1) through (3) and the requirements outlined in this Agreement.

The CHC-MCO must include the PCPT approach as part of the service planning and Service Coordination processes for Participants who require LTSS. CHC-MCOs may include the PCPT approach as part of the overall care coordination approach for Participants who do not require LTSS. The CHC-MCO PCPT approach must be person-centered and must take into account all goals and requirements of CHC. The CHC-MCO must annually submit and obtain Department prior approval of its PCPT policy to PCSP development and implementation.

G. Person-Centered Service Plans

The CHC-MCO must develop and implement a written, holistic PCSP for each Participant who requires LTSS. The CHC-MCO must comply with the requirements specified in 42 CFR §441.301(c)(1)-(3) and in this Agreement in developing the PCSP.

The CHC-MCO must require that the PCSP address how the Participant's physical, cognitive, and behavioral health needs will be managed, including how Medicare coverage (if the Participant is Dual Eligible) will be coordinated and, how the Participant's LTSS services will be coordinated. The holistic PCSP for LTSS Participants, at a minimum, must include the following:

- 1. Care Management Plan.** A Care Management Plan to identify and address how LTSS Participants' physical, cognitive, and behavioral healthcare needs will be care managed, including:
 - Active chronic problems, current non-chronic problems, cognitive needs, and problems that were previously controlled or classified as maintenance care but have been exacerbated by disease progression or other intervening conditions.
 - Current medications.
 - All services authorized and the scope and duration of the services authorized, including any services that were authorized by the CHC-MCO since the last PCSP was finalized that need to be authorized moving forward.
 - A schedule of preventive service needs or requirements.
 - Disease Management action steps.
 - Known needed physical and behavioral healthcare and services.
 - All designated points of contact and the Participant's authorizations of who may request and receive information about the Participant's services.
 - How the Service Coordinator will assist the Participant in accessing Covered Services identified in the PCSP.
 - How the CHC-MCO will coordinate with the Participant's Medicare, Veterans, BH-MCO, and other health coverage.

- 2. LTSS Service Plan.** A LTSS Service Plan to identify and address how

LTSS needs will be met and how services will be provided in accordance with the PCSP. The LTSS Service Plan must include the following:

- All LTSS services necessary to support the Participant in living as independently as possible and remaining as engaged in their community as possible.
- For the needs identified in the comprehensive needs assessment, the interventions to address each need or preference, reasonable long-term and short-term goals, the measurable outcomes to be achieved by the interventions, the anticipated time lines in which to achieve the desired outcomes, and the staff responsible for conducting the interventions and monitoring the outcomes.
- Potential problems that can be anticipated, including the risks and how these risks can be minimized to foster the Participant's maximum functioning level of well-being.
- Participant decisions around self-directed care and whether the Participant is participating in Participant-Direction.
- Communications plan.
- How frequently specific services will be provided.
- Whether and, if so, how technology and telehealth will be used.
- Participant choice of Providers.
- Individualized Back-Up Plans.
- The person(s)/Providers responsible for specific interventions/services.
- Participant's available, willing, and able informal support network and services.
- Participant's need for and plan to access community resources, non-covered services, and other supports, including any reasonable accommodations.
- How to accommodate preferences for leisure activities, hobbies, and community engagement.
- Any other needs or preferences of the Participant.
- Participant's goals for the least restrictive setting possible, if they are being discharged or transitioned from an inpatient setting.
- How the CHC-MCO will coordinate with the Participant's Medicare, Veterans, BH-MCO, other health coverage, and other supports.
- Participant's employment and educational goals.

The PCSP may specify the need for referrals and the need for assistance from the Service Coordinator in obtaining referrals. To the extent that the PCP is part of the PCSP development or PCTP process, the PCSP may also articulate referrals that the Service Coordinator will enter in the appropriate systems.

The PCSP must consider both In and Out-of-Network Covered Services to support the individual in the environment of their choice as well as caregivers' support needs.

PCSPs must be completed no more than 30 days from the date the comprehensive needs assessment or reassessment is completed.

PCSPs for Participants who require LTSS will be developed by the Service Coordinator, the Participant, and the Participant's PCPT. Participants may appeal part or all of their Service Plan as provided in Exhibit T Complaint, Grievance and DHS Fair Hearing Processes.

H. Care Management and Care Plans

The CHC-MCO must make available care management to all Participants. Additionally, the CHC-MCO must develop and implement a written care plan for Participants who do not require LTSS but who have unmet needs, service gaps, or a need for Service Coordination. The care plan must address how the Participant's physical, cognitive, and behavioral healthcare needs will be care managed, including how Medicare coverage (if the Participant is Dual Eligible) will be coordinated. The CHC-MCO must include in care plans for Participants who do not require LTSS, at a minimum, the following:

- Active chronic problems, current non-chronic problems, cognitive needs, and problems that were previously controlled or classified as maintenance care but have been exacerbated by disease progression or other intervening conditions.
- Current medications.
- All services authorized and the scope and duration of the services authorized, including any services that were authorized by the CHC- MCO since the last care plan was finalized that need to be authorized moving forward.
- A schedule of preventive service needs or requirements.
- Disease Management action steps.
- Known needed physical and behavioral health care and services.
- All designated points of contact and the Participant's authorizations of who may request and receive information about the Participant's services.
- How the care manager will assist the Participant in accessing Covered Services identified in the care plan.
- How the CHC-MCO will coordinate with the Participant's Medicare, Veterans, BH-MCO, Lottery-funded Services and other health coverage.

I. Department Review of Changes in PCSPs

The Department may review, question, and request revision to PCSP. The CHC-MCO must provide the Department with weekly aggregate reports on PCSP changes in a format specified by the Department.

J. Service Coordination

Service Coordinators must assist Participants in obtaining the services that they need. Service Coordinators lead the Person-Centered Service Planning process and oversee the implementation of PCSPs. The CHC-MCO must annually submit and obtain Department approval of its Service Coordination staffing plan including after-hours and emergency staffing, Service Coordinator to Participant communications and contact plans including the required frequency of in-person Service Coordinator contact, Service Coordinator caseloads, and how Service Coordinators share and receive real-time information about Participants and Participant encounters.

Service Coordinators identify, coordinate and assist Participants gain access to needed LTSS services and State Plan services, as well as non-Medicaid funded medical, social, housing, educational, and other services and supports. Service Coordination includes the primary functions of providing information to Participants and facilitating access, locating, coordinating and monitoring needed services and supports for LTSS Participants. Service Coordinators are responsible to: inform Participants about available LTSS, required needs assessments, the Participant-centered service planning process, service alternatives, service delivery options including opportunities for Participant-direction, roles, rights including DHS Fair Hearing rights, risks and responsibilities, and to assist with fair hearing requests when needed and requested, and to protect a Participant's health, welfare and safety on on-going basis.

Service Coordinators must also: collect additional necessary information, including, at a minimum, Participant preferences, strengths and goals to inform the development of the PCSP; conduct reevaluation of level of care annually or more frequently as needed in accordance with Department requirements; assist the Participant and his or her PCPT in identifying and choosing willing and qualified Providers; coordinate efforts and prompt the Participant to complete activities necessary to maintain LTSS eligibility; explore coverage of services to address Participant identified needs through other sources, including services provided under the State Plan, Medicare or private insurance and other community resources; and actively coordinate with other individuals and entities essential in the physical and behavioral care delivery for the Participant to provide for seamless coordination between physical, behavioral and support services.

CHC-MCOs must develop, submit for DHS approval, and implement a plan to monitor the performance of Service Coordinators.

The CHC-MCO must assign to every Participant with a PCSP or care plan a Service Coordinator to implement and coordinate the services called for in the PCSP or care plan.

The CHC-MCO provides Service Coordination as an administrative function

through staff or contracts with Service Coordination Entities. While Participants who are transitioning into CHC at the Start Date for the CHC zone will have a continuity of care period for their Service Coordinator, Participants who transition between CHC-MCOs after the Start Date will not have a continuity of care period for their Service Coordinator. The CHC-MCO must provide Service Coordination through appropriately qualified Service Coordinators employed by or under contract with the CHC-MCO.

K. Service Coordinator and Service Coordinator Supervisor Requirements

The CHC-MCO must provide Service Coordinators and Service Coordinator supervisors that have the following qualifications:

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- Service Coordinators must be an RN or have a Bachelor's degree in social work, psychology or other related fields, and at least three years of experience in a social service or health care related setting except that Service Coordinators hired prior to the CHC zone Start Date must have the qualifications and standards proposed by the CHC-MCOs and approved by the Department.
- Service Coordinator Supervisors must be an RN or a PA licensed social worker or PA licensed mental health professional with at least three years of relevant experience except that Service Coordinator Supervisors hired prior to the CHC zone Start Date (who do not have a license), 1) must obtain a license within their first year of this Agreement or 2) must have the qualifications and standards proposed by the CHC-MCOs and approved by the Department.

L. Nursing Home Transition

CHC-MCOs must provide NHT activities to Participants residing in NFs who express a desire to move back to their homes or other community-based settings. The CHC-MCO must provide NHT activities using appropriately qualified staff, whether employed by or under contract with the CHC-MCO.

M. Coordination of Services

The CHC-MCO must facilitate and coordinate Participants' access to all necessary Covered Services and Medicare, BH, and other services. The CHC-MCO must provide for seamless and continuous coordination and data sharing across a continuum of services for the Participant with a focus on improving healthcare outcomes and independent living. The CHC-MCO will provide these activities as part of Person-Centered Service Planning and the PCSP implementation process for Participants who have a PCSP. The continuum of services may include the Covered Services, out-of-plan services, and non-MA services provided by other community resources.

1. CHC-MCO and BH-MCO Coordination

To enhance the treatment of Participants who need both Covered Services and BH Service, the CHC-MCO must develop and implement written agreements with each BH-MCO in the CHC zone regarding the interaction and coordination of services provided to Participants enrolled in the CHC Program. The CHC-MCO must submit complete agreements for Department review and prior approval at least thirty (30) days prior to the Start Date and make the agreements available to the Department upon request. The CHC-MCOs and BH-MCOs are encouraged to develop uniform coordination agreements to promote consistency in the delivery and administration of services.

The CHC-MCO must work in collaboration with the BH-MCOs through participation in joint initiatives to improve overall health outcomes of its Participants and those activities that are required by the Department, including:

- a. Information exchanges including BH utilization data provided by the Department to control avoidable hospital admissions, readmissions and emergency department usage for Participants with SMI or SUDs or both.
- b. Development of specific coordination mechanisms to assess and, where appropriate, reduce the use of psychotropic medications prescribed for Participants.

The CHC-MCO will comply with the requirements set forth in Exhibit M, Coordination with BH-MCOs.

- a. The CHC-MCO must, and the Department will require BH-MCOs to submit to independent binding arbitration in the event of a dispute between the CHC-MCO and a BH-MCO concerning the respective obligations. The agreement of the CHC-MCO and a BH-MCO to an arbitration process must be included in the written agreement between the CHC-MCO and the BH-MCO.
- b. The CHC-MCO must comply with the requirements specific to Outpatient Drug (Pharmacy) Services specified in Exhibit CC.

2. Disability Advocacy Program

The CHC-MCO must cooperate with the Department's Disability Advocacy Program, which provides assistance to Participants in applying for SSI or Social Security Disability benefits by sharing Participant-specific information and performing coordination activities as requested by the Department, on a

case-by-case basis.

N. CHC-MCO Responsibility for Reportable Conditions

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

O. Participant Enrollment, Disenrollment, Outreach, and Communications

1. General

The CHC-MCO is prohibited from restricting Participants from changing CHC-MCO. A Participant has the right to change his or her CHC-MCO plans at any time.

The CHC-MCO is prohibited from offering or exchanging financial payments, incentives, commissions, etc., to another CHC-MCO not receiving a CHC agreement or choosing not to continue in CHC for the exchange of information on the other MCO's Participants. This includes offering incentives to a terminating CHC-MCO to recommend that its Participants join the CHC-MCO offering the incentives. The CHC-MCO is not prohibited from making a payment in connection with an assignment, which has received the Department's prior written approval, of the rights and obligations to another entity.

The Department will disenroll a Participant from the CHC-MCO when a change in residence places the Participant outside the CHC zone, as indicated on the individual county file maintained by the Department's Office of Income Maintenance.

The Department will enroll Participants transferring from one CHC zone to another with the same CHC-MCO, if that CHC-MCO operates in both zones, unless the Participant chooses to enroll in LIFE or to enroll in another CHC-MCO.

2. CHC-MCO Outreach Materials

The CHC-MCO must develop outreach materials such as pamphlets and brochures to be used by the IEE to assist Participants in choosing a CHC-MCO and PCP. The CHC-MCO must develop such materials in the form and context required by the Department. The Department must approve such materials in writing prior to their use. The Department's review will be conducted within thirty (30) calendar days and approval will not be

unreasonably withheld.

The CHC-MCO must develop outreach materials, including the Participant Handbook, and other Participant-facing materials which are accessible, easily understood and written at not more than a sixth (6th) grade reading level

The CHC-MCO is prohibited from distributing directly or through an agent or independent contractor, outreach materials without advance written approval of the Department. In addition, the CHC-MCO must comply with the following:

- a. The CHC-MCO may not seek to influence an individual's Enrollment with the CHC-MCO in conjunction with the sale of any other insurance.
- b. The CHC-MCO must comply with the Enrollment procedures established by the Department so that an individual is provided accurate oral and written information sufficient to make an informed decision on Enrollment.
- c. The CHC-MCO may not directly or indirectly conduct door-to-door, telephone or other cold-call marketing activities.
- d. The CHC-MCO must develop and provide outreach plans, procedures and materials that are accurate and do not mislead, confuse or defraud either the Participant or the Department and must comply with Exhibit O, CHC-MCO Guidelines for Advertising, Sponsorships, and Outreach.

3. CHC-MCO Outreach Activities

- a. The CHC-MCO is prohibited from engaging in Marketing activities associated with Enrollment into the CHC-MCO, except as provided below.

The CHC-MCO is prohibited from subcontracting with an outside entity to engage in outreach activities associated with any form of Enrollment to Potential Participants. The CHC-MCO must not engage in outreach activities associated with Enrollments at the following locations and activities:

- CAOs
- Providers' offices
- Malls/Commercial or retail establishments
- Hospitals
- Nursing Facilities
- Adult Day Centers
- Senior Centers
- Check cashing establishments
- Door-to-door visitations

- Telemarketing
 - Community Centers
 - Churches
 - Direct Mail
- b. The CHC-MCO may market its approved, companion D-SNP product to Full Dual Eligible CHC-MCO Participants.
- c. The CHC-MCO, either individually or as a joint effort with other CHC-MCOs in the zone, may use commonly accepted media methods for the advertisement of quality initiatives, educational outreach, and health-related materials and activities.

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

- d. The CHC-MCO may participate in or sponsor health fairs or community events. The Department may set limits on contributions and payments made to non-profit groups in connection with health fairs or community events and requires advance written approval for contributions and payments of \$2,000.00 or more. The Department will consider participation or sponsorship when the CHC-MCO submits a written request thirty (30) days in advance of the event or fair, thus allowing the Department reasonable time to review the request and provide timely advance written approval. All contributions and payments are subject to audit by the Department.
- e. The CHC-MCO may offer items of little or no intrinsic value such as trinkets with promotional CHC-MCO logos at approved health fairs or other approved community events. The CHC-MCO must make such items available to the general public and items may not exceed \$5.00 in retail value and must not be connected in any way to Enrollment activity. All such items are subject to advance written approval by the Department.
- f. As permitted by Section V.A.4 Expanded or Value-Added Service, the CHC-MCO may offer Participants Expanded or Value-Added Services and is permitted to feature such Services in approved outreach materials.
- g. The CHC-MCO may offer Participants consumer incentives only if they are directly related to improving health outcomes. The CHC-MCO may not use an incentive to influence a Participant to receive any item or

service from a particular Provider, practitioner or supplier. In addition, the incentive cannot exceed the total cost of the service being provided. The CHC-MCO must receive advance written approval from the Department prior to offering a Participant incentive.

- h. Unless approved by the Department, CHC-MCOs are not permitted to directly provide products of value unless they are health-related and are prescribed by a licensed Provider. CHC-MCOs may not offer Participant coupons for products of value.
- i. Except where review and approval is specifically required, the Department may review any and all other outreach activities and advertising materials and procedures used by the CHC-MCO, including all outreach activities, advertising materials, and corporate initiatives that are likely to reach MA Beneficiaries. In addition to any other sanctions, the Department may impose monetary or restrict Enrollment if the Department determines the CHC-MCO used unapproved outreach materials or engaged in unapproved outreach practices. The Department may suspend all outreach activities and the completion of applications for new Participants. Such suspensions may be imposed for a period of up to sixty (60) days from notification by the Department to the CHC-MCO citing the violation.
- j. The CHC-MCO may not, under any conditions use the Department's eligibility system to identify and market to individuals participating in the LIFE Program or enrolled in another CHC-MCO. The CHC-MCO may not share or sell Participant lists for any purpose, with the limited exception of sharing Participant information with Affiliates or subcontractors under Department approved arrangements to fulfill the requirements of this Agreement.
- k. The CHC-MCO must submit a plan for advertising, sponsorship, and outreach procedures to the Department for advance written approval in accordance with Exhibit O Guidelines for CHC-MCO Advertising, Sponsorships, and Outreach.
- l. The CHC-MCO must conduct and participate in Department Provider and Participant outreach efforts.

4. Limited English Proficiency Requirements

Beginning at Enrollment, the CHC-MCO must seek to identify Participants who speak or read a language other than English as their first language. The CHC-MCO must identify and communicate using spoken and written language preferences identified by the IEE and CHC-MCO during its contacts with the Participant.

The CHC-MCO must provide, at no cost to Participants, oral interpretation services in the requested language or sign language interpreter services to meet the needs of Participants. The CHC-MCO must require Network Providers to offer interpretation services and prohibit Network Providers from requiring a Participant's family member be used for interpretation. Interpretation services must also include all services dictated by federal requirements. If a Network Provider is unable or unwilling to provide these services, the CHC-MCO must provide interpretation services.

The CHC-MCO must make all Vital documents disseminated to English speaking Participants available in the prevalent languages designated by the Department. The CHC-MCO must include appropriate instructions in all materials about how to access or receive assistance to access materials in an alternate language.

The CHC-MCO must post Vital documents on its website.

5. Alternate Format Requirements

The CHC-MCO must provide alternative methods of communication for Participants who have neurocognitive impairments or who are visually or hearing impaired or both, including Braille, audio tapes, large print, compact disc, DVD, computer diskette, special support services, and/or electronic communication. The CHC-MCO must, upon request from the Participant, make all written materials disseminated to Participants accessible to visually impaired Participants. The CHC-MCO must provide TTY and/or Pennsylvania Telecommunication Relay Service for communicating with Participants who are deaf or hearing impaired, upon request.

The CHC-MCO must include appropriate instructions in all materials about how to access or receive assistance to access materials in an alternate format.

6. CHC-MCO Enrollment Procedures

The CHC-MCO must have in effect written enrollment policies and procedures for newly enrolled Participants. The CHC-MCO must also provide written policies and procedures for coordinating Enrollment information with the Department's IEE. The CHC-MCO must receive advance written approval from the Department regarding these policies and procedures.

The CHC-MCO must enroll any Potential Participant who selects or is assigned to the CHC-MCO in accordance with the Enrollment/Disenrollment dating rules that are determined and provided by the Department on the CHC Intranet and Exhibit AA Auto Assignment regardless of the individual's

race, color, creed, religion, age, sex, national origin, ancestry, marital status, sexual orientation, gender identity, income status, program participation, Grievance status, MA category status, health status, pre-existing condition, physical or mental disability or anticipated need for healthcare.

7. Enrollment of Newborns

Newborns will not be enrolled in the CHC.

8. Transitioning Participants Between CHC-MCOs

Service Coordinators will assist Participants to facilitate a seamless transition between CHC-MCOs. The CHC-MCO must follow the Department's established procedures as outlined in Exhibit P, CHC-MCO Participant Coverage Document.

9. Transitioning Participants Between CHC-MCOs and LIFE Programs

The Service Coordinator will assist Participants eligible for LIFE who voluntarily choose to transition between the CHC-MCO and LIFE, where available, in order to facilitate a seamless transition. All transitions to the LIFE program will be effective on the date specified by the Department.

10. Change in Status

The CHC-MCO must report to the Department on a weekly Enrollment/Alert file the following: pregnancy not on CIS, death, and return mail alerts in accordance with Section VIII.B.4 Alerts.

The CHC-MCO must report to the appropriate CAO using the CAO notification form any changes in the status of families or individual Participants within ten (10) business days of the change becoming known, including changes of phone number, address, pregnancy, death and family addition/deletion. The CHC-MCO also must provide a detailed explanation of how the information was verified.

11. Participant Files

a. Monthly File

The Department will provide a Monthly Participant File for the CHC-MCO on the next to the last Saturday of each month. The file contains the MA Eligibility Period, CHC-MCO coverage, BH-MCO coverage and other Participant demographic information. It will contain only one record for each CHC Participant (the most current) where the Participant is both MA

and CHC eligible at some point in the following month. The CHC-MCO must reconcile this Participant file against its internal Participant information and notify the Department of any discrepancies found within the data on the file within thirty (30) business days.

The CHC-MCO is not responsible for Participants not included on this file with an indication of prospective coverage unless a subsequent Daily Participant File indicates otherwise. The CHC-MCO is not responsible for Participants with an indication of future month coverage if an 834 Daily Participant File received by the CHC-MCO prior to the beginning of the future month indicates otherwise.

b. Daily File

The Department will provide to the CHC-MCO a Daily Participant File that contains record(s) for each Participant where data for that Participant has changed that day. The file will contain add, termination and change records, but will contain only one type of managed care coverage, either CHC, PH or BH. The file contains demographic changes, eligibility changes, Enrollment changes, Participants enrolled through the automatic assignment process, and TPL information. The CHC-MCO must process this file within 24 hours of receipt.

The CHC-MCO must reconcile this file against its internal Participant information and notify the Department of any discrepancies within thirty (30) business days.

12. Enrollment and Disenrollment Updates

a. Weekly Enrollment/Alert Reconciliation File

The Department will provide, every week by electronic file transmission, information on Participants enrolled or disenrolled and the dispositions on Alerts submitted by the CHC-MCO. The CHC-MCO must use this file to reconcile Alerts submitted to the Department.

b. Disenrollment Effective Dates

Participant disenrollments will become effective on the date specified by the Department. The CHC-MCO must have written policies and procedures which have been reviewed and approved by the Department for complying with disenrollment decisions made by the Department.

13. Services for New Participants

The CHC-MCO must make available all Covered Services to new

Participants as of the Participant's effective date of Enrollment provided by the Department and must comply with the Continuity of Care requirements outlined in Section V.C. of this Agreement.

14. New Participant Orientation

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

- Educational and preventative care programs that include an emphasis on health promotion, wellness and healthy lifestyles and practices,
- The proper use of the CHC-MCO identification card and the ACCESS Card,
- The role of the PCP,
- The role of the Service Coordinator,
- The needs assessment process,
- The role of the PCPT,
- PCSPs and the service planning process,
- Access to behavioral health services, transportation, home modifications, etc.,
- Participant Self-Directed models,
- What to do in an emergency or urgent medical situation,
- How to utilize services in other circumstances,
- How to request information from the CHC-MCO
- How to register a Complaint, file a Grievance or request a DHS Fair Hearing,
- Service Coordination Unit and how to contact it directly, if necessary.
- Notice that balance billing is prohibited and what to do in the event a Provider balance bills,
- What Expanded or Value-Added Services the CHC-MCO has been approved to provide and how long these are required to be available to Participants who qualify to receive them,
- Assistance in coordination Medicare services that are available to the Participant,
- The benefit of enrolling in a Medicare Part D plan with a zero copay.

The CHC-MCO must obtain the Department's advance written approval of the policies and procedures, plan or program.

The CHC-MCO is prohibited from contacting a Potential Participant who is identified on the Daily Participant Enrollment File with an automatic assignment indicator (either an "A" auto assigned or "M" Participant assigned) until five (5) business days before the effective date of the Participant's Enrollment unless otherwise requested by the Department.

15. CHC-MCO Identification Cards

The CHC-MCO must issue its own identification card to Participants. The CHC-MCO must issue a single identification card to Participants enrolled in the aligned D-SNP for both the CHC-MCO and the D-SNP.

16. Participant Handbook

The CHC-MCO must provide a Participant handbook, or other written materials, with information on Participant rights and protections as outlined in this Agreement and Exhibit FF Participants' Rights and how to access services, in the appropriate language or alternate format to Participants within five (5) business days of a Participant's effective date of Enrollment. The CHC-MCO may provide the Participant handbook in formats other than hard copy. If this option is exercised, the CHC-MCO must inform Participants what formats are available and how to access each format. The CHC-MCO must annually review the Participant handbook and document it reviewed the Participant handbook for accuracy and that all necessary modifications were made. The CHC-MCO must notify all Participants on an annual basis of any changes made, and the formats and methods available to access the handbook. Upon request, the CHC-MCO must provide a hard copy of the Participant handbook to the Participant.

a. Participant Handbook Requirements

The CHC-MCO must develop and provide a Participant handbook that is accessible, easily understood, and written at no higher than a sixth grade reading level and includes, at a minimum, the information outlined in Exhibit R, CHC-MCO Participant handbook.

In the Participant handbook, the CHC-MCO must include a reference and a link to the handbook for the aligned D-SNP so that Participants enrolled in both plans may easily reference the D-SNP handbook.

Additionally, the CHC-MCO must (i) use a font and format are readily accessible, (ii) place the information its CHC-MCO website where it is prominent and available, and (iii) provide that information in an electronic form can be electronically retained and printed.

b. Department Approval

The CHC-MCO must submit the Participant handbook to the Department for advance written approval prior to distribution to Participants. The CHC-MCO must make any modifications to the Participant handbook if required for Department approval.

17. Provider Directory

The CHC-MCO must make a single directory for all types of Network Providers.

The CHC-MCO must utilize a web-based Provider directory. The CHC-MCO must establish a process to address the accuracy of electronically posted content, including a method to monitor and update changes in Provider information. The CHC-MCO must perform at least monthly reviews and revisions of the web-based Provider directory, subject to random monitoring by the Department.

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

- Correct Provider ID
- All Providers in the Network
- The location where the PCP will see Participants, as well as whether the PCP has evening and/or weekend hours
- Accessibility of the Provider site to persons with physical disabilities
- Language indicators including non-English language spoken by the Providers.

The CHC-MCO must notify its Participants annually of their right to request and obtain a hard copy Provider directory and where the online directory may be found. Upon request, the CHC-MCO must provide Participants with its Provider directory which includes, at a minimum, the information listed in Exhibit S, Provider Directories. Upon request from the Participant, the CHC-MCO will print the most recent electronic version from its Provider file and mail it to the Participant.

The CHC-MCO must submit the Provider directory to the Department for advance written approval before distribution to its Participants. Unless the CHC-MCO makes significant format changes, the CHC-MCO is not required to submit changes to the Department for approval.

The CHC-MCO must reference and include a link to the directory for the aligned D-SNP in the Provider directory so that Participants enrolled in both plans may easily reference the D-SNP directory.

18. Participant Advisory Committee

The CHC-MCO must establish and maintain a PAC for the zone in which it operates. The PAC must include Participants and Network Providers to advise on the experiences and needs of Participants. The CHC-MCO must include Participants who are representative of the population being served as well as family caregivers as members of the PAC. Provider representation must include PH, BH, dental health and LTSS. The CHC-MCO must provide the Department annually with the membership (including designation) of the PAC. The PAC membership must be composed of at least 60% of Participants, with 25% of the total membership receiving LTSS. In addition to the individual diversity, the CHC-MCO should seek to have geographic diversity including both rural and urban representation.

The CHC-MCO must schedule PAC meetings no less than quarterly with in-person meetings, and will reimburse travel expenses for Participants, caregivers, and their family members. The CHC-MCO will provide necessary reasonable accommodations to allow for in-person access to the PAC. PAC communications and meetings must be accessible to Participants with LEP.

The CHC-MCO must provide DHS with advance notification of the date, time, and location of all PAC meetings.

The CHC-MCO must also work with the Department to provide its PAC members with an effective means to consult with each other and, when appropriate, coordinate efforts and resources for the benefit of the entire CHC population in the zone and/or populations with LTSS needs. The CHC-MCO must report out any updates or proposed changes, the number and nature of complaints, and any quality improvement strategies or implementations and invite PAC members to raise questions and concerns about topics affecting their quality of life and their experience with the CHC-MCO. The CHC-MCO must provide minutes of the PAC meeting to the Department and post them on the CHC-MCO website.

19. Voluntary Disenrollment

Participants may only voluntarily disenroll from the CHC program if:

- They are eligible for and transition to LIFE,
- They are moving to a zone in which CHC is not yet operational, or
- They are choosing to no longer receive any MA covered services.

20. Involuntary Disenrollment

The Department will involuntarily disenroll Participants from the CHC Program when it determines the Participant is no longer eligible for CHC. The CHC-MCO may not request disenrollment of a Participant for

any reason.

The CHC-MCO Service Coordinator will provide assistance to the disenrolled Participant to assist in transitioning to other resources to provide for continuity of care.

P. Participant Services

1. General

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

- Explaining the operation of the CHC-MCO and assisting Participants in PCP selection.
- Assisting Participants with making appointments and obtaining services, including interpreter services, as needed.
- Assisting with transportation for Participants through the MATP as required in Section V.A.14., Transportation and Exhibit J, Medical Assistance Transportation Program.
- Receiving, identifying and resolving Emergency Participant Issues.

The CHC-MCO is prohibited from using unlicensed Participant services staff to provide health-related advice to Participants requesting clinical information. The CHC-MCO must require that all such inquiries be addressed by clinical personnel acting within the scope of their licensure to practice a health-related profession.

The CHC-MCO must forward all calls received by the Participant Service area in which the caller requests their Service Coordinator to the Participant's Service Coordinator. In the event the call is received beyond the hours of availability, CHC-MCO staff must record a message, including the Participant's name, Participant identification number and call back number, and forward the information to the Service Coordinator staff for a return call. The Service Coordinator or the Service Coordinator's designated back-up person must return the call as soon as possible but no longer than two (2) business days from the receipt of the call unless the Participant indicates the need for immediate assistance. The CHC-MCO will then direct the Participant to the Nurse Hotline for assistance.

2. CHC-MCO Internal Participant Dedicated Hotline

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

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

The CHC-MCO is not permitted to utilize electronic call answering methods, as a substitute for staff persons. The CHC-MCO must have a dedicated hotline that meets the following performance standards:

- Provides for a dedicated toll-free phone line for Participants.
- Provides for necessary translation and interpreter assistance for LEP Participants.
- Requires representatives to document calls and forward call notes to the Participant's Service Coordinator.
- Be staffed by individuals trained in:
 - Cultural, Linguistic, and Disability Competency.
 - Addressing the needs of covered populations.
 - The availability of contact information for, and the functions of the Service Coordination.
 - Requirements for accessibility.
 - Coordination with BH-MCOs.
 - How to identify and handle any emergency.
 - When to transfer callers to the Nurse Hotline.
 - Covered Services and the availability of protective and social services within the community.
 - Medicare coverage and addressing questions relating to the CHC-MCO's companion D-SNP plan.
 - Medical and non-medical transportation.
- Be staffed with adequate service representatives so that the abandonment rate is less than or equal to five percent (5%) of the total

- calls.
- Be staffed with adequate service representatives so that at least 85% of all calls are answered within thirty (30) seconds.
- Provide for TTY and/or Pennsylvania Telecommunication Relay Service availability for Participants who are deaf or hard of hearing.

3. Nurse Hotline

The CHC-MCO must maintain and staff a twenty-four (24) hour, seven (7) day-a-week toll-free dedicated Nurse Hotline to respond to Participants' urgent health matters.

4. Education and Outreach/Health Education Advisory Committee

The CHC-MCO must establish and maintain a Health Education Advisory Committee that includes Participants and Providers in the community to advise on the health education needs of Participants. Provider representation includes physical health, LTSS, behavioral health, and dental health Providers. The CHC-MCO must provide the Department annually with the membership including designation and meeting schedule of the Health Education Advisory Committee.

The CHC-MCO must provide for and document coordination of health education materials, activities, and programs with public health entities, particularly as they relate to public health priorities and population-based interventions. Population-based interventions include those that are relevant to the populations being served and that take into consideration the ability of these populations to understand and act upon health information. The CHC-MCO must also work with the Department to provide its Health Education Advisory Committees with an effective means to consult with each other and, when appropriate, coordinate efforts and resources for the benefit of the entire CHC population in the CHC zone and/or populations with Special Needs.

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

5. Informational Materials

The CHC-MCO must distribute Participant newsletters at least three times a year to each Participant household. The CHC-MCO may provide Participant newsletters in formats other than hard copy, but must provide a hard copy to a Participant who asks for one. The CHC-MCO must include information about common procedures in its Participant newsletter and information

provided by the Department related to Department initiatives, and make the same information available on its website in an effort to increase Participant health literacy. The CHC-MCO will also provide information about its aligned D-SNP including the services covered, the enhanced Service Coordination available to those enrolled in both, and how to request enrollment. The CHC-MCO must obtain advance written approval from the Department of all Participant newsletters. The CHC-MCO must notify all Participants of the availability and methods to access each Participant newsletter.

The CHC-MCO must obtain advance written approval from the Department to use Participant or CHC related information on electronic web sites and bulletin boards which are accessible to the public or to the CHC-MCO's Participants.

Q. Additional Addressee

The CHC-MCO must comply with HIPAA and state law requirements and have administrative mechanisms for sending copies of information, notices and other written materials to a Participant's legal guardian, agent under power of attorney, or other designated third party, as per the request and signed consent of the Participant. The CHC-MCO must develop plans to process such individual requests and for obtaining the necessary releases signed by the Participant to protect the Participant's confidentiality rights.

R. Participant Complaint, Grievance and DHS Fair Hearing Process

1. Participant Complaint, Grievance and DHS Fair Hearing Process

The CHC-MCO must develop, implement, and maintain a Complaint and Grievance process that provides for settlement of Participants' Complaints and Grievances and the processing of requests for DHS Fair Hearings as outlined in Exhibit T Complaint, Grievance, and DHS Fair Hearing Processes. The CHC-MCO must use templates T(1) through T(14) to inform Participants regarding decisions and the process.

The CHC-MCO must require each of its subcontractors to comply with the Participant Complaint, Grievance, and DHS Fair Hearing Process, including reporting requirements established by the CHC-MCO, which have received advance written approval by the Department. The CHC-MCO must provide to the Department for approval, its written procedures governing the resolution of Complaints and Grievances and the processing of DHS Fair Hearing requests. The CHC-MCO may not delegate the Complaint, Grievance and Fair Hearing process to a subcontractor without prior written approval of the Department.

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

When a Participant files an external appeal of a second level Grievance decision, the CHC-MCO must abide by the decision of the DOH's certified review entity, which was assigned to conduct the independent external review, unless appealed to the court of competent jurisdiction.

The CHC-MCO must abide by the decision of BHA for those cases when a Participant has requested a DHS Fair Hearing, unless the CHC-MCO or the Participant files a timely request for reconsideration before the Secretary of the Department. A request for reconsideration to the Secretary of the Department will stay the action proposed in the BHA decision. In cases where a timely request for reconsideration is made and the Secretary issues a timely decision on reconsideration, the CHC-MCO and Participant must comply with the reconsideration decision. Only the Participant may appeal a BHA final administrative action and the reconsideration decision to Commonwealth Court.

2. DHS Fair Hearing Process for Participants

Throughout the Grievance process, and in some instances involving Complaints, the Participant has the right to request a DHS Fair Hearing. The CHC-MCO must comply with the DHS Fair Hearing Process requirements defined in Exhibit T Complaint, Grievance and DHS Fair Hearing Processes.

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

S. OLTL and other DHS Hotlines

The CHC-MCO will cooperate with OLTL and other DHS Hotlines, which are intended to address clinically-related systems issues encountered by Participants and their advocates or Providers.

T. Provider Dispute Resolution Process

The CHC-MCO must develop, implement, and maintain a Provider Dispute Resolution Process, which provides for informal resolution of Provider Disputes at the lowest level and a formal process for Provider Appeals. The CHC-MCO and the Provider must handle the resolution of all issues regarding the interpretation of Provider Agreements and shall not involve the Department; therefore, Provider

disputes and appeals are not within the jurisdiction of the Department's BHA.

Prior to implementation, the CHC-MCO must submit to the Department its policies and procedures for resolution of Provider Disputes and Provider Appeals for approval.

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

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

U. Certification of Authority and County Operational Authority

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

The CHC-MCO must also maintain operating authority in each county within the zone and must provide to the Department a copy of the DOH correspondence granting operating authority in each county upon request.

V. Executive Management

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

- A full-time Administrator with authority over the entire operation of the CHC-MCO.
- A full-time CHC Program Manager to oversee the operation of the

Agreement, if different than the Administrator.

- A full-time Medical Director who is a current Pennsylvania-licensed physician. The Medical Director must be actively involved in all major clinical program components of the CHC-MCO and directly participate in the oversight of the QM Department and UM Department. The Medical Director and his/her staff/consultant physicians must devote sufficient time to the CHC-MCO to provide timely medical decisions, including after-hours consultation, as needed.
- A full-time Pharmacy Director who is a current Pennsylvania-licensed pharmacist. The Pharmacy Director oversees the pharmacy management and serves on the CHC-MCO P&T Committee.
- A full-time Director of Quality Management who is a Pennsylvania-licensed RN, physician or physician's assistant or is a Certified Professional in Healthcare Quality by the National Association for Healthcare Quality Certified in Healthcare Quality and Management by the American Board of Quality Assurance and Utilization Review Providers. The Director of Quality Management must be located in Pennsylvania and have experience in quality management and quality improvement. Sufficient local staffing under this position must be in place to meet quality management Requirements. The primary functions of the Director of Quality Management position are:
 - Evaluate individual and systemic quality of care
 - Integrate quality throughout the organization
 - Implement process improvement
 - Resolve, track, and trend quality of care complaints
 - Develop and maintain a credentialed Provider network
- A full-time Director of LTSS who is responsible for and oversight of all LTSS. The Director of LTSS must have at least five (5) years of experience administering managed long-term care programs. On a case-by-case basis, equivalent experience in administering long-term care programs and services, including HCBS, or in managed care may be substituted, subject to the prior approval of the Department.
- A full-time CFO to oversee the budget and accounting systems implemented by the CHC-MCO. The CFO is responsible for providing accurate and timely financial reports. The CFO shall devote sufficient time and resources to responsibilities under this agreement.
- A full-time Information Systems Coordinator, who is responsible for the oversight of all information systems issues with the Department. The Information Systems Coordinator must have a good working knowledge of the CHC-MCO's entire program and operation, as well as the technical

expertise to answer questions related to the operation of the information system.

Aside from the CFO, these full time positions must be solely dedicated to the Pennsylvania's Community HealthChoices Program.

W. Other Administrative Components

The CHC-MCO must provide for each of the administrative functions listed below.

- A Quality Management/Quality Improvement Coordinator who is a Pennsylvania-licensed physician, RN or physician's assistant with past experience or education in QM systems. The Department may consider other advanced degrees relevant to QM in lieu of professional licensure. The QM/QI Coordinator is responsible for overseeing reporting and outcome measurement and HEDIS data collection, serving as point person between the Department and the Department's EQR contractor.
- A BH Coordinator who is a behavioral health professional and is located in Pennsylvania. The Behavioral Health Coordinator shall monitor the CHC-MCO for adherence to BH requirements in this Agreement. The primary functions of the BH Coordinator are:
 - Coordinate Participant care needs with BH Providers.
 - Develop processes to coordinate behavioral healthcare between PCPs and BH Providers.
 - Participate in the identification of best practices for BH in a primary care setting.
 - Coordinate behavioral care with medically necessary services.
 - Be knowledgeable of the BH Managed Care agreement requirements and coordinate with the BH-MCO to effectuate the requirements.
- A Director of Network Management who coordinates all communications and contractual relationships between the CHC-MCO and its subcontractors and Providers. The Director of Network Management must be located in Pennsylvania and is responsible for providing Providers with prompt resolution of their problems or inquiries and appropriate education about participation in CHC and maintaining a sufficient Network. Individual Provider representatives will report directly to the Director of Network Management.
- A UM Coordinator who is a Pennsylvania-licensed physician, RN or physician's assistant with past experience or education in UM systems. The Department may consider other advanced degrees relevant to UM in lieu of professional licensure.
- A Director of Service Coordination oversees all Service Coordination

functions of the CHC plan and who shall have the qualifications of a Service Coordinator and a minimum of five years of management/supervisory experience in the healthcare field. The Director of Service Coordination is responsible for all Service Coordination functions, whether the CHC-MCO provides all Service Coordinator functions in house or contracts with outside entities to meet Service Coordination requirements.

- A Government Liaison who serves as the Department's primary point of contact with the CHC-MCO for day-to-day management of contractual and operational issues. The CHC-MCO must have a designated back-up trained to be able to handle urgent or time-sensitive issues when the Government Liaison is not available.
- A Participant Services Manager who oversees staff to coordinate communications with Participants and enables Participants to receive prompt resolution of their issues, problems or inquiries.
- A Provider Services Manager who oversees staff to coordinate communications between the CHC-MCO and its Providers. There must be sufficient CHC-MCO Provider services, or equivalent department that addresses this function, staff to promptly resolve Provider Disputes, problems or inquiries. Staff must also be adequately trained to understand Cultural, Linguistic, and Disability competencies.
- A Provider Claims Educator who is located in Pennsylvania and facilitates the exchange of information between the Grievances, Claims processing, and Provider relations systems. The primary functions of the Provider Claims Educator are to:
 - Educate contracted and non-contracted Providers (e.g. HCBS Providers and Participant-Directed Services Providers) regarding appropriate Claims submission requirements, coding updates, electronic Claims transactions and electronic fund transfer, and available CHC-MCO resources such as Provider manuals, website, fee schedules, etc.
 - Interface with the CHC-MCO's call center to compile, analyze, and disseminate information from Provider calls.
 - Identify trends and guide the development and implementation of strategies to improve Provider satisfaction.
 - Communicate frequently (i.e., telephonic and on-site) with Providers to provide for the effective exchange of information and to gain feedback regarding the extent to which Providers are informed about appropriate claims submission practices.
- A Complaint, Grievance and DHS Fair Hearing Coordinator whose qualifications demonstrate the ability to assist Participants throughout the Complaint, Grievance and DHS Fair Hearing processes.

- A Claims Administrator who oversees staff to provide for the timely and accurate processing of Claims, Encounter forms and other information necessary for meeting agreement requirements and the efficient management of the CHC-MCO.
- A Contract Compliance Officer who monitors the CHC-MCO's compliance with all the requirements of the Agreement.

All CHC-MCO staff must have appropriate training, education, experience, and orientation to fulfill the requirements of their position. The CHC-MCO must update job descriptions for each of the positions if responsibilities for these positions change.

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

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

The CHC-MCO must have in place sufficient administrative staff and organizational components to comply with the requirements of this Agreement and include in its organizational structure the components outlined in the Agreement. The CHC-MCO must staff these functions with qualified persons in numbers appropriate to the CHC-MCO's size of Enrollment. The Department will determine whether or not the CHC-MCO is in compliance.

The CHC-MCO may contract with a third party to perform one (1) or more of its functions, subject to the subcontractor conditions described in Section XII, Subcontractual Relationships. The CHC-MCO is required to keep the Department informed at all times of the management individuals whose duties include each of the responsibilities outlined in this section.

X. Administration

The CHC-MCO must have an administrative office within the CHC zone. In its discretion, the Department may grant exceptions if the CHC-MCO has administrative offices elsewhere in Pennsylvania and the CHC-MCO is in compliance with all standards set forth by the DOH and PID.

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

1. Participant Lock-in Program

BPI manages a Centralized Recipient Lock-in Program for the MA FFS and the managed care delivery systems. The Department is solely responsible for restricting Participants.

The CHC-MCO will maintain a Participant Restriction Program to interface with the Department's Recipient Lock-in Program, and will provide for appropriate professional resources to manage the CHC-MCO program and to cooperate with the Department in all procedures necessary to restrict Participants. The CHC-MCO must obtain approval from the Department prior to implementing a Lock-in, including approval of written policies and procedures and correspondence to Participants. The CHC-MCO's process must include:

- Identifying Participants who are overutilizing or misutilizing medical services.
- Evaluating the degree of abuse including review of pharmacy and medical claims history, diagnoses and other documentation, as applicable.
- Proposing whether the Participant should be restricted to obtaining services from a single, designated Provider for a fixed period.
- Forwarding case information and supporting documentation to BPI for review to determine appropriateness of lock-in and to approve the action.
- Upon BPI approval, sending notification via certified mail to Participant of proposed Lock-in, including reason, effective date and length of Lock-in, name of designated Provider(s) and option to change Provider, with a copy to BPI.
- Sending notification of Participant's Lock-in to the designated Provider(s) and the CAO.
- Enforcing Lock-ins through appropriate notifications and edits in the claims payment system.

- Preparing and presenting case at a DHS Fair Hearing to support Lock-in action.
- Monitoring subsequent utilization to ensure compliance.
- Changing the selected Provider per the Participant's or Provider's request, within thirty (30) days from the date of the request, with prompt notification to BPI through the Intranet Provider change process.
- Continuing a Participant Lock-in from the previous delivery system as a Participant enrolls in a MCO, with written notification to BPI.
- Reviewing the Participant's services prior to the end of the Lock-in period to determine if the Lock-in should be removed or maintained, with notification of the results of the review to BPI, Participant, Provider(s) and CAO.
- Performing necessary administrative activities to maintain accurate records.
- Educating Participants and Providers to the Lock-in program, including explanations in handbooks and printed materials.

MA Participants may appeal a Lock-in by requesting a DHS Fair Hearing but may not file a Complaint or Grievance with the CHC-MCO. A request for a DHS Fair Hearing must be in writing, signed by the Participant and sent to:

Department of Human Services Office of Administration
 Bureau of Program Integrity
 Division of Program and Provider Compliance Recipient Restriction
 P.O. Box 2675
 Harrisburg, Pennsylvania 17105-2675
 Phone number: (717) 772-4627

2. Contracts and Subcontracts

CHC-MCO may rely on subcontractors to perform or arrange for the performance of services to be provided to Participants. Notwithstanding its use of subcontractor(s), the CHC-MCO is responsible for compliance with the Agreement, including:

- a. The provision of and/or arrangement for the services under this Agreement.
- b. The evaluation of a prospective subcontractor's ability to perform the activities to be delegated.
- c. The payment of claim payment liabilities owed to Providers for services rendered to Participants under this Agreement, for which a subcontractor is the primary obligor provided that the Provider has exhausted its remedies against the subcontractor; provided further that such Provider would not be required to continue to pursue its remedies against the

subcontractor in the event the subcontractor becomes insolvent, in which case the Provider may seek payment of such Claims from the CHC-MCO. For the purposes of this section, the term “insolvent” shall mean:

- i. The adjudication by a court of competent jurisdiction or administrative tribunal of a party as a bankrupt or otherwise approving a petition seeking reorganization, readjustment, arrangement, composition, or similar relief under the applicable bankruptcy laws or any other similar, applicable Federal or State law or statute; or
 - i. The appointment by such a court or tribunal having competent jurisdiction of a receiver or receivers, or trustee, or liquidator or liquidators of a party or of all or any substantial part of its property upon the application of any creditor or other party entitled to so apply in any insolvency or bankruptcy proceeding or other creditor’s suit; and
- d. The oversight and accountability for any functions and responsibilities delegated to a subcontractor.

The above notwithstanding, if the CHC-MCO makes payments to a subcontractor over the course of a year that exceed one-half of the amount of the Department’s payments to the CHC-MCO, the CHC-MCO is responsible for any obligation by the subcontractor to a Provider that is overdue by at least sixty (60) days.

The CHC-MCO shall require that all subcontractors and Network Providers comply with all applicable CHC requirements.

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

In accordance with Exhibit D Standard Terms and Conditions, the CHC-MCO must submit for prior approval Subcontracts to perform part or all of the selected CHC-MCO’s responsibilities under this agreement. This provision includes, but is not limited to, contracts for vision services, dental services, Claims processing, Participant services, and pharmacy services.

3. Records Retention

The CHC-MCO will comply with the program standards regarding records retention, which are set forth in federal and state law and regulations, in Exhibit D Standard Terms and Conditions for Services, and Exhibit Y CHC Audit Clause, unless otherwise authorized by the Department. Upon thirty (30) days’ notice from the Department, the CHC-MCO must provide copies of

all records to the Department at the CHC-MCO's site or other location determined by the Department, if requested. This thirty (30) day notice does not apply to records requested by the state or federal government for purposes of fiscal audits or Fraud and Abuse investigations. The retention requirements in this section do not apply to DHS-generated Remittance Advices.

4. Fraud and Abuse

The CHC-MCO must develop and implement administrative and management arrangements and procedures and a mandatory written compliance plan to prevent, detect, and correct Fraud, waste, and Abuse that contains the elements described in CMS publication "Guidelines for Constructing a Compliance Program for Medicaid Managed Care Organizations and Prepaid Health Plans" found at:

<https://www.cms.gov/Medicare-Medicaid-Coordination/Fraud-Prevention/FraudAbuseforProfs/Downloads/mccomplan.pdf>

and that includes the following:

- Written policies, procedures, and standards of conduct that articulate the CHC-MCO's commitment to comply with all Federal and State standards related to MA MCOs.
- The designation of a compliance officer and a compliance committee that is accountable to CHC-MCO senior management.
- Effective training and education for the compliance officer and CHC-MCO employees.
- Effective lines of communication between the compliance officer and CHC-MCO employees.
- Enforcement of standards through well publicized disciplinary guidelines.
- Provisions for internal monitoring and auditing.
- Provisions for prompt response to detected offenses and the development of corrective action initiatives.
- Procedures for systematic confirmation of services actually provided.
- Policies and procedures for reporting all Fraud, waste and Abuse to the Department.
- Policies and procedures for Fraud, waste, and Abuse prevention, detection and investigation.
- A policy of non-intimidation and non-retaliation for good faith participation in the compliance program, including but not limited to reporting potential issues, investigating issues, conducting self-evaluations, audits and remedial actions, and reporting to appropriate officials.
- A policy and procedure for monitoring provider preclusion through data bases identified by the Department.

a. Fraud, Waste and Abuse Unit

The CHC-MCO must establish a Fraud, Waste and Abuse Unit comprised of experienced Fraud, Waste and Abuse reviewers. This Unit must have the primary purpose of preventing, detecting, investigating, referring, and reporting suspected Fraud, waste and Abuse that may be committed by Network Providers, Participants, caregivers, employees, or other third parties. If the CHC-MCO has multiple lines of business, the Fraud, Waste and Abuse Unit must devote sufficient time and resources to the CHC Fraud, Waste and Abuse activities. The Department will determine whether or not the CHC-MCO is in compliance with these requirements.

b. Written Policies

The CHC-MCO must create and maintain written policies and procedures for the prevention, detection, investigation, reporting and referral of suspected Fraud, waste and Abuse, including any and all fraud and abuse policies delineated under state and or federal mandate.

c. Access to Provider Records

The CHC-MCO's Fraud, Waste and Abuse policies and procedures must provide that the CHC-MCO's Fraud, Waste and Abuse Unit has access to records of Network Providers.

d. Audit Protocol

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

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

e. Procedure for Identifying Fraud, Waste and Abuse

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

- i. A description of the methodology and standard operating procedures used to identify and investigate Fraud, Waste and Abuse, including a method for verifying with Participants whether services billed by Providers were received, and to recover

overpayments or otherwise sanction Providers.

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

f. Referral to the Department

The CHC-MCO must establish and implement a policy on referral of suspected Provider Fraud, Waste and Abuse to the Department. A standardized referral process is outlined in Exhibit U, Reporting Suspected Fraud, Waste and Abuse to the Department.

g. Education Plan

The CHC-MCO must create and disseminate written materials for the purpose of educating its employees, Providers, subcontractors and subcontractors' employees about healthcare Fraud laws, the CHC-MCO's policies and procedures for preventing and detecting Fraud, Waste and Abuse and the rights of individuals to act as whistleblowers.

h. Referral to Senior Management

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

i. Prior Department Approval

The CHC-MCO must submit its Fraud, Waste and Abuse policies and procedures to the Department for prior approval, and the Department may, upon review of these policies and procedures, require that specified changes be made within a designated time in order for the CHC-MCO to remain in compliance with the this Agreement.

j. Duty to Cooperate with Oversight Agencies

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

Such cooperation must include providing access to all necessary case information, computer files, and appropriate staff. In addition, such cooperation will include participating in periodic Fraud, Waste and Abuse training sessions, meetings, and joint reviews of Providers or Participants.

I. Hotline Information

The CHC-MCO must distribute the Department's toll-free MA Provider Compliance Hotline number and accompanying explanatory statement to its Participants and Providers through its Participant handbook and Provider directory.

m. Duty to Notify

i. Department's Responsibility

The Department will provide the CHC-MCO with immediate notice via electronic transmission or access to Medichex listings or upon request if a Network Provider is subsequently suspended or terminated from participation in the MA or Medicare Programs. Upon notification from the Department, the CHC-MCO must immediately act to terminate the Provider from its Network. A CHC-MCO's termination must coincide with the MA effective date of termination for loss of licensures and criminal convictions.

ii. CHC-MCO's Responsibility

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

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

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

- A director, officer, or partner of the CHC-MCO.
- A person with beneficial ownership of five percent (5%) or more of the CHC-MCO's equity.
- A person with an employment, consulting or other arrangement for

the provision of items and services that are significant and material to the CHC-MCO's obligations under this Agreement.

The CHC-MCO must immediately notify the Department, in writing, if a Network Provider or subcontractor is suspended, terminated or voluntarily withdraws from participation in the MA program as a result of suspected or confirmed Fraud, Waste or Abuse. The CHC-MCO must also immediately notify the Department, in writing, if it terminates or suspends an employee as a result of suspected or confirmed Fraud or Abuse. The CHC-MCO must inform the Department, in writing, of the specific underlying conduct that led to the suspension, termination, or voluntary withdrawal. The CHC-MCO must include in its Provider Agreements notification of the prohibition and sanctions for submission of false Claims and statements. CHC-MCOs who fail to report such information are subject to sanctions, or other actions. The Department's enforcement guidelines are outlined in Exhibit X, Guidelines for Sanctions Regarding Fraud, Waste and Abuse.

The CHC-MCO must also notify the Department if it recovers overpayments or improper payments related to Fraud, Abuse or Waste of MA funds from non-administrative overpayments or improper payments made to Network Providers, or otherwise takes an adverse action against a Network Provider, such as. restricting the Participants or services of a PCP.

n. Sanctions

The Department may impose sanctions, or take other actions if it determines that a CHC-MCO, Network Provider, employee, caregiver or subcontractor has committed Fraud or Abuse as defined in this Agreement or has otherwise violated applicable law. Exhibit X, Guidelines for Sanctions Regarding Fraud, Waste and Abuse, identifies the Fraud, Waste and Abuse issues that may result in sanctions.

o. Subcontracts and Provider Agreements

- i. The CHC-MCO must require all Network Providers and all subcontractors take actions as are necessary to permit the CHC-MCO to comply with the Fraud, Waste and Abuse requirements in this agreement.
- ii. To the extent that the CHC-MCO delegates oversight responsibilities to a third party such as a Pharmacy Benefit Manager, the CHC-MCO must require that such third party complies with sections V.X.4.a – 4.b. above.

- iii. The CHC-MCO will require, via its Provider Agreement that Network Providers comply with MA regulations and any enforcement actions initiated by the Department under its regulations, including termination and restitution actions.

p. Overpayment Recovery

- The CHC-MCO shall audit, review and investigate Providers within its Network. The CHC-MCO shall recover any overpayments directly from its Network Providers for audits, reviews or investigations conducted solely by the CHC-MCO.
 - The CHC-MCO will void Encounters for those claims involving full recovery of the payment and adjust Encounters for partial recoveries.
 - The CHC-MCO must report all voids and adjustments to Encounters to the Department
- The Department may audit, review and investigate MA Providers within the CHC-MCO's Network.
 - The Department will develop a process to coordinate audits, reviews or investigations of Network Providers to avoid duplication of effort.
 - The CHC-MCO cannot initiate a review of a Network Provider after the Department advises the CHC-MCO of an open review or investigation by the Department, its representative, or another state or federal agency, without written Departmental authorization to proceed.
 - The Department will inform the CHC-MCO of its findings related to Network Providers.
 - The CHC-MCO must recoup overpayments resulting from audits, reviews or investigations conducted solely by the Department.
 - The CHC-MCO must recover overpayments identified by the Department from its Network Provider after the CHC-MCO receives the final results of the Department review.
 - The CHC-MCO must remit the overpayment to the Department no later than 180 calendar days after the mailing date of the final result of the review.
- The Department may require the CHC-MCO to withhold payment to a Network Provider or to initiate a pre-payment review as a result of law enforcement reviews and activities or the Department's audits, reviews or investigations.
- Joint reviews, audits or investigations between the CHC-MCO, the Department or the RAC may be conducted. Any recoveries as a

result of a joint audit, review or investigation shall be shared equally between the CHC-MCO and Department after payment of contingency fee to the RAC.

5. Management Information Systems

The CHC-MCO must have a comprehensive, automated and integrated health MIS that is capable of meeting the requirements listed below and throughout this agreement. See the information provided on the DHS Internet at the following link: <http://www.dhs.pa.gov/provider/busandtechstandards/index.htm>.

- a. The CHC-MCO must have at a minimum the following MIS components or the capability to interface with other systems containing this information: Participants, Provider, Claims processing, Prior Authorization, and Reference.
- b. The CHC-MCO must have an MIS sufficient to support data reporting requirements specified in this agreement.
- c. The Participant management system must have the capability to receive, update and maintain the CHC-MCO's Participant files consistent with information provided by the Department. The CHC-MCO must have the capability to provide daily updates of Participant information to subcontractors or Providers with responsibility for processing Claims or authorizing services based on Participant information.
- d. The CHC-MCO must maintain its Provider file with detailed information on each Provider sufficient to support Provider payment and meet the Department's reporting and Encounter Data requirements. The CHC-MCO must be able to cross-reference its internal Provider identification number to the correct PROMISe™ Provider ID and/or the Provider's NPI number in PROMISe™ for each location in which the Provider renders services for the CHC-MCO. The CHC-MCO must verify that each Network Provider service location is enrolled and active with MA. In addition, the CHC-MCO must maintain all service locations in their own system. The CHC-MCO must verify that each Network Provider's license information is valid in PROMISe, and must outreach to Network Providers to stress the importance of maintaining up to date information in PROMISe. The CHC-MCO must require its Network Providers with a specific Provider type/specialty have the same Provider type/specialty in PROMISe for each service location.
- e. The CHC-MCO's Claims processing system must have the capability

to process Claims consistent with timeliness and accuracy requirements identified in this agreement.

- f. The CHC-MCO's Prior Authorization system must be linked with the Claims processing component.
- g. The CHC-MCO's MIS must be able to maintain Claims history with sufficient detail to meet all Department reporting and Encounter requirements.
- h. The CHC-MCO's credentialing system must have the capability to store and report on Provider specific data sufficient to meet the Provider credentialing requirements outlined in the framework provided by the Department as well as those listed in Exhibit K(1), Quality Management and Utilization Management Program Requirements.
- i. The CHC-MCO must have sufficient telecommunication capabilities, including electronic mail, to meet the requirements of this Agreement.
- j. The CHC-MCO must have the capability to electronically exchange data files with the Department and the IEE. The CHC-MCO must use a secure FTP product that is compatible with the Department's data exchange standard within the Department's Business and Technical Standards.
- k. The CHC-MCO's MIS must be bidirectionally linked to the other operational systems listed in this agreement, in order that data captured in Encounter records accurately matches data in Participant, Provider, Claims and authorization files, and in order to enable Encounter Data to be utilized for Participant profiling, Provider profiling, Claims validation, Fraud and Abuse monitoring activities, rate setting and any other research and reporting purposes defined by the Department. The Encounter Data system must have a mechanism in place to receive and process the U277 and NCPDP response files; and to store the PROMISE™ ICN claim identifier associated with each processed Encounter Data record returned on the files.
- l. The CHC-MCO must comply with all applicable business and technical standards at stated in Appendix 1, CHC RFP.

The CHC-MCO must comply with the standards for connectivity to the Commonwealth's network. The CHC-MCO's MIS must be compatible with the Department's MIS. The CHC-MCO must also comply with the Department's Se-Government Data Exchange Standards. In addition, the CHC-MCO must comply with any changes made to the

Commonwealth's Business and Technical Standards and demonstrate their capacity to manage all business transactions and performance requirements. Whenever possible, the Department will provide advance notice of at least sixty (60) days prior to the implementation of changes. For more complex changes, the Department will make every effort to provide additional notice.

- m. The CHC-MCO must have the ability to expand claims processing or MIS capacity should either or both be exceeded through the Enrollment of Participants.
- n. The CHC-MCO must designate appropriate staff to participate in DHS directed development and implementation activities.
- o. The CHC-MCO must have formalized System Development Life Cycle processes, procedures, controls, and governance frameworks in place for management of its MIS and affiliated infrastructure; affiliated application, technology, and infrastructure roadmaps in place that outlines the current capabilities and future direction of the MIS; and procedures for when CHC-MCO and DHS representatives will be engaged to address current and future business needs and requirements.
- p. The CHC-MCO must require subcontractors to meet the same MIS requirements as the CHC-MCO and the CHC-MCO will be held responsible for MIS errors or noncompliance resulting from the action of a subcontractor. The CHC-MCO must provide its subcontractors with the appropriate files and information to meet this requirement (i.e. the Daily Eligibility File, Provider files, etc.)
- q. The CHC-MCO's MIS shall be subject to review and approval during the Department's Readiness Review process.
- r. The CHC-MCO must maintain the security of Commonwealth data and information. This includes; compliance with all applicable federal and state laws and regulations regarding security standards; demonstration that specific controls are in place to safeguard MIS and Commonwealth data and information; demonstration of procedures for mitigating data breaches;
- s. Prior to any major modifications to the CHC-MCO's MIS system, including upgrades and/or new purchases, the CHC-MCO must inform the Department in writing of the potential changes at least 60 days prior to the change. The CHC-MCO must include a work plan detailing recovery effort and use of parallel system testing.

- t. The CHC-MCO must accept and generate HIPAA compliant transactions as required in the ASC X12 Implementation Guides.
- u. The Department will make reference files (Drug, Procedure Code, Diagnosis Code) available to the CHC-MCO on a routine basis that will allow it to effectively meet its obligation to provide services and record information consistent with requirements in this Agreement. If the CHC-MCO chooses not to use these files, it must use comparable files. Exhibit Q, Data Support for CHC-MCOs, provides a listing of these files. Information about these files is available on the CHC Intranet.
- v. The Department will make available Provider informational files on a routine basis that will allow the CHC-MCO to effectively meet its obligation consistent with requirements in this Agreement. The CHC-MCO must use these files to record and provide Provider information, and to reconcile their Provider file with the Department's Provider file on a regular basis. These files include the List of Active and Closed Providers (PRV-414 and/or PRV-415) file to meet the obligation to maintain valid PROMISe Provider IDs; Managed Care Affiliations (PRV-640Q) file to meet the obligation to provide updates on the MCO Provider File (PRV-640); and NPI Crosswalk (PRV-430) file to provide all NPI records active with the Department. Exhibit Q, Data Support for CHC-MCOs, provides a listing of these files. Information about these files is available on the Intranet supporting CHC.
- w. The CHC-MCO must have a disaster recovery plan in place, and written policies and procedures documenting the disaster recovery plan including information on system backup and recovery in the event of a disaster. The CHC-MCO must demonstrate their routine back-up and recovery mechanisms, processes, and procedures.
- x. In addition to the CHC-MCO reconciling the 834 daily and monthly Participants files against its internal Participant information as referenced in Section V.O.1. Participant Files, the CHC-MCO must reconcile the 820 capitation payment file against its internal Participant information, and report any discrepancies to the Department with thirty (30) days.

6. Department Access

The CHC-MCO must provide Department staff access to appropriate on-site private office space and equipment.

In addition to other access requirements, the CHC-MCO must provide the Department with access to administrative policies and procedures pertaining to

operations, including, but not limited to:

- Personnel policies and procedures.
- Procurement policies and procedures.
- Public relations policies and procedures.
- Operations policies and procedures.
- Policies and procedures developed to comply with this Agreement.

Y. Selection and Assignment of PCPs

The CHC-MCO must have a PCP selection process that includes, at a minimum, the following:

- Honors a Participant's selection of a PCP or PCP group if permitted through the IEE.
- Honor a Dual Eligible Participant's selection of a PCP. A Dual Eligible Participant is not required to have a Network Provider as a PCP and must be permitted to designate his or her Medicare participating PCP as their CHC PCP.
- For all non-dual eligible Participants, the PCP must be a Network Provider except where an Out-Of-Network PCP is permitted under DOH regulations.
- May allow selection of a PCP group. In addition, the CHC-MCO may assign a PCP group to a Participant if the Participant has not selected a PCP or a PCP group at the time of Enrollment.
- If the Participant has not selected a PCP through the IEE for reasons other than cause, the CHC-MCO must contact with the Participant within seven (7) business days of his or her Enrollment and provide information on options for selecting a PCP, unless the CHC-MCO has information that the Participant should be immediately contacted due to a medical condition requiring immediate care.
- If a Participant does not select a PCP within fourteen (14) business days of Enrollment, the CHC-MCO must make an assignment. If the Participant is enrolled in the D-SNP aligned with the CHC-MCO, the CHC-MCO must assign the PCP who the Participant uses in the D-SNP. The CHC-MCO must consider such factors to the extent they are known, as current Provider relationships that may be identified through Encounters, existing Service Plans, or any CHC-MCO contacts with the Participant, specific medical needs, physical disabilities of the Participant, language needs, cultural compatibility, area of residence and access to transportation. The CHC-MCO must then notify the Participant by telephone and in writing of his/her PCP's name, location and office telephone number. The CHC-MCO must make every effort to determine PCP choice and confirm this with the Participant prior to the commencement of the CHC-MCO coverage in accordance with Participant Enrollment and Disenrollment, so that new Participants do not go without a PCP for a period of time after Enrollment begins.

- The CHC-MCO must have written policies and procedures for allowing Participants to select or be assigned to a new PCP whenever requested by the Participant, when a PCP is terminated from the Network or when a PCP change is required as part of the resolution to a Grievance or Complaint proceeding. The policies and procedures must receive advance written approval from the Department.
- In cases where a PCP has been terminated from the Network for reasons other than cause, the CHC-MCO must immediately inform Participants assigned to that PCP in order to allow them to select another PCP prior to the PCP's termination effective date. In cases where a Participant fails to select a new PCP, re-assignment must take place prior to the PCP's termination effective date.
- Participants can request a specialist as a PCP. If the CHC-MCO denies the request, that Denial is appealable.
- If a Participant uses a Pediatrician or Pediatric Specialist as a PCP, the CHC-MCO must, upon request from a family member, assist with the transition to a PCP who provides services for adults.

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

Z. Selection and Assignment of Service Coordinators

The CHC-MCO must develop and maintain a process for the selection and assignment of Service Coordinators that includes, at a minimum, the following:

- The CHC-MCO must offer the Participant a choice of Service Coordinators from amongst those employed by or under contract with the CHC-MCO.
- The CHC-MCO must make contact with the Participant within seven (7) business days of a comprehensive needs assessment indicating the need for LTSS and provide information on options for selecting a Service Coordinator unless the CHC-MCO has information that the Participant should be immediately contacted due to a medical condition requiring immediate care.
- If a Participant does not select a Service Coordinator within fourteen (14) business days of a comprehensive needs assessment, the CHC-MCO must make an assignment of Service Coordinator. The CHC-MCO may consider such factors (to the extent they are known), as current Provider relationships, prior service coordinator, the person assigned to the Participant for care management in the CHC-MCO's aligned D-SNP, specific medical needs, physical disabilities of the Participant, language needs, cultural compatibility, area of residence and access to transportation. The CHC-MCO must then notify the Participant by telephone and in writing of his/her Service Coordinator's name, location and office telephone number. The CHC-MCO must make every effort to determine Service Coordinator

choice and confirm this with the Participant. The CHC-MCO may contact new Participants prior to the commencement of their CHC-MCO coverage, so that new Participants do not go without a Service Coordinator for a period of time after Enrollment begins or after assessment of needs for LTSS.

- If a Participant requests a change in his or her selected or assigned Service Coordinator, the CHC-MCO must promptly grant the request and process the change in a timely manner.
- The CHC-MCO must have written policies and procedures for allowing Participants to select or be assigned to a new Service Coordinator whenever requested by the Participant, when a Service Coordinator is terminated from the Network or when a Service Coordinator change is required as part of the resolution to a Grievance or Complaint proceeding.
- The CHC-MCO must submit its policies and procedures for review and approval by the Department.

AA. Provider Services

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

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

1. Provider Manual

The CHC-MCO must keep its Network Providers informed and up-to-date with the latest policy and procedures changes as they affect the MA Program and must develop and maintain a Provider Manual. The CHC-MCO must distribute the Provider Manual in a manner that makes them easily accessible to all Network Providers. The CHC-MCO may specifically delegate this responsibility to large Providers in its Provider Agreement. The Provider Manual must be updated annually. The Department may grant an exception to this annual requirement upon written request from the CHC-MCO provided there are no

major changes to the manual.

The CHC-MCO must submit its Provider Manual to the Department for review and prior approval.

The CHC-MCO must include the information in its Provider manual as specified in Exhibit W, Provider Manuals.

2. Provider Education

The CHC-MCO must develop and maintain a Provider Network that is knowledgeable and experienced in treating and supporting Participants in CHC. The CHC-MCO must submit and obtain prior approval from the Department of an annual Provider education and training work plan that outlines its plans to educate and train Network Providers and its process for measuring outcomes, including the tracking of schedules and attendance. The format for this work plan will be designated by the Department through its operations reporting requirements found on the CHC Intranet. The CHC-MCO must develop its work plan in conjunction with the Department, and must include all topic areas identified by the Department. The CHC-MCO must also include Participants, advocates and family members in designing and implementation of the work plan.

At a minimum, the CHC-MCO must conduct the Provider education and training, as appropriate, in the following areas:

- a. Needs screening, comprehensive needs assessment and reassessment, and service planning system and protocols and a description of the Provider's role in service planning and Service Coordination.
- b. Service Coordination and how the Provider will fit into the PCPT approach.
- c. The population being served through CHC.
- d. Accessibility requirements with which Providers must comply.
- e. Application of the Agreement definition of Medically Necessary.
- f. Information around Alzheimer's Disease and related dementias, including information on assisting with and managing the symptoms and care needs of people with dementia throughout the course of their disease.
- g. Identification and appropriate referral for mental health, drug, and alcohol, and substance abuse services.

- h. The diverse needs of persons with disabilities, such as persons who are deaf or hard of hearing, how to obtain sign language interpreters and how to work effectively with sign language interpreters.
- i. CHC-MCO policies against discrimination to achieve competency in treating Participants without discrimination on the basis of race, color, creed, sex, religion, age, national origin, ancestry, marital status, sexual orientation, gender identity, language, MA status, income status, program participation, health status, disease or pre-existing condition, anticipated need for healthcare or physical or mental handicap.
- j. Cultural, Linguistic and Disability Competency, including: the right of Participants with LEP to engage in effective communication in their language; how to obtain interpreters; and how to work effectively with interpreters.
- k. Treating the populations served by the CHC-MCO, including treatment for Participants with disabilities.
- l. Administrative processes that include, but are not limited to: COB, Participant Restriction Program, and Encounter Data reporting.
- m. Issues identified by Provider relations or Provider hotline staff in response to calls or complaints by Providers.
- n. Issues identified through the QM process.
- o. The process to submit materials to the CHC-MCO for utilization review and Prior Authorization review decisions. Submitted materials must include but are not limited to letters of medical necessity.
- p. The Complaint, Grievance and DHS Fair Hearing and Appeals process including but not limited to expectations for a Provider should a Provider represent a Participant at a Grievance hearing.
- q. PIP and how Providers may benefit from participation in these programs.
- r. Dual eligibility for Medicare and Medicaid and coordination of services for Participants who are Dual Eligible.

The CHC-MCO may submit for review and Department prior approval, an alternate Provider training and education work plan should the CHC-MCO wish to combine its activities with other CHC-MCOs operating in the CHC zone or wish to develop and implement new and innovative methods for Provider training and education. Should the Department approve an alternative work plan, the CHC-MCO must have the ability to track and report on the

components included in the CHC-MCO's alternative Provider training and education work plan.

BB. Provider Network

The CHC-MCO must enroll in its Network all willing and qualified LTSS Providers that provide HCBS through the OLTL waivers in effect prior to Zone Start Date and through all NF in the zone so that Participants receiving LTSS as of the date of their Enrollment may maintain their current services with their current Providers.

A willing LTSS Provider is a Provider that is willing to contract with the CHC MCO to provide services for a payment rate that is agreed upon by the Provider and the CHC-MCO. A qualified Provider is a Provider that meets applicable MA program participation or waiver requirements for the Provider's provider type.

This requirement will remain in effect for LTSS Providers for 180 days after the Zone Start Date. Following the 180 day period, the CHC-MCO may adjust its Provider Network in accordance with the Network access and adequacy standards outlined in this agreement.

The CHC-MCO must establish and maintain adequate Networks to serve all of the eligible CHC population in the CHC zone. The CHC-MCO must include Providers or all Covered Services in its Network. The CHC-MCO must comply with the composition of Networks and Participant access to services set forth in Exhibit BB, Provider Network Composition/Service Access.

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

1. Provider Qualifications

The CHC-MCO may only include Providers in its Network that meet the minimum qualification requirements established by the Department. The CHC-MCO must credential Providers in accordance with the credentialing framework provided by the Department.

2. Provider Agreements

The CHC-MCO must have written Provider Agreements with a sufficient number of Providers to provide Participant access to all Covered Services as set forth in Exhibit BB Provider Network Composition/Service Access.

The requirements for these Provider Agreements are set forth in Exhibit DD, CHC-MCO Provider Agreements.

3. Cultural Competency, Linguistic Competency, and Disability Competency

Both the CHC-MCO and Network Providers must demonstrate Cultural Competency, Linguistic Competency, and Disability Competency.

Racial, ethnic, linguistic, and cultural differences between Provider and Participant must not present barriers to Participants' access to and receipt of quality services. CHC-MCOs must develop and implement policies to prevent and monitor access free from racial, ethnic, linguistic, and cultural barriers. CHC-MCOs must be willing and able to make the necessary distinctions between traditional treatment methods and/or non-traditional treatment methods that are consistent with the Participant's racial, ethnic, linguistic or cultural background and which may be equally or more effective and appropriate for the particular Participant; and must demonstrate consistency in providing quality care across a variety of races, ethnicities and cultures. For example, language, religious beliefs, cultural norms, social-economic conditions, diet, etc., may make one treatment method more palatable to a Participant of a particular culture than to another of a differing culture.

CHC-MCOs must also develop and implement and monitor policies that require Network Providers to demonstrate willingness and ability to make necessary accommodations in providing services, to employ appropriate language when referring to and talking with people with disabilities, and to understand communication, transportation, scheduling, structural, and attitudinal barriers to accessing services.

4. Primary Care Practitioner Responsibilities

The CHC-MCO must have written policies and procedures for the choice and assignment of PCPs. The PCP must serve as the Participant's initial and most important point of contact regarding healthcare needs. At a minimum, the CHC-MCO Network PCPs are responsible for:

- a. Providing primary and preventive care and acting as the Participant's advocate, and providing, recommending, and arranging for care.
- b. Documenting all care rendered in a complete and accurate Encounter record that meets or exceeds the DHS data specifications.
- c. Maintaining continuity of each Participant's healthcare.

- d. Communicating effectively with the Participant by using specialized interpretive services Participants who are deaf and blind and oral interpreters for those Participants with LEP when needed. Interpreter services must be free of charge to the Participant and the PCP cannot require family members to be used for interpretation.
- e. Making referrals for specialty care and other Medically Necessary services, both in and out-of-plan.
- f. Maintaining a current medical and other service record for the Participant, including documentation of all services provided to the Participant by the PCP, as well as any specialty or referral services.
- g. Coordinating BH Services by working with BH-MCOs as specified in Exhibit M: Coordination with the BH-MCOs.
- h. The CHC-MCO will retain responsibility for monitoring PCP actions for compliance with this Agreement.

5. Specialists as PCPs

The CHC-MCO must allow a Participant to select a specialist as PCP.

The CHC-MCO must adopt and maintain procedures by which a Participant may request and receive:

- A standing referral to a specialist with clinical expertise in treating the disease or condition; or
- The designation of a specialist to provide and coordinate the Participant's primary and specialty care.

When possible, the specialist must be a Healthcare Provider participating in the CHC-MCO's Network. If the specialist is not a Network Provider, the CHC-MCO may require the specialist to meet the requirements of the CHC-MCO's Network Providers, including the CHC-MCO's credentialing criteria outlined in the framework provided by the Department and QM/UM Program policies and procedures.

The CHC-MCO must provide Participants with information on the procedures to request and receive approval for a Specialist to act as a PCP.

The CHC-MCO must have adequate Network capacity of qualified specialists to act as PCPs. These physicians may be predetermined and listed in the directory but may also be determined on an as needed basis.

The CHC-MCO must establish a credentialing and recredentialing policies and procedures to ensure compliance with these specifications that meets the credentialing requirements outlined in the framework provided by the Department.

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

6. Related Party

A hospital, NF, or home health agency that is a Related Party to a CHC-MCO must negotiate in good faith with other CHC-MCOs regarding the provision of services to Participants. The Department may terminate this Agreement with the CHC-MCO if it determines that a Provider related to the CHC-MCO has refused to negotiate in good faith with other CHC-MCOs and the CHC-MCO must negotiate and make referrals in good faith with non-related providers.

A CHC-MCO must negotiate with and make referrals in good faith to providers that are not Related Parties.

The CHC-MCO must offer Participants a choice of Related-Party and Non-Related Party Network Providers.

7. Integration

The CHC-MCO must prohibit Network Providers from intentionally segregating or discriminating against Participants in any way on the basis of race, color, creed, sex, religion, age, national origin, ancestry, marital status, sexual orientation, gender identity, language, MA status, income status, program participation, health status, disease or pre-existing condition, anticipated need for health care or physical or mental disability, except where medically indicated.

The CHC-MCO must investigate Complaints and take affirmative action when Participants experience discriminatory treatment or are segregated

without a medical indication. Examples of prohibited practices include, but are not limited to, the following:

- Denying or not providing a Participant a Covered Service or availability of a facility within the CHC-MCO's Network.
- Subjecting a Participant to segregated, separate, or different treatment, including a different place or time from that provided to other Participants, public or private patients, in any manner related to the receipt of any Covered Service, except where Medically Necessary.
- The assignment of times or places for the provision of services on the basis of the race, color, creed, religion, age, sex, national origin, ancestry, marital status, sexual orientation, gender identity, income status, program participation, language, Medical Assistance status, health status, disease or pre-existing condition, anticipated need for healthcare or physical or mental disability of the participants to be served.

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

The CHC-MCO must have explicit policies to provide access to complex interventions such as cardiopulmonary resuscitations, intensive care, transplantation and rehabilitation when medically indicated and must educate its Network Providers on these policies. Healthcare and treatment necessary to preserve life must be provided to all Participants who are not terminally ill or permanently unconscious, except where a competent Participant objects to such care on his or her own behalf or has objected through an executed Advanced Healthcare Directive.

8. Network Changes/Provider Terminations

a. Network Changes

i) Notification to the Department

Other than terminations outlined below in Section 8.b Provider Terminations, the CHC-MCO must notify the Department within 10 days of any changes to its Provider Network such as closed panels, relocations, death of a Provider which would negatively impact the ability of Participants to access services.

ii) Procedures and Work Plans

The CHC-MCO must have procedures to address changes in its Network that impact Participant access to services, in accordance with the requirements of Exhibit BB Provider Network/Services Access. The Department may find the CHC-MCO in default based on its failure

to address changes in Network composition that negatively affect Participant access.

iii) Time frames for Notification to Participants

The CHC-MCO must update web-based Provider directories to reflect any changes in the Provider Network.

b. Provider Terminations

The CHC-MCO must comply with the requirements for Provider terminations as outlined in Exhibit C, CHC-MCO Requirements for Provider Terminations.

9. Other Provider Enrollment Standards

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

The CHC-MCO must require all Network Providers to be enrolled in the Commonwealth's MA program and possess an active PROMISe™ Provider ID for each location in which they provide services for the CHC-MCO. In addition, the CHC-MCO must be able to store and utilize the PROMISe™ Provider ID and NPI stored in PROMISe™ for each location.

10. Twenty-Four Hour Coverage

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

CC. QM and UM Program Requirements

1. Overview

The CHC-MCO shall provide a Quality Assessment and Performance Improvement Program consistent with federal guidelines under Title XIX of

the SSA, 42 CFR Part 438, Subpart D and must comply with the Department's QM and UM Program standards and requirements set forth in Exhibit K(1) Quality Management and Utilization Management Program Requirements, Exhibit K(2) External Quality Review, and Exhibit K(4) Healthcare Effectiveness Data and Information Set (HEDIS) and Consumer Assessment of Healthcare Providers and Systems (CAHPS®). The CHC-MCO must comply with the critical incident reporting and management, provider-preventable condition, and provider serious adverse events reporting requirements outlined in Exhibit K(3), Critical Incident Reporting and Management and Provider Preventable Conditions/Preventable Service Adverse Events Reporting.

The CHC-MCO must comply with the Quality Management/Utilization Management Reporting Requirements found on the CHC Intranet. The Department retains the right of advance written approval and to review on an ongoing basis all aspects of the CHC-MCO's QM and UM programs, including subsequent changes. The CHC-MCO must comply with all QM and UM program reporting requirements and must submit data in formats to be determined by the Department.

The Department, in collaboration with the CHC-MCO, will determine and prioritize QM and UM activities and initiatives based on areas of importance to the Department and CMS.

2. Quality Management and Performance Improvement

The Department's goal for CHC is to deliver quality care that enables Participants to stay healthy, get better, manage chronic illnesses and disabilities, and maintain/improve their quality of life. The CHC-MCO shall provide quality LTSS to Participants and promote improvement in the quality of care provided to Participants through established quality management and performance improvement processes. The CHC-MCO shall have a written QM/QI program that clearly defines its quality improvement structures and processes and assigns responsibility to appropriate individuals. The CHC-MCO shall have a QMC which shall include medical and LTSS staff and Providers. The role of the committee is to analyze and evaluate the results of QM/QI activities and to develop appropriate policies, actions and follow-up to provide appropriate services to Participants. The CHC-MCO must establish the QMC a distinct unit within the organizational structure and remain separate from other units in the organization.

The CHC-MCO must include the following in its QM program:

- A written Quality Assessment and Performance Improvement plan completed on an annual basis with quarterly updates.
- Monitoring and evaluating activities which include peer review and

QMC.

- Protection of Participant records.
- Communicate and honor to Participant rights and responsibilities as outlined in this Agreement and Exhibit FF Participants' Rights.
- Tracking and trending Participant and Provider issues.
- Mechanism to assess the quality and appropriateness of care furnished to Participants.
- Performance Improvement programs.
- Submission of Participant's specific data.
- Reporting on designated quality measures as will be outlined in Department reporting requirements to identify outcomes and trends and how trends will be addressed.
- Procedures outlining how and when information will be entered into the Department's quality data reporting system.

3. Utilization Management

The CHC-MCO shall establish a Utilization Management structure consistent with guidance from the Department.

4. Healthcare Effectiveness Data and Information Set

The CHC-MCO must comply with the requirements for HEDIS as set forth in Exhibit K(4) Healthcare Effectiveness Data and Information Set. The previous calendar year is the standard measurement year for HEDIS data.

5. External Quality Review

The CHC-MCO must comply with the requirements set forth in Exhibit K(2) External Quality Review. On at least an annual basis, the CHC-MCO will cooperate fully with any external evaluations and assessments of its performance authorized by the Department under this agreement and conducted by the Department's contracted EQRO or other designee. Independent assessments will include, but not be limited to, any independent evaluation required or allowed by federal or state statute or regulation. The Department may use the term PA Performance Measures in place of EQR performance measures throughout this Agreement.

6. Pay for Performance Programs

The Department may establish a Pay for Performance (P4P) Program to provide financial incentives for CHC-MCOs to assist Participants remain financially eligible through redetermination. The Department may establish other P4Ps designed to meet quality goals in subsequent years.

7. QM/UM Program Reporting Requirements

The CHC-MCO must comply with all QM and UM program reporting requirements and time frames outlined in Exhibit K(1) Quality Management and Utilization Management Program Requirements and Quality Management/Utilization Management Deliverables, available on the CHC Intranet supporting CHC. The Department will, on a periodic basis, review the required reports and make changes to the information/data and/or formats requested based on the changing needs of CHC. The CHC-MCO must comply with all requested changes to the report information and formats as deemed necessary by the Department. The Department will provide the CHC-MCO with at least sixty (60) days notice of changes to the QM/UM reporting requirements. Information regarding QM and UM reporting requirements may be found on the CHC Intranet.

8. Delegated Quality Management and Utilization Management Functions

The CHC-MCO may not structure compensation or payments to individuals or entities that conduct UM activities so as to provide incentives for the individual or entity to deny, limit, or discontinue Medically Necessary services to any Participant.

9. Participant Involvement in the Quality Management and Utilization Management Programs

The CHC-MCO will participate and cooperate in the work and review of the Department's formal advisory body through participation in the MAAC and its subcommittees. Additionally, the CHC-MCO will solicit input on its QM and UM programs from the PAC.

10. Confidentiality

The CHC-MCO must have written policies and procedures for maintaining the confidentiality of data that addresses medical records, Participant information and Provider information and is in compliance with the provisions set forth in HIPAA, Section 2131 of the Insurance Company Law of 1921, 40 P.S. §991.2131; 55 Pa. Code Chapter 105; and 45 CFR Parts 160 and 164 (Standards for Privacy of Individually Identifiable Health Information).

The CHC-MCO must require its Network Provider to have mechanisms that guard against unauthorized or inadvertent disclosure of confidential information.

The CHC-MCO must obtain the Department's prior written approval to release data to third parties, except for releases for the purpose of individual care and coordination among Providers, releases authorized by the Participant or those releases required by court order, subpoena or law.

11. Department Oversight

The CHC-MCO and its subcontractor(s) and Network Providers, will make available to the Department upon request, data, clinical and other records and reports for review of quality of care, access and utilization issues including but not limited to activities related to EQR, HEDIS, Encounter Data validation, and other related activities.

The CHC-MCO must submit a plan, in accordance with the time frames established by the Department, to resolve any performance or quality of care deficiencies identified through ongoing monitoring activities and any independent assessments or evaluations requested by the Department.

The CHC-MCO must obtain advance written approval from the Department before releasing or sharing data, correspondence and/or improvements from the Department regarding the CHC-MCO's internal QM and UM programs with any of the other CHC-MCOs or any external entity.

The CHC-MCO must obtain advance written approval from the Department before participating in or providing letters of support for QM or UM data studies and/or any data related external research projects related to CHC with any entity.

12. CHC-MCO Cooperation with Research and Evaluation

The CHC-MCO must cooperate fully with research and evaluation activities as requested by the Department.

DD. Mergers, Acquisitions, Mark, Insignia, Logo and Product Name

1. Mergers and Acquisitions

The CHC-MCO must notify the Department at least thirty (30) days in advance of a merger or acquisition of the CHC-MCO. The CHC-MCO must bear the cost of reprinting CHC outreach material, if a change involving content is made prior to the IEE's annual revision of materials.

2. Mark, Insignia, Logo, and Product Name Changes

The CHC-MCO must submit mark, insignia, logo, and product name changes within thirty (30) calendar days of projected implementation for the

Department's review. The CHC-MCO is responsible for the cost of reprinting CHC outreach materials, if a change is made prior to the IEE's annual revision of materials.

EE. Cooperation with IEE

The CHC-MCO must cooperate with the IEE, as instructed by the Department.

FF. Employment Support

The CHC-MCO must include employment-related needs and requirements of Participants as part of the person-centered planning process. The CHC-MCO will provide information about services available through OVR or similar resources to Participants who are not working but express an interest in work or who are working but whose employment status may be jeopardized due to their disability; and will refer the Participant to OVR or other resources, unless the Participant makes an informed choice not to be referred for this support. The CHC-MCO must cooperate with OVR or other resources.

CHC-MCOs will collect and publish aggregate data on Participant competitive-integrated employment outcomes, including but not limited to number and percentage of Participants, by age group and disability type, in self-employment or competitive-integrated employment as defined by the Workforce Innovation and Opportunities Act, wage rates, weekly wages earned, weekly hours worked, type or classification of job, and whether benefits are part of the compensation package.

CHC-MCOs will offer services that promote or lead to securing or maintaining competitive employment, including but not limited to job coaching and job finding, customized employment, Discovery (for participants with to-be-defined challenging needs) (with strict credentialing requirements for providers), benefits counseling, and transportation.

SECTION VI: PROGRAM OUTCOMES AND DELIVERABLES

Prior to the Enrollment of Participants and the Zone Start Date, the Department will conduct Readiness Review activities to determine the CHC-MCO's ability to provide services as required by this Agreement. The CHC-MCO must cooperate with all the Readiness Review activities, including on site reviews conducted by the Department. If the Department determines the CHC-MCO has not demonstrated readiness to provide services as required by this Agreement, the Department will not permit the enrollment of Potential Participants with the CHC-MCO and may extend the time period for the Readiness Review or not operationalize this Agreement.

SECTION VII: FINANCIAL REQUIREMENTS

A. Financial Standards

1. Equity Requirements and Solvency Protection

The CHC-MCO must meet the Equity and solvency protection requirements set forth below and with all financial requirements included in this Agreement, in addition to those of the PID.

The CHC-MCO must maintain SAP-basis Equity equal to the highest of the amounts determined by the following "Three (3) Part Test" as of the last day of each calendar quarter:

- \$20.00 million;
- 7.000% of revenue earned by the licensed HMO during the most recent four (4) calendar quarters; or
- 7.000% of revenue earned by the licensed HMO during the current quarter multiplied by three (3).

Revenue, for the purpose of the Equity requirement calculation, is defined as the total gross Direct Business Premiums, for all Pennsylvania lines of business, reported in Schedule T, "Premiums and Other Considerations," of the PID report.

For the purpose of this requirement, Equity amounts, as of the last day of each calendar quarter, shall be determined in accordance with statutory accounting principles as specified or accepted by the PID. The Department will accept PID determinations of Equity amounts, and in the absence of such determination, will rely on required financial statements filed by the CHC-MCO with PID to determine Equity amounts.

The CHC-MCO must provide the Department with reports as specified in Section VIII.D, Financial Reports.

2. Risk Based Capital

The RBC ratio is defined as:

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

The CHC-MCO must maintain a RBC ratio of 2.0.

3. Prior Approval of Payments to Affiliates

With the exception of payment of a Claim for a medical product or service that was provided to a Participant, and that is paid in accordance with a written Provider Agreement, the CHC-MCO may not pay money or transfer any assets for any reason to an Affiliate without prior approval from the Department, if any of the following criteria apply:

- a. The CHC-MCO's RBC ratio was less than 2.0 as of December 31 of the most recent year for which the due date for filing the annual unaudited PID financial report has passed;
- b. The CHC-MCO was not in compliance with the Agreement Equity and solvency protection requirement as of the last day of the most recent quarter for which the due date for filing PID financial reports has passed;
- c. After the proposed transaction took place, the CHC-MCO would not be in compliance with the Agreement Equity and solvency protection requirement; or
- d. Subsequent adjustments are made to the CHC-MCO's financial statement as the result of an audit, or otherwise modified, such that after the transaction took place, a final determination is made that the CHC-MCO was not in compliance with the agreement's Equity requirements. In this event, the Department may require repayment of amounts involved in the transaction.

The Department may elect to waive the requirements of this section.

4. Change in Independent Actuary or Independent Auditor

The CHC-MCO must notify the Department within ten (10) days when its contract with an independent auditor or actuary has ended. The CHC-MCO must include in the notification, the date and reason for the change or termination and the name of the replacement auditor or actuary, if any. If the change or termination occurred as a result of a disagreement or dispute, the CHC-MCO must disclose the nature of the disagreement or dispute

5. Modified Current Ratio

The CHC-MCO must maintain current assets, plus long-term investments that can be converted to cash within five (5) Business Days without incurring a penalty of more than twenty (20) percent that equal or exceed current liabilities.

- If a penalty for conversion of long-term investments is applicable, only the value net of the penalty may be counted for the purpose of

- compliance with this requirement.
- The definitions of current assets and current liabilities are included in the Financial Reporting Requirements.
- Restricted assets may be included only with authorization from the Department.
- The following types of long-term investments may be counted, consistent with above requirements, so long as they are not issued by or include an interest in an Affiliate:
 - Certificates of Deposit
 - United States Treasury Notes and Bonds
 - United States Treasury Bills
 - Federal Farm Credit Funding Corporation Notes and Bonds
 - Federal Home Loan Bank Bonds
 - Federal National Mortgage Association Bonds
 - Government National Mortgage Association Bonds
 - Municipal Bonds
 - Corporate Bonds
 - Stocks
 - Mutual Funds

6. Sanctions

In addition to the Department's general sanction authority specified in Section VIII.H, Sanctions, if the CHC-MCO fails to comply with the requirements of Section VII.A Financial Requirements, the Department may take any or all of the following actions, in accordance with 42 CFR §§438.700; 438.702; and 438.704:

- Discuss fiscal plans with the CHC-MCO's management;
- Suspend payments or a portion of payments for Participants enrolled after the effective date of the sanction and until CMS until the Department is satisfied that the reason for the imposition of the sanction no longer exists and is not likely to recur;
- Require the CHC-MCO to submit and implement a corrective action plan;
- Suspend some or all Enrollment of Participants into the CHC-MCO, including auto-assignments, after the effective date of the sanction;
- Terminate this Agreement upon forty-five (45) days written notice, in accordance with Section X of this Agreement, Termination and Default.

In addition, the Department may impose sanctions described above when a CHC-MCO acts or fails to act as follows:

- Fails substantially to arrange for Medically Necessary services that the CHC-MCO is required to provide to a Participant under law or under its Agreement.

- Imposes on Participants premiums or charges that are in excess of the premiums or charges permitted under the MA program.
- Acts to discriminate among Participants on the basis of their health status or need for health care services.
- Misrepresents or falsifies information that it furnishes to CMS, the Commonwealth, Participants, Potential Participants, or Healthcare Providers.
- Fails to comply with requirements for PIPs as set forth in 42 CFR §§422.208 and 422.210.
- Has distributed directly, or indirectly through any agent or independent contractor, marketing materials that have not been approved by the Department or that contain false or materially misleading information.

7. DSH/GME Payment for Disproportionate Share Hospitals and Graduate Medical Education

The Department will make direct Disproportionate Share Hospital and Graduate Medical Education Payments to hospitals.

8. Participant Liability

In accordance with 42 C.F.R. §438.106, the CHC-MCO must provide that its Participants are not held liable for the following:

- a. Debts of the CHC-MCO in the event of the CHC-MCO's insolvency.
- b. Services provided to the Participant in the event of the CHC-MCO fails to receive payment from the Department for such services.
- c. Services provided to the Participant in the event of a Healthcare Provider with a contractual, referral or other arrangement with the CHC-MCO failing to receive payment from the Department or the CHC-MCO for such services.
- d. Payments to a Provider that furnishes compensable services under a contractual, referral or other arrangement with the CHC-MCO in excess of the amount that would be owed by the Participant if the CHC-MCO had directly provided the services.
- e. Balance billing for Covered Services.

B. Commonwealth Capitation Payments

1. Payments for Covered Services

The obligation of the Department to make payments shall be limited to

Capitation payments and any other payments provided by this Agreement.

a. Capitation Payments

- i. The CHC-MCO shall receive capitated payments for Covered Services as defined in Section VII.B.1, Payments for Covered Services, and in Appendix 3b, Explanation of Capitation Payments.
- ii. The Department will compute Capitation payments using per diem rates. The Department will make a monthly payment to the CHC-MCO for each Participant enrolled in the CHC-MCO, for the first day in the month the Participant is enrolled in the CHC-MCO and for each subsequent day, through and including the last day of the month.
- iii. The Department will not make a Capitation payment for a Participant Month if the Department notifies the CHC-MCO before the first of the month that the individual's MA eligibility or CHC-MCO Enrollment ends prior to the first of the month.
- iv. The Department will make payments by wire transfer or electronic funds transfer unless the CHC-MCO is unable or unwilling to receive payment through wire or electronic funds transfer. If such arrangements are not in place, the Department will provide payments through the U.S. Mail.
- v. Upon notice to the CHC-MCO, and for those months specified by the Department, by the fifteenth (15th) of each month, the Department will make a Capitation payment, referenced in Section VII.B.1.a, for each Participant for all dates of Enrollment indicated on the Department's CIS through the last day of the current month. This payment will be limited to those days for which the Department has not previously made payment to the CHC-MCO.
- vi. This paragraph vi. is applicable unless it is superseded by paragraph v. above. By the fifteenth (15th) of each month, the Department will make a Capitation payment, referenced in Section VII.B.1.a, for each Participant for all dates of Enrollment indicated on the Department's CIS prior to the first day of the current month. This payment will be limited to those days for which the Department has not previously made payment to the CHC-MCO.
- vii. The Department will recover Capitation payments made for Participants 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 Participants for up to eighteen (18)

months after the service month for which payment was made. See Exhibit P of this Agreement, CHC-MCO Participant Coverage Document.

2. Program Changes

Amendments, revisions, or additions to the Medicaid State Plan, the CHC 1915(c) Waiver, or to state or federal regulations, laws, guidelines, or policies shall, insofar as they affect the scope or nature of benefits available to eligible persons, amend the CHC-MCO's obligations as specified herein, unless the Department notifies the CHC-MCO otherwise. The Department will inform the CHC-MCO of any changes, amendments, revisions, or additions to the Medicaid State Plan or 1915(c) Waiver or changes in the Department's regulations, guidelines, or policies in a timely manner.

If the scope of Eligible Individuals or services, inclusive of limitations on those services that are the responsibility of the CHC-MCO is changed, the Department will determine whether the change is sufficient that an actuarial analysis might conclude that a rate change is appropriate. If yes, the Department will arrange for the actuarial analysis, and the Department will determine whether a rate change is appropriate. The Department will take into account the actuarial analysis, and will consider input from the CHC-MCO, when making this determination. At a minimum, the Department will adjust the rates as necessary to maintain actuarial soundness. If the Department makes a change, the Department will provide the analysis used to determine the rate adjustment. If the scope of services or Eligible Individuals that are the responsibility of the CHC-MCO is changed, upon request by the CHC-MCO, the Department will provide written information on whether the rates will be adjusted and how, along with an explanation for the Department's decision.

The Department will appropriately adjust the rates provided by Appendix 3d, Capitation Rates, to reflect changes in an Assessment, Premium Tax, or other similar tax.

The rates in Appendix 3d, Capitation Rates will remain in effect until an agreement is reached on new rates and their effective date, unless modified to reflect changes to the scope of services or consumers in the manner described in the preceding paragraph.

C. Acceptance of Actuarially Sound Rates

By executing the Agreement, the CHC-MCO has reviewed the rates set forth in Appendix 3d, Capitation Rates, and accepts the rates for the relevant Agreement period.

D. Claims Processing Standards, Monthly Report and Penalties

1. Timeliness Standards

The CHC-MCO must adjudicate Provider Claims consistent with the requirements below. These requirements apply collectively to Claims processed by the CHC-MCO and any subcontractor. Subcapitation payments and claims adjustments are excluded from these requirements.

The adjudication timeliness standards are as follows:

Claims received from any Provider:

90.0% of Clean Claims must be adjudicated within thirty (30) days of receipt.

100.0% of Clean Claims must be adjudicated within forty-five(45) days of receipt.

100.0% of all Claims must be adjudicated within ninety (90) days of receipt.

The adjudication timeliness standards do not apply to Claims submitted by Providers under investigation for Fraud or Abuse from the date of service to the date of adjudication of the Claims. The CHC-MCO however must provide immediate notification to the Department of providers under investigation by the CHC-MCO.

The CHC-MCO must adjudicate every Claim entered into its computer information system that is not a Rejected Claim. The CHC-MCO must maintain an electronic file of Rejected Claims, inclusive of a reason or reason code for rejection. The CHC-MCO will deny a claim for services provided to an individual who was not a CHC-MCO Participant as of the date of service and notify the Provider of the denial.

The amount of time required to adjudicate a paid Claim is computed by comparing the date the Claim was received with the check date or the CHC-MCO bank notification date for electronic payment. The check date is the date printed on the check. The amount of time required to adjudicate a Denied Claim is computed by comparing the date the Claim was received with the date the denial notice was created or the transmission date of an electronic denial notice. The CHC-MCO must mail checks no later than three (3) Business Days from the check date. Electronic payments must also occur within three (3) Business Days of the bank notification date.

The CHC-MCO must record, on every Claim processed, the date the Claim was received. A date of receipt imbedded in a Claim reference number is acceptable. The CHC-MCO must have this date carried on Claims records in the Claims processing computer system. Each hardcopy Claim received by

the CHC-MCO, or the electronic image thereof, must be date-stamped with the date of receipt no later than the first (1st) Business Day after the date of receipt. The CHC-MCO must add a date of receipt to each Claim received in the form of an electronic record or file within one (1) Business Day of receipt.

If responsibility to receive Claims is subcontracted, the date of initial receipt by the subcontractor determines the date of receipt applicable to these requirements.

2. Sanctions

The Department will utilize the monthly report that is due on the fifth (5th) calendar day of the fifth (5th) subsequent month after the Claim is received to determine compliance with Claims processing standards. For example, the Department shall utilize the monthly report that is due January 5th, to determine Claims processing compliance for Claims received in the previous August.

The Department will consider all Claims received during the month, for which compliance is being determined and that remain non-adjudicated at the time compliance is being determined, to be a Clean Claim.

If a Commonwealth audit, or an audit done on the Commonwealth's behalf, determines Claims processing timeliness data that are different than data submitted by the CHC-MCO, or if the CHC-MCO has not submitted required Claims processing data, the Department will use the audit results to determine compliance.

If the Department determines that a CHC-MCO has not complied with the Claims Processing timeliness standards, the Department may separately impose the following sanctions to the following claims types:

Inpatient Claims.

NF.

Claims other than Inpatient, NF, and drug.

The sanctions provided by this Section apply to all Claims, including Claims processed by any subcontractor.

The CHC-MCO will be considered in compliance with the requirement for adjudication of 100.0% of all Inpatient and NF Claims if 99.5% of all Inpatient and NF Claims are adjudicated within ninety (90) days of receipt. The CHC-MCO will be considered in compliance with the requirement of adjudication of 100.0% of all Claims other than Inpatient, NF and drug if 99.5% of all Claims other than Inpatient, NF and drug are adjudicated within ninety (90)

days of receipt.

The Department will reduce sanction below by one-third if the CHC-MCO has 50,000-100,000 Participants and by two-thirds if the CHC-MCO has less than 50,000 Participants.

CLAIMS ADJUDICATION MONTHLY SANCTIONS CHART

The Department will compute sanctions as for failure to adjudicate Inpatient, NF Claims and Claims other than Inpatient, NF or pharmacy.

Percentage of Clean Claims Adjudicated in 30 Days	Sanctions
88.0 – 89.9	\$2,000
80.0 – 87.9	\$6,000
70.0 – 79.9	\$10,000
60.0 – 69.9	\$16,000
50.0 – 59.9	\$20,000
Less than 50.0	\$30,000
Percentage of Clean Claims Adjudicated in 45 Days	Sanctions
98.0 – 99.5	\$2,000
90.0 – 97.9	\$6,000
80.0 – 89.9	\$10,000
70.0 – 79.9	\$16,000
60.0 – 69.9	\$20,000
Less than 60.0	\$30,000
Percentage of All Claims Adjudicated in 90 Days	Sanctions
98.0 – 99.5	\$2,000
90.0 – 97.9	\$6,000
80.0 – 89.9	\$10,000
70.0 – 79.9	\$16,000
60.0 – 69.9	\$20,000
Less than 60.0	\$30,000

E. Other Financial Requirements

1. Physician Incentive Arrangements

- a. CHC-MCOs must comply with the PIP requirements included under 42 CFR § 422.208 and 422.210, which apply to MA managed care under 42 CFR §438.6(h).
- b. The CHC-MCO may operate PIPs if 1) no specific payment is made directly or indirectly to a physician or physician group as an inducement

to reduce or limit Medically Necessary services furnished to a Participant; and 2) the disclosure, computation of Substantial Financial Risk, Stop-Loss Protection, and Participant survey requirements of this section are met.

- c. The CHC-MCO must provide information specified in the regulations to the Department and CMS, upon request. In addition, the CHC-MCO must provide the information on its PIPs to any Participant, upon request. CHC-MCOs that have PIPs placing a physician or physician group at Substantial Financial Risk for the cost of services the physician or physician group does not furnish must require that the physician or physician group has adequate Stop-Loss Protection. CHC-MCOs that have PIPs placing a physician or physician group at Substantial Financial Risk for the cost of service the physician or physician group does not furnish must also conduct surveys of Participants and disenrollees addressing their satisfaction with the quality of services and their degree of access to the services.
- d. CHC-MCOs must provide the following information concerning its PIPs to the Department:
 - whether referral services are included in the PIP,
 - the type of incentive arrangement used, i.e. withhold, bonus, capitation,
 - a determination of the percent of payment under the contract that is based on the use of referral services to determine if Substantial Financial Risk exists,
 - panel size, and if patients are pooled, pooling method used to determine if Substantial Financial Risk exists, and
 - Evidence that the physician or physician group has adequate Stop-Loss Protection and the type of coverage, if this requirement applies.

Where Participant/disenrollee survey requirements exist, the CHC-MCO must provide the survey results.

- e. The CHC-MCO must provide the disclosure information specified in 1.d. above to the Department annually, unless the Department has notified the CHC-MCO of the suspension of this requirement.

2. Retroactive Eligibility Period

The CHC-MCO shall not be responsible for any payments owed to Providers for services that were rendered prior to the effective date of a Participant's Enrollment into the CHC-MCO.

3. In-Network Services

The CHC-MCO must make timely payment for Medically Necessary, Covered Services rendered by Network Providers when:

- a. Services were rendered to treat an Emergency Medical Condition;
- b. Services were rendered under the terms of the Provider Agreement;
- c. Services were Prior Authorized or did not require Prior Authorization;
- d. The CHC-MCO denied Prior Authorization of services but the Department determined, after a hearing, that the services should have been authorized.

4. Payments for Out-of-Network Providers

The CHC-MCO must make timely payments to Out-of-Network Providers for Medically Necessary Covered Services as otherwise provided for in this Agreement, including but not limited to when:

- a. Services were rendered to treat an Emergency Medical Condition;
- b. Services were Prior Authorized;
- c. Services were not available in Network;
- d. The CHC-MCO denied Prior Authorization of services but the Department determined, after a hearing, that the services should have been authorized.

The CHC-MCO is not financially liable for:

- a. Services rendered to treat a non-emergency condition in a hospital ED except to the extent required elsewhere in law, unless the services were Prior Authorized;
- b. Prescriptions presented at Out-of-Network Pharmacies that were written by non-participating/non-network prescribers unless:
 - the non-participating/non-network Provider arrangements were approved in advance by the CHC-MCO and any prior authorization requirements (if applicable) were met;
 - the non-participating/non-network prescriber and the pharmacy are the Participant's Medicare Providers; or
 - the Participant is covered by a third party carrier and the non-participating/non-network prescriber and the pharmacy are the Participant's third party Providers.

The CHC-MCO is responsible, in accordance with applicable law, for emergency services and urgently needed services as defined in 42 CFR §417.401 that are obtained by its Participants from Providers and suppliers outside the Network even in the absence of the CHC-MCO's prior approval.

5. Payments to FQHCs and Rural Health Centers (RHCs)

The CHC-MCO must pay all FQHCs and RHCs rates that are not less than FFS Prospective Payment System rates, as determined by the Department. The CHC-MCO must also include in its Network every FQHC and RHC that are willing to accept FFS Prospective Payment System rates as payment in full and are located within the CHC zone.

The CHC-MCO may require that an FQHC and RHC comply with Service Coordination procedures that apply to other entities that provide similar benefits or services.

6. Liability during an Active Grievance or Appeal

The CHC-MCO shall not be liable to pay Claims to Providers if the validity of the Claim is being challenged by the CHC-MCO through a Grievance or appeal, unless the CHC-MCO is obligated to pay the Claim or a portion of the Claim through a separate agreement with the Provider.

7. Financial Responsibility for Dual Eligible Participants

The CHC-MCO must pay Medicare deductibles and coinsurance amounts relating to any Medicare-covered service for Dual Eligible Participants not to exceed the contracted CHC-MCO rate. The CHC-MCO will not be responsible for copayments or cost-sharing for Medicare Part D prescriptions.

If no contracted CHC-MCO rate exists or if the Provider of the service is an Out-of-Network Provider, the CHC-MCO must pay deductibles and coinsurance up to the applicable MA fee schedule rate for the service.

For Medicare services that are not covered by MA or the CHC, the CHC-MCO must pay cost-sharing to the extent that the payment made under Medicare for the service and the payment made by the CHC-MCO do not exceed eighty percent (80%) of the Medicare-approved amount.

The CHC-MCO, its subcontractors and Providers are prohibited from balance billing Participants for Medicare deductibles or coinsurance. The CHC-MCO must provide a Dual Eligible Participant access a Medicare products and services from the Medicare Provider of his or her choice. The CHC-MCO is responsible to pay any Medicare coinsurance and deductible amount, whether or not the Medicare Provider is included in the CHC-

MCO's Provider Network and whether or not the Medicare Provider has complied with the Prior Authorization requirements of the CHC-MCO.

8. Confidentiality

The Department may elect from time to time to share with the CHC-MCO an internal Business Requirements Document or an internal Business Design Document, FFSFFS inpatient hospital rates, cost-to-charge ratio information, and other LTSS rates. The CHC-MCO shall not use this information for a purpose other than to support the CHC-MCO's performance of its responsibilities under this Agreement and related responsibilities provided by law. The CHC-MCO may share a Business Requirements Document, a Business Design Document, or the FFS inpatient hospital rates, cost-to-charge ratio, and relative value information provided by the Department with another party, provided that the other party does not use the information for a purpose other than to support the CHC-MCO's performance of its responsibilities of this Agreement and any other related responsibilities provided by law.

9. Audits

The CHC-MCO must comply with audit requirements as specified in Exhibit Y, Community HealthChoices Audit Clause.

10. Restitution for Overpayments

The CHC-MCO must make full and prompt restitution to the Department, as directed by the Department, for any payments received in excess of amounts due to the CHC-MCO such overpayment is discovered by the CHC-MCO, the Department, or other third party.

11. Penalty Periods

The CHC-MCO must, in coordination with the Department, monitor the completion of all NF and HCBS related processes, including the maintenance of a Penalty Period, if applicable.

F. Third Party Liability

The CHC-MCO must comply with the TPL procedures implemented by the Department. Under this Agreement, the TPL responsibilities of the Department will be allocated between the Department and the CHC-MCO.

1. Cost Avoidance Activities

- a. The CHC-MCO will have primary responsibility for cost avoidance through the COB relative to federal and private health insurance-type

resources including, but not limited to, Medicare, private health insurance, ERISA plans, and workers compensation. Except as provided in subparagraph ii, the CHC-MCO must attempt to avoid initial payment of Claims, whenever possible, where federal or private health insurance-type resources are available. The CHC-MCO must report all funds that are cost avoided by the CHC-MCO to the Commonwealth via Encounter Data submissions. The number of claims cost avoided by the CHC-MCO's claims system should be reported in Financial Report #8A, "Claims Cost Avoided." The use of the appropriate HIPAA 837 Loop(s) for Medicare and Other Insurance Paid shall indicate that TPL has been pursued and the amount which has been cost-avoided. The CHC-MCO shall not be held responsible for any TPL errors in EVS or the Department's TPL file.

- b. The CHC-MCO will pay, and to require that its subcontractors pay, all Clean Claims for prenatal or preventive pediatric care, and services to children having medical coverage under a Title IV-D child support order to the extent the CHC-MCO is notified by the Department of such support orders or to the extent the CHC-MCO becomes aware of such orders, and then seek reimbursement from liable third parties. The CHC-MCO recognizes that cost avoidance of these Claims is prohibited with the exception of hospital delivery Claims, which may be cost-avoided.
- c. The CHC-MCO may not deny or delay approval of otherwise covered treatment or services based upon TPL considerations. The CHC-MCO may neither unreasonably delay payment nor deny payment of Claims unless the probable existence of TPL is established at the time the Claim is adjudicated.

2. Post-Payment Recoveries

- a. Post-payment recoveries are categorized by (a) health-related insurance resources and (b) Other Resources. Health-related insurance resources are ERISA health benefit plans, Blue Cross/Blue Shield subscriber contracts, Medicare, private health insurance, workers' compensation, and health insurance contracts.
- 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 Section II of this Agreement, Definitions. The CHC-MCO assigns to the Department the CHC-MCO's subrogation rights to collect the Other Resources. The CHC-MCO must immediately forward to the Division of TPL any correspondence or Inquiry received by the CHC-MCO (by an attorney, Provider of service, insurance carrier, etc.) relating to a personal injury accident or trauma-related medical service, or which in any way indicates that there is, or may be, legal involvement regarding

the Participant and the services which were provided. The CHC-MCO may neither unreasonably delay payment nor deny payment of Claims because they involve an injury stemming from an accident such as a motor vehicle accident, where the services are otherwise covered. The Commonwealth will retain funds recovered by the Commonwealth as Other Resources.

With respect to any third party payment received by the CHC-MCO from a Provider, the CHC-MCO shall return all casualty funds to the Department. CHC-MCOs will not instruct Providers to send funds directly to the Department. The CHC-MCO may not hold these third party payments more than 30 days. If the casualty funds received by the Department must be returned to the CHC-MCO for any reason, for example, an outdated check or the amount of the check does not match supporting documentation, the CHC-MCO shall have 90 days to return all casualty funds to the Department using the established format.

- c. The CHC-MCO is responsible for pursuing, collecting, and retaining recoveries of (1) a claim involving Workers' Compensation or (2) where the liable party has improperly denied payment based upon either lack of a medically necessary determination or lack of coverage. The CHC-MCO is encouraged to develop and implement cost-effective procedures to identify and pursue cases that are susceptible to collection through either legal action or traditional subrogation and collection procedures.
- d. If the Department fails to identify and establish a casualty or estate claim prior to settlement due to the CHC-MCO's untimely submission of notice of legal involvement, the Department may assess the amount of its claim against the CHC-MCO. The Department's assessment will not include the attorney's fees or other costs.
- e. The CHC-MCO has the sole and exclusive responsibility and right to pursue, collect and retain all health-related insurance resources for a period of nine (9) months from the date of service or six (6) months after the date of payment, whichever is later. The CHC-MCO must indicate their intent to recover on health-related insurance by providing to the Department an electronic file of those cases it will pursue. The cases must be identified and a file provided to the Department by the CHC-MCO within the window of opportunity afforded by the nine (9) months from the date of service or six (6) months after the date of payment unless otherwise permitted by the Department. The Department's Division of TPL may pursue, collect and retain recoveries of all health-related insurance cases which are not identified by the CHC-MCO for recovery, after the later of nine (9) months from the date of service or six (6) months after the date of payment. Notification of intent to pursue, collect and retain health-related insurance is the sole responsibility of the CHC-MCO, and cases not identified for recovery will become the sole

and exclusive right of the Department to pursue, collect and retain. In such cases where the CHC-MCO has identified the cases to be pursued, the CHC-MCO shall retain the exclusive responsibility for the cases for a period not to exceed eighteen (18) months. The calculation of the eighteen (18) month period shall commence with receipt of the file from the CHC-MCO identifying the cases to be pursued. Any case not completed within the eighteen (18) month period will become the sole and exclusive right of the Department to pursue, collect and retain. The CHC-MCO is responsible to notify the Department through the prescribed electronic file process of all outcomes for those cases identified for pursuit. Cases included in Encounter files that were suspended will not be able to be included in the flagging process since the Claims cannot be adjusted in the Department's automated processing system.

- f. 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 filing that specific Claim is directly related to untimely submission of Encounter Data or additional records under special request, or inappropriate denial of Claims for accidents or emergency care in casualty related situations, the Department may the amount of the unrecoverable Claim against the CHC-MCO.
- g. Encounter Data that is not submitted to the Department in accordance with the data requirements and/or time frames identified in this Agreement can possibly result in a loss of revenue to the Department. Strict compliance with these requirements and time frames shall therefore be enforced by the Department and could result in the assessment of sanctions against the CHC-MCO.

3. Requests for Additional Data

The CHC-MCO must provide, at the Department's request, such information not included in the Encounter Data submissions that may be necessary for the administration of TPL activity, specifically casualty and estate recoveries. The CHC-MCO must provide casualty information within fifteen (15) calendar days of the Department's request. The CHC-MCO must provide information for urgent requests involving casualty and Encounter data for estate case 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 must be maintained as required by federal and state regulations.

4. Accessibility to TPL Data

The Department will provide the CHC-MCO with access to data maintained on the TPL monthly file.

5. Third Party Resource Identification

The CHC-MCO must supply the Department with TPR information identified by the CHC-MCO or its subcontractors, which does not appear on the Department's TPL database, as well as information on coverage for other household members, addition of a coverage type, changes to existing resources, including termination of coverage and changes to coverage dates. The method of reporting must be by electronic file or by any alternative method approved by the Department. TPL resource information must be submitted within two weeks of its receipt by the CHC-MCO. A web-based referral is only to be submitted in the following instance: to correct or negate an already end-dated resource. For web-based referrals, the CHC-MCO must use an exact replica of the TPL resource referral form supplied by the Department. For electronic submissions, the CHC-MCO must follow the required report format, data elements, and tape specifications supplied by the Department.

The Department will contact the CHC-MCO when the validity of a resource is in question. The CHC-MCO shall verify inconclusive resource information within two (2) business days of notification by the Department that the resource information is in dispute. Unless the verification notification is requested on the last business day of the week, then the MCO must respond by the close of business that day to avoid a potential access to care issue for their Participant.

The CHC-MCO must use EVS and secured services on the internet (previously known as POSNet) to identify insurance information the Participants have on file. If there is additional or different insurance information CHC-MCO or their subcontractors need to communicate the information as listed above.

6. Estate Recovery

The Department is required to recover MA costs paid on behalf of certain deceased individuals age fifty-five (55) and older who were receiving MA benefits for any of the following services:

- a. Public or private NF services;
- b. Residential care at home or in a community setting;
- c. Any hospital care and prescription drug services provided while receiving NF services or residential care at home or in a community setting.

The Department's Division of TPL is solely responsible for administering the Estate Recovery Program. The CHC-MCO must supply all requested Encounter data timely to permit the Department's timely filing of a claim.

SECTION VIII: REPORTING REQUIREMENTS

A. General

The CHC-MCO must comply with state and federal reporting requirements that are set forth in this Agreement, and provided in guidance from the Department.

The CHC-MCO must certify and submit to the Department the data required to be certified under 42 CFR §438.604, whether in written or electronic form. Such certification must be submitted concurrently with the data and must be based on the knowledge, information and belief of the Chief Executive Officer, Chief Financial Officer or an individual who has delegated authority to sign for, and who reports directly to the CEO or CFO in accordance with 42 CFR § 438.604.

The CHC-MCO will provide the certification in the manner prescribed by the Department.

B. Systems Reporting

The CHC-MCO must submit electronic files and data as specified by the Department. To the extent possible, the Department will provide reasonable advance notice of such reports.

The CHC-MCO must submit data as set forth in Exhibit Q, Data Support for CHC-MCOs. Information on the submission of the Department's data files is available on the CHC Intranet.

1. Encounter Data Reporting

The CHC-MCO must record Encounter Data and submit it to the Department. The CHC-MCO shall only submit Encounter Data for its Participants.

The CHC-MCO must maintain appropriate systems to obtain all necessary data from its Providers to enable it to comply with the Encounter Data reporting requirements. The failure of a Provider or Subcontractor to provide the CHC-MCO with necessary Encounter Data shall not excuse the CHC-MCO's noncompliance with this requirement.

The CHC-MCO must record the Encounter Data in a format prescribed by DHS. DHS will provide sixty days advance written notice of any changes to Encounter Data requirements.

a. Data Format

The CHC-MCO must submit Encounter Data to the Department pursuant to protocols to be established by the Department.

- i. Encounter File Specifications

- ii. The CHC-MCO must adhere to the file size and format specifications and file submission schedule provided by the Department.

The CHC-MCO must provide Encounter Data files in the following ASC X12 transactions:

- 837 Professional
- 837P - Drug
- 837I - Inpatient
- 837I – Outpatient
- 837I – LTC
- 837I – Outpatient Drug
- 837 Dental
- NCPDP batch files

b. Timing of Data Submittal

- i. Provider Claims

The CHC-MCO must require Providers to submit claims to the CHC-MCO within one hundred eighty (180) days after the date of service.

The CHC-MCO may require more prompt submissions of Claims or Encounter records in Provider Agreements and Subcontracts. Claims adjudicated by a third party vendor must be provided to the CHC-MCO by the end of the month following the month of adjudication.

- ii. Encounter Submissions

The CHC-MCO must submit all Encounter records except pharmacy transactions and have them determined acceptable by the Department on or before the last calendar day of the third month after the payment/adjudication calendar month in which the CHC-MCO paid/adjudicated the Claim. The CHC-MCO must have pharmacy transactions submitted and approved in PROMISe™ within 30 days following the adjudication date.

Encounter records sent to the Department are considered acceptable when they pass all Department edits.

The CHC-MCO must correct and return all Encounter Records that the Department determines are unacceptable. Denied Encounter records must be resubmitted as a “new” Encounter record within the timeframe referenced above.

Corrections and resubmissions must pass all edits before they are accepted by the Department.

iii. Response Files

The CHC-MCO's Encounter Data system must be able to receive and process the U277 and NCPDP response files; and to store the PROMISe™ ICN associated with each processed Encounter Data record returned on the files.

c. Data Completeness

The CHC-MCO must submit data each time a Participant has an Encounter with a Provider. The CHC-MCO must have a monitoring program in place that:

- i. Evaluates whether all Claims and Encounters submitted to the CHC-MCO by the Providers, including Subcontractors, are submitted accurately and timely as Encounters to the Department and whether denied Encounters are resolved and/or resubmitted;
- ii. Evaluates Provider and Subcontractor compliance with contractual reporting requirements; and
- iii. Demonstrates the CHC-MCO has processes in place to act on information from the monitoring program and takes appropriate action to ensure full compliance with Encounter Data reporting to the Department.

The CHC-MCO must submit to the Department an annual Data Completeness Plan for advance written approval. This Plan must include the three elements listed above.

d. Financial Sanctions

Assessment of financial sanctions is based on the identification of occurrences of noncompliance. The Department may impose sanctions for Encounter Data non-compliance as outlined in Exhibit Z, Encounter Data Submission Requirements and Sanctions Applications.

e. Data Validation

The CHC-MCO must assist the Department, or the Department's designee, in validation of Encounter Data by making available medical records and Claims data as requested.

f. Release of Encounter Data

All Encounter Data for Participants is the property of the Department. The CHC-MCO may use this data for the sole purpose of operating the CHC Program under this Agreement.

g. Drug Rebate Supplemental File

The CHC-MCO must submit a complete, accurate and timely monthly file containing supplemental data for NCPDP transactions used for the purpose of drug rebate dispute resolution. The file must be submitted by the 15th day of the month following the month in which the drug transaction was processed in PROMISe as specified on the Intranet supporting CHC.

2. Third Party Liability Reporting

In addition to the TPL reporting requirements in Section VII.F Third Party Liability, the CHC-MCO must report by electronic submission via a batch file or by hardcopy document, whichever is deemed most convenient and efficient by the CHC-MCO for its individual use. For electronic submissions, the CHC-MCO must follow the required report format, data elements, and tape specifications supplied by the Department. For hardcopy submissions, the CHC-MCO must use an exact replica of the TPL resource referral form supplied by the Department. Submissions lacking information key to the TPL database update process will be considered incomplete and will be returned to the CHC-MCO for correction and subsequent resubmission.

3. PCP Assignment

The CHC-MCO must provide a file through the Department to PROMISe™ of PCP assignments for all its Participants.

The CHC-MCO must provide this file at least weekly or more frequently if requested by the Department. The CHC-MCO must provide PCP assignment information that is consistent with all requirements specified by the Department by utilizing the response report provided by the Department. The CHC-MCO must use this report to reconcile and correct any errors. Information on the PCP file submission is available on the CHC Intranet.

4. Provider Network

The CHC-MCO must provide a file through the Department, to the

Department's PROMISE™ contractor, of its entire Network, including the network of its subcontractors.

The CHC-MCO must provide this file monthly. The CHC-MCO must provide information that is consistent with all requirements specified by the Department by utilizing the response report provided by the Department. The CHC-MCO must use this report to reconcile and correct any errors. Information on the Provider Network file submission is available on the CHC Intranet.

5. Alerts

The CHC-MCO must report to the Department on a Weekly Enrollment/Alert file: pregnancy, death, and return mail alerts.

The CHC-MCO must provide this file weekly. The CHC-MCO must provide the information that is consistent with all requirements specified by the Department. Information on the submission of alerts on the Weekly Enrollment/Alert File is on the CHC Intranet.

C. Operations Reporting

The CHC-MCO is required to submit such reports as specified by the Department to enable the Department to monitor the CHC-MCO's internal operations and service delivery. These reports include, but are not limited to, the following:

1. Fraud and Abuse

The CHC-MCO must submit to the Department quarterly statistical reports which relate to its Fraud and Abuse detection and sanctioning activities regarding Providers. The quarterly report must include information for all situations where a Provider action caused an overpayment to occur. The quarterly report must identify cases under review (including approximate dollar amounts), Providers terminated due to Medicare/Medicaid preclusion, and overpayments recovered.

D. Financial Reports

The CHC-MCO must submit such reports as specified by the Department to assist the Department in assessing the CHC-MCO's financial viability and compliance with this Agreement.

The Department will distribute financial reporting requirements to the CHC-MCO. The CHC-MCO must furnish all financial reports timely and accurately, with content in the format prescribed by the Department. This includes, but is not limited to, the CHC financial reporting requirements issued by the Department.

E. Equity

Not later than May 25, August 25, and November 25 of each agreement year, the CHC-MCO must provide the Department with:

- A copy of quarterly reports filed with PID.
- A statement that its Equity is in compliance with the Equity requirements or is not in compliance with the Equity requirements.
- If Equity is not in compliance with the Equity requirements, the CHC-MCO must supply a report that provides an analysis of its fiscal health and steps that management plans to take, if any, to improve fiscal health.

Not later than March 10 of each agreement year, the CHC-MCO must provide the Department with:

- A copy of unaudited annual reports filed with PID.
- A statement that its Equity is in compliance with the Equity requirements or is not in compliance with the Equity requirements.
- If Equity is not in compliance with the Equity requirements, the CHC-MCO must supply a report that provides an analysis of its fiscal health and steps that management plans to take, if any, to improve fiscal health.

F. Claims Processing Reports

The CHC-MCO must provide the Department with monthly Claims processing reports with content and in a format specified by DHS. The reports are due on the fifth (5th) calendar day of the second (2nd) subsequent month. Claims returned by a web-based clearinghouse (example WebMD Envoy) are not considered as claims received and would be excluded from claims reports.

The Department may impose the following sanction for the CHC-MCO's failure to submit a timely Claims processing report that is accurate and fully compliant with the reporting requirements: \$200 per day for the first ten (10) calendar days from the date that the report is due and \$1,000 per day for each calendar day thereafter.

G. Presentation of Findings

The CHC-MCO must obtain advance written approval from the Department before publishing or making formal public presentations of statistical or analytical material based on its CHC Participant Population.

H. Sanctions

1. The Department may impose sanctions for noncompliance with the requirements under this Agreement and failure to meet applicable

requirements in Sections 1932, 1903(m), and 1905(t) of the SSA in accordance with §§ 42 CFR 438.700; 438.702; and 438.704 in addition to any sanctions described in Exhibit D of this Agreement, Standard Terms and Conditions for Services, and in Exhibit E(1) of this Agreement, DHS Addendum to Standard Contract Terms and Conditions. The sanctions which can be imposed shall depend on the nature and severity of the breach, which the Department, in its reasonable discretion, will determine as follows:

- a. Imposing civil monetary penalties of a minimum of \$1,000.00 per day for noncompliance;
 - b. Requiring the submission of a corrective action plan;
 - c. Limiting Enrollment of new Participants;
 - d. Suspension of payments;
 - e. Temporary management subject to applicable federal or state law; and/or
 - f. Termination of the Agreement
2. Where this Agreement provides for a specific sanction for a defined infraction, the Department may, at its discretion, apply the specific sanction provided for the noncompliance or apply any of the general sanctions set forth in this Section VIII.H, Sanctions. Specific sanctions contained in this Agreement include the following:
- a. Claims Processing: Sanctions related to Claims processing are provided in Section VII D.2 of this Agreement, Sanctions.
 - b. Report or File, exclusive of Audit Reports: If the CHC-MCO fails to provide any report or file that is specified by this Agreement by the applicable due date, or if the CHC-MCO provides any report or file specified by this Agreement that does not meet established criteria, a subsequent payment to the CHC-MCO may be reduced by the Department. The reduction shall equal the number of days that elapse between the due date and the day that the Department receives a report or file that meets established criteria, multiplied by the average Per-Member-Per-Month Capitation rate that applies to the first (1st) month of the Agreement year. If the CHC-MCO provides a report or file on or before the due date, and if the Department notifies the CHC-MCO after the fifteenth (15th) calendar day after the due date that the report or file does not meet established criteria, no reduction in payment shall apply to the sixteenth (16th) day after the due date through the date that the

Department notifies the CHC-MCO.

- c. Encounter Data Reporting: The sanctions related to the submission of Encounter Data are set forth in Section VIII.B of this Agreement, Systems Reports, and Exhibit Z, Encounter Data Submission Requirements and Sanctions Applications.
- d. Marketing: The sanctions for engaging in unapproved marketing practices are described in Section V.F.3 of this Agreement, CHC-MCO Outreach Activities.
- e. Access Standard: The sanction for noncompliance with the access standard is set forth in Exhibit BB Provider Network Service Access.
- f. Subcontractor Prior Approval: The CHC-MCO's failure to obtain advance written approval of a Subcontract will result in the application a sanction of one (1) month's Capitation rate for a categorically needy adult female TANF consumer for each day that the subcontract was in effect without the Department's approval.
- g. Outpatient Drug Encounters: The sanctions for non-compliance with outpatient drug encounter data timeliness is set forth in Exhibit CC, Outpatient Drug (Pharmacy) Services.

I. Non-Duplication of Financial Penalties

If the Department assesses a financial sanction pursuant to one (1) of the provisions of Section VIII.H of this Agreement, Sanctions, it will not impose a financial sanction pursuant to Section VIII.H with respect to the same infraction.

SECTION IX: REPRESENTATIONS AND WARRANTIES OF THE CHC-MCO

A. Accuracy of Proposal

The CHC-MCO must notify the Department within ten (10) Business Days, of any material fact, event, or condition which arises or is discovered subsequent to the date of the submission of its Proposal, which affects the truth, accuracy, or completeness of such representations and information.

B. Disclosure of Interests

The CHC-MCO must disclose to the Department information on ownership and control, business transactions, and persons convicted of crimes in accordance with 42 C.F.R. Part 455, Subpart B. The CHC-MCO must require its Network Providers to disclose complete ownership, control, and relationship information.

The CHC-MCO warrants that the members of its governing body and its officers and directors have no interest and will not acquire any interest, direct or indirect, which conflicts with the performance of its services hereunder. The CHC-MCO will not knowingly employ any person having such interest.

The Department may terminate this agreement based on the CHC-MCO's failure to properly disclose required information and may recover as overpayments, any payments improperly made by the CHC-MCO.

C. Disclosure of Change in Circumstances

The CHC-MCO must notify the Department in writing of all changes affecting the delivery of care, the administration of its program, or its performance of Agreement requirements. The CHC-MCO must notify the Department in writing no later than 90 days prior to any significant change to the manner in which services are rendered to Participants, including but not limited to procurement or termination of a Provider.

The CHC-MCO will report to the Department, as well as the DOH and PID, within ten (10) Business Days of the CHC-MCO's notice of same, circumstances that may have a material adverse effect upon financial or operational conditions of the CHC-MCO or CHC-MCO's parent(s), including but not limited to the following:

1. Suspension, or debarment, or exclusion from federally funded healthcare programs of the CHC-MCO, CHC-MCO's parent(s), or any Affiliate or Related Party of either, by any state or the federal government;
2. Having a person who is debarred or suspended, or excluded act as a director, officer, or partner of the CHC-MCO with beneficial ownership of more than five percent (5%) of the CHC-MCO's Equity who has been debarred from participating in procurement activities under federal regulations.
3. Notice of suspension or debarment or exclusion from participation in healthcare program or notice of an intent to suspend, debar, or exclude issued by any state or the federal government to CHC-MCO, CHC-MCO's parent(s), or any Affiliate or Related Party; and
4. Any lawsuits or investigations by any federal or state agency involving CHC-MCO, CHC-MCO's parent(s), or any Affiliate or Related Party.

SECTION X: TERMINATION AND DEFAULT

A. Termination by the Department

1. Termination for Convenience upon Notice

The Department may terminate this Agreement for convenience as provided in Section 18 of Exhibit D Standard Terms and Conditions for Services. The Department is not required to provide advance notice of termination if this Agreement is replaced by another agreement to operate a CHC Program in the zone.

2. Termination for Cause

The Department may terminate this Agreement for cause as provided in Section 18 of Exhibit D Standard Terms and Conditions for Services. The Department is not required to provide advance written notice if it is terminating the Agreement based on:

- a. An act of theft or Fraud against the Department, any state agency, or the Federal Government; or
- b. An adverse material change in circumstances as described in Section IX.C, Disclosure of Change in Circumstances.

3. Termination Due to Unavailability of Funds or Approvals

In addition to Section 18 of Exhibit D Standard Terms and Conditions for Services, the Department may terminate this Agreement immediately upon the occurrence of any of the following events:

- a. Notification by the US DHHS of the withdrawal or disapproval of Federal Financial Participation in all or part of the cost for CHC Covered Services;
- b. Notification of the unavailability of funds for the CHC Program; or
- c. Notification that the federal approvals necessary to operate the CHC Program are not obtained or not retained; or
- d. Notification by the PID or DOH that the authority under which the CHC-MCO operates is subject to suspension or revocation proceedings or sanctions, has been suspended, limited, or curtailed, has been revoked, or has expired and shall not be renewed.

B. Termination by the CHC-MCO

The CHC-MCO may terminate this Agreement upon giving one hundred twenty (120) days advance written notice to the Department as provided in Section 18 of Exhibit D Standard Terms and Conditions for Services.

C. Responsibilities of the CHC-MCO upon Termination

1. Continuing Obligations

Termination or expiration of this Agreement shall not discharge the CHC-MCO of obligations with respect to services or items furnished prior to termination, including retention of records and verification of overpayments or underpayments. The Department's payment obligations to the CHC-MCO and the CHC-MCO's payment obligations to its subcontractors and Providers for services provided prior to the termination or expiration survive the termination or expiration of the Agreement.

Upon any termination or expiration of this Agreement, the CHC-MCO must:

- a. Provide the Department with all information deemed necessary by the Department within thirty (30) days of the request;
- b. Be financially responsible for Claims with dates of service through the expiration or termination, except as provided. below, including those submitted within time limits;
- c. Be financially responsible for hospitalized patients through the date of discharge or thirty-one (31) days after termination or expiration, whichever is earlier;
- d. Be financially responsible for services provided to NF Participants until the NF has completed a safe and orderly transfer of Participant care and records to another CHC-MCO in which the NF is operating after termination or expiration of this Agreement;
- e. Be financially responsible for services rendered through 11:59 p.m. on the date of termination or expiration, except as provided below, for which payment is denied by the CHC-MCO and subsequently approved upon appeal;
- f. Be financially responsible for Participant appeals of adverse decisions rendered by the CHC-MCO concerning services requested prior to termination or expiration that would have been provided but for a Denial which is overturned at a DHS Fair Hearing or Grievance proceeding; and
- g. Arrange for the orderly transfer of Participant care and records to those Providers who will be assuming care for the Participants.

2. Notice to Participants and Network Providers

If this Agreement is terminated, or expires without a new agreement in place, the CHC-MCO must notify all Participants and Network Providers of such

termination or expiration at least forty-five (45) days in advance of the effective date of termination or expiration, if practical. The CHC-MCO must make notices available in an accessible format and in the relevant language as required for Vital documents. The CHC-MCO must coordinate the continuation of care prior to termination or expiration for Participants who are undergoing treatment for an acute condition.

3. Submission of Invoices

Upon termination or expiration, the CHC-MCO must submit to the Department all outstanding invoices for allowable services rendered prior to the date of termination or expiration in the form stipulated by the Department no later than forty-five (45) days from the effective date of termination or expiration. The Department will not make payment for invoices submitted after forty five (45) days. This does not apply to submissions and payments in Appendices 3a – 3g.

4. Termination Requirements

Within 180 days of expiration or termination of the Agreement, the CHC-MCO must also provide the Department with all outstanding Encounter Data. The Department will withhold ten percent (10%) of one (1) month's Capitation payment until the Department determines that the CHC-MCO has complied with this requirement. The Department will not unreasonably delay or deny a determination of compliance. The Department will provide its determination to the CHC-MCO by the first (1st) day of the fifth (5th) month after the Agreement ends. If the Department determines that the CHC-MCO has not complied, the Department will provide subsequent determinations by the first (1st) day of each subsequent month.

D. Transition at Expiration or Termination of Agreement

If the CHC-MCO and the Department have not entered into a new Agreement, the Department will develop a transition plan. During the transition period, the CHC-MCO must comply with the requirements of the plan and must cooperate with any subsequent CHC-MCO and the Department. The Department will consult with the CHC-MCO regarding the transition plan, including information requirements and the relationship between the CHC-MCOs. The length of the transition period shall be no less than three (3) months and no more than six (6) months in duration.

The CHC-MCO is responsible for the costs relating to the transfer of materials and responsibilities as a normal part of doing business with the Department.

SECTION XI: RECORDS

A. Financial Records Retention

1. The CHC-MCO must maintain and must cause its subcontractors to maintain all books, records, and other evidence pertaining to revenues, expenditures, and other financial activity pursuant to this Agreement in accordance with the standards and procedures specified in this Agreement, including Section X3., Records Retention and Exhibit Y CHC Audit Clause.
2. The CHC-MCO will include the requirements set forth in Section XII , Subcontractual Relationships, in all Subcontracts it enters for the CHC Program, and will monitor subcontractors for compliance with these requirements.

B. Operational Data Reports

The CHC-MCO must maintain and must require its subcontractors to maintain all source records for data reports in accordance with the procedures specified in Section V.X.3., Records Retention.

C. Medical Records and Comprehensive Medical and Service Records Retention

The CHC-MCO must maintain and must cause its subcontractors to maintain all Comprehensive Medical and Service records in accordance with the procedures outlined in this Agreement, including Section V.X.3., Records Retention.

The CHC-MCO must provide Participants' Comprehensive Medical and Service Records, to the Department or its representatives within twenty (20) Business Days of the Department's request. The CHC-MCO will mail copies of such records to the Department if requested.

D. Review of Records

1. The CHC-MCO must make all records relating to the CHC Program, including but not limited to the records referenced in this Section, available for audit, review, or evaluation by the Department, federal agencies or their designees. Such records shall be made available on site at the CHC-MCO's chosen location, subject to the Department's approval, during normal business hours or through the mail. The Department will, to the extent required by law, maintain as confidential any confidential information provided by the CHC-MCO.
2. In the event that the Department or federal agencies request access to records, subject to this Agreement, after the expiration or termination of this Agreement or at such time that the records no longer are required by the terms of this Agreement to be maintained at the CHC-MCO's location, but in any case, before the expiration of the period for which the CHC-MCO is

required to retain such records, the CHC-MCO, at its own expense, must send copies of the requested records to the requesting entity within thirty (30) days of such request.

SECTION XII: SUBCONTRACTUAL RELATIONSHIPS

A. Compliance with Program Standards

With the exception of Provider Agreements, the CHC-MCO must comply with the procedures set forth in Section V.X.2. Contracts and Subcontracts and in Exhibit V, Required Contract Terms for Administrative Subcontractors.

Prior to the award of a contract or Subcontract, the CHC-MCO must disclose to the Department in writing information on ownership interests of five percent (5%) or more in the proposed Subcontractor.

The CHC-MCO's contracts and Subcontracts for CHC must be in writing and must contain all items as required by this Agreement.

The CHC-MCO must require its subcontractors to provide written notification of a denial, partial approval, reduction, or termination of service or coverage, or a change in the level of care, according to the standards outlined in Exhibit K(1), Quality Management and Utilization Management Program Requirements using the denial notice templates provided on the CHC Intranet. In addition, the CHC-MCO must include in its contracts or Subcontracts that cover the provision of Covered Services to the CHC-MCO's Participants the following provisions:

1. A requirement for cooperation with the submission of all Encounter Data for all services provided within the time frames required in Section VIII, Reporting Requirements, no matter whether reimbursement for these services is made by the CHC-MCO either directly or indirectly through capitation.
2. Language which requires compliance with all applicable federal and state laws.
3. Language which prohibits gag clauses which would limit the subcontractor from disclosure of Medically Necessary or appropriate health care information or alternative therapies to Participants, other Healthcare or LTSS Providers, or to the Department.
4. A requirement that ensures that the Department has ready access to any and all documents and records of transactions pertaining to the provision of services to Participants.
5. The definition of Medically Necessary as outlined in Section II, Definitions.

6. The CHC-MCO must require, if applicable, that its Subcontractors adhere to the standards for Network composition and adequacy.
7. Should the CHC-MCO use a subcontracted utilization review entity, the CHC-MCO must require that its subcontractors process each request for benefits in accordance with Section V.B.1, General Prior Authorization Requirements.
8. Should the CHC-MCO subcontract with an entity to provide any information systems services, the Subcontract must include provisions for a transition plan in the event that the CHC-MCO terminates the Subcontract or enters into a Subcontract with a different entity. This transition plan must include information on how the data shall be converted and made available to the new subcontractor. The data must include all historical Claims and service data.

B. Consistency with Regulations

The CHC-MCO must require all Subcontracts to be consistent, as may be applicable, with DOH regulations governing HMO Contracting with Integrated Delivery Systems at 28 Pa. Code §§9.721 – 9.725 and PID regulations at 31 Pa. Code §§ 301.301 – 301.314.

SECTION XIII: CONFIDENTIALITY

- A. The CHC-MCO must comply with all applicable federal and state laws regarding the confidentiality of Participant records, including medical records. The CHC-MCO must also require each of its subcontractors to comply with all applicable federal and state laws regarding the confidentiality of medical records. The CHC-MCO must comply with the Management Information System and System Performance Review (SPR) Standards, available on the CHC Intranet, regarding maintaining confidentiality of data. The federal and state laws with regard to confidentiality of medical records include, but are not limited to: Mental Health Procedures Act, 50 P.S. 7101 et seq.; Confidentiality of HIV-Related Information Act, 35 P.S. 7601 et seq.; 45 CFR Parts 160 and 164 (Standards for Privacy of Individually Identifiable Health Information); and the Pennsylvania Drug and Alcohol Abuse Control Act, 71 P.S. 1690.101 et seq., 42 U.S.C. §1396a(a)(7); 62 P.S. §404; 55 Pa. Code §105.1 et seq.; and 42 CFR Part 431 et seq.
- B. The CHC-MCO will be liable for any state or federal fines, financial penalties, or damages levied upon the Department for a breach of confidentiality due to the negligent or intentional conduct of the CHC-MCO in relation to the CHC-MCO's systems, staff, or other area of responsibility.
- C. The CHC-MCO will return all data and material obtained in connection with this

Agreement and the implementation thereof, including confidential data and material, at the Department's request. The CHC-MCO is not permitted to use this material for any purpose after the expiration or termination of this Agreement.

- D. The CHC-MCO is entitled to receive all information relating to the health status of its Participants in accordance with applicable confidentiality laws.

SECTION XIV: INDEMNIFICATION AND INSURANCE

A. Indemnification

1. In addition to Section 14 of Exhibit D, Standard Grant Terms and Conditions for Services, the CHC-MCO must indemnify and hold the Department and the Commonwealth of Pennsylvania, their respective employees, agents, and representatives harmless against any and all liabilities, losses, settlements, Claims, demands, and expenses of any kind (including, but not limited to, attorneys' fees) which may result or arise out of any dispute by and between the CHC-MCO and its subcontractors or Providers with Participants, agents, clients, in the performance or omission of any act or responsibility assumed by the CHC-MCO pursuant to this Agreement.
2. In addition to Section 14 of Exhibit D, Standard Grant Terms and Conditions for Services, the CHC-MCO must indemnify and hold harmless the Department and the Commonwealth of Pennsylvania from any audit disallowance imposed by the federal government resulting from the CHC-MCO's failure to follow state or federal rules, regulations, or procedures unless prior authorization was given by the Department. The Department shall provide timely notice of any disallowance to the CHC-MCO and allow the CHC-MCO an opportunity to participate in the disallowance appeal process and any subsequent judicial review to the extent permitted by law. Any payment required under this provision shall be due from the CHC-MCO upon notice from the Department. The indemnification provision hereunder shall not extend to disallowances which result from a determination by the federal government that the terms of this Agreement are not in accordance with federal law. The obligations under this paragraph shall survive any termination or cancellation of this Agreement.

B. Insurance

The CHC-MCO must maintain for itself, each of its employees, agents, and representatives, general liability and all other types of insurance in such amounts as reasonably required by the Department and all applicable laws. In addition, the CHC-MCO must require that each of the Network Providers with which the CHC-MCO contracts maintains professional malpractice and all other types of insurance in such amounts as required by all applicable laws. The

CHC-MCO must provide to the Department, upon the Department's request, certificates evidencing such insurance coverage.

SECTION XV: DISPUTES

In the event of a dispute between the parties to this Agreement, the Project Officer for the Department will make a determination in writing of his or her interpretation and will send the determination to the CHC-MCO. The determination is final and binding on the CHC-MCO and unreviewable unless the CHC-MCO files a written appeal with the Department's BHA. The CHC-MCO must file an appeal of an appealable agency action regarding this agreement in accordance with 67 Pa.C.S. §§101-11006 and implementing regulations at 55 Pa.Code Chapter 41.

SECTION XVI: GENERAL

A. Suspension from Other Programs

If the CHC-MCO learns that a Network Provider is suspended or excluded from participation in any federally funded healthcare Program by another state or the or the federal government, the CHC-MCO must promptly notify the Department, in writing, of such suspension or exclusion.

The CHC-MCO may not make any payments to a Provider for services rendered during the period in which the Provider is suspended excluded from participation in a federally funded healthcare program.

B. Rights of the Department and the CHC-MCO

The rights and remedies of the Department provided herein shall not be exclusive and are in addition to any rights and remedies provided by law.

Except as otherwise stated in Section XV, Disputes, the rights and remedies of the CHC-MCO provided herein shall not be exclusive and are in addition to any rights and remedies provided by law.

C. Invalid Provisions

Any provision of this Agreement which is in violation of any state or federal law or regulation shall be deemed amended to conform with such law or regulation, pursuant to the terms of this Agreement, except that if such change would materially and substantially alter the obligations of the parties under this Agreement, any such provision shall be renegotiated by the parties. The invalidity or unenforceability of any terms or provisions hereof shall in no way affect the validity or enforceability of any other terms or provisions hereof.

D. Notice

Any written notice to any party under this Agreement shall be deemed sufficient if delivered personally, or by facsimile, telecopy, electronic or digital transmission (provided such delivery is confirmed), or by recognized overnight courier service (e.g., DHL, Federal Express, etc.), with confirmed receipt, or by certified or registered United States mail, postage prepaid, return receipt requested, sent to the address set forth below or to such other address as such party may designate by notice given pursuant to this section:

To the Department via U.S. Mail:
Department of Human Services
Deputy Secretary, Office of Long-Term Living
P.O. Box 8052
Harrisburg, Pennsylvania 17105

To the Department via UPS, FedEx, DHL or other delivery service:
Department of Human Services
Director, Bureau of Managed Care Operations

With a Copy to:

Department of Human Services
Office of Legal Counsel
3rd Floor West, Health and Welfare Building
625 Forster Street
Harrisburg, Pennsylvania 17120
Attention: Chief Counsel

To the CHC-MCO –.

E. Counterparts

This Agreement may be executed in counterparts, each of which shall be deemed an original for all purposes, and all of which, when taken together shall constitute but one and the same instrument.

F. Headings

The section headings used herein are for reference and convenience only, and shall not enter into the interpretation of this Agreement.

G. No Third Party Beneficiaries

This Agreement does not, nor is it intended to, create any rights, benefits, or interest to any third party, person, or organization.

APPENDIX 3a

ACA Health Insurance Providers Fee

This Appendix provides for potential payments by the Department to the CHC-MCO related to the Health Insurance Providers Fee (HIPF).

Fee Year – The year in which a HIPF payment is due from the CHC-MCO to the Internal Revenue Service (IRS) is referred to as the Fee Year.

Data Year – The IRS calculates HIPF due in the Fee Year using submitted information on net premiums written for the previous calendar year, which is referred to as the Data Year.

- A. If a CHC-MCO is a covered entity or a member of a controlled group under Section 9010 of the Affordable Care Act that is required to file IRS Form 8963, Report of Health Insurance Provider Information (Report 8963), the CHC-MCO must perform the following steps. Submission is not required if the CHC-MCO is exempt from the HIPF.
1. By May 5th of each calendar year, the CHC-MCO shall provide the Department with a copy of Form 8963 submitted to the IRS. The CHC-MCO shall also provide, for each line on Form 8963 that reports premiums written, the amount of Community HealthChoices premium included on that line.
 2. The CHC-MCO will provide to the Department a copy of the IRS HIPF preliminary fee calculation notice within 10 business days of its receipt from the IRS.
 3. If a corrected Form 8963 is submitted to the IRS during the error correction period, the CHC-MCO shall provide the Department with a copy of all such reports within 10 business days of submission to the IRS. The CHC-MCO shall also provide, for each line on a corrected Form 8963 that reports premiums written, the amount of Community HealthChoices premium that is included on that line.
 4. By September 7 of each Fee Year, the CHC-MCO will provide the Department with a copy of the IRS HIPF final fee calculation notice for that Fee Year.
 5. If the CHC-MCO's net income is subject to federal income tax and the CHC-MCO desires the Department to consider this in its calculation of the payment amount, the CHC-MCO shall provide the average federal income tax rate that applies to its income for the Data Year. The CHC-MCO will also provide the amount of taxable income subject to federal income tax and the amount of federal income tax paid for the most recent income tax year for which a tax

filing has been made. The CHC-MCO will specify the tax year and will provide the information by September 7.

6. If the CHC-MCO's net income is subject to Pennsylvania corporate net income tax and the CHC-MCO desires the Department to consider this in its calculation of the payment amount, the CHC-MCO shall provide the average state income tax rate that applies to its Pennsylvania corporate net income for the Data Year. The CHC-MCO will also provide the amount of taxable income subject to Pennsylvania corporate net income tax and the amount of Pennsylvania corporate net income tax paid for the most recent income tax year for which a tax filing has been made. The CHC-MCO will specify the tax year and will provide the information by September 7.

B. The Department will:

1. Review each submitted document and notify the CHC-MCO of any questions. The CHC-MCO must respond to questions from the Department within five work days.
2. By September 15 of each Fee Year, the Department will pay the portion of the Data Year HIPF Withhold Amounts that covers the Community HealthChoices portion (specific to this Agreement) of the CHC-MCO's HIPF obligation per the IRS HIPF preliminary fee calculation notice (as noted in A.2 above). This payment will be called the Initial HIPF Payment. To calculate the payment amount, the Department will:
 - a. Calculate the HIPF obligation rate (the "HIPF%") from information on the IRS document "Annual Fee on Health Insurance Providers for 20xx", where 20xx is the Fee Year. For a CHC-MCO that is a single-person covered entity, the IRS will send this document to the CHC-MCO. For a CHC-MCO that is a member of controlled group, the IRS will send this document to the designated entity of the controlled group on behalf of all members of the controlled group.

Single-person covered entity or controlled group HIPF% =

$$\frac{\text{Amount labeled "Your share of fee"}}{\text{Amount labeled "Sum of total net premiums written as reported"}}$$

The amount "Sum of total net premiums written as reported" is before the reduction of 100% of the first \$25 million of premium and 50% of the next \$25 million of premium. The single-person covered entity or controlled group HIPF% is unique to each entity that is subject to the HIPF. The above formula produces the HIPF% to be used in subsequent steps of the calculation in the following circumstances:

- i. The CHC-MCO is a single-person covered entity.
- ii. The CHC-MCO is a member of a controlled group and none of the controlled group's premiums are reported as "Premiums eligible for partial exclusion for certain exempt activities" (listed on Form 8963 as attributable to 501(c)3, (c)4, (c)26, or (c)29 entities).
- iii. The CHC-MCO is a member of a controlled group and all of the controlled group's premiums are reported as "Premiums eligible for partial exclusion for certain exempt activities" (listed on Form 8963 as attributable to 501(c)3, (c)4, (c)26, or (c)29 entities).

If the document "Annual fee on Health Insurance Providers for 20xx" has an amount for the "Premiums eligible for partial exclusion for certain exempt activities" that is not zero and not equal to the amount "Sum of total net premiums written as reported", then information from Form 8963 on the premiums attributable to 501(c)3, (c)4, (c)26, or (c)29 entities will be used to develop a non-profit HIPF% for the 501(c)3, (c)4, (c)26, or (c)29 entities that is 50% of the HIPF% for the other (for-profit) entities, where the application of the two rates to the respective premiums produces the amount "Your share of fee". The HIPF% to be used in subsequent steps of the calculations is either the non-profit or for-profit HIPF%, as determined by the status of the CHC-MCO.

- b. Calculate Figure A. Figure A is the total revenue for coverage in the Data Year that the Department has provided the CHC-MCO for this Agreement, as known through payments made by August 1 of the Fee Year. The Figure A amount has no provision for the HIPF obligation.
- c. Calculate Figure B. Figure B is the portion of Figure A that is for services subject to the HIPF. Capitation revenue for services that are excludable under Section 9010, such as long-term care services, will not be included in Figure B. The Figure B amount has no provision for the HIPF obligation.

Calculate Figure C. Figure C is the calculation of total revenue that incorporates provision for the HIPF and other taxes. The Department will use the following formula to calculate Figure C. If the CHC-MCO has not provided satisfactory documentation of federal income tax obligations under section A.5, then the Average Federal Income Tax Rate (AvgFIT%) in the formula will be zero. If the CHC-MCO has not provided satisfactory documentation of Pennsylvania corporate net income tax obligations under section A.6, then the Average State Income Tax Rate (AvgSIT%) in the formula will be zero. The applicable Gross Receipts Tax percentage (GRT%) is inclusive of any statewide tax or assessment on CHC-MCO revenue that is levied by the Commonwealth that is separate and distinct from the State Income Tax. If there are no qualifying taxes or assessments, then the GRT% amount is zero.

$$\frac{\text{Figure B} \times (1 - \text{GRT}\%)}{\text{GRT}\% - (\text{HIPF}\% / (1 - \text{AvgSIT}\% - \text{AvgFIT}\% \times (1 - \text{AvgSIT}\%)))} \quad 1 -$$

- d. Calculate Figure D. The Department will calculate Figure D by subtracting Figure B from Figure C.
 - e. The Department will compare Figure D with the sum of the HIPF Withhold amounts it has withheld for this Agreement for the Data Year. The lesser of these two figures will be the Initial HIPF Payment amount.
3. The Department will utilize the steps provided in B.2. above to calculate a Final HIPF Settlement Amount, with these exceptions:
- a. The Department will utilize the IRS HIPF final fee calculation notice for that Fee Year instead of the preliminary fee calculation notice.
 - b. Figure A is the total revenue for coverage in the Data Year, excluding the Initial HIPF Payment under section B.2, that the Department has provided the CHC-MCO for this Agreement, as known through payments made by November 1 of the Fee Year.
 - c. The Final HIPF Settlement Amount will be the difference between the new Figure D and the Initial HIPF Payment Amount, except that the sum of payments may not exceed the sum of the HIPF Withhold Amounts for the Data Year.
- C. The Department will perform the steps provided by this Appendix 3a for any year that a CHC-MCO pays a HIPF, even if the CHC-MCO is no longer providing Community HealthChoices services during that Fee Year.
- D. The CHC-MCO shall notify the Department if the HIPF actually paid is less than the amount in the IRS final fee calculation notice or if the IRS refunds any portion of the HIPF. If such changes affect the calculations provided in Appendix 3a, the Department will recalculate its obligation and the CHC-MCO will refund the difference.
- E. The Department will not make a payment per this Appendix 3a if the CHC-MCO is not subject to the HIPF.

APPENDIX 3b

Explanation of Capitation Payments

If there are Health Insurance Providers Fee (HIPF) withholds present on Appendix 3e, then Base Capitation Rates for the purpose of this appendix are defined as Base Capitation Rates net of HIPF withholds and prior to risk adjustment.

I. Base Capitation Rates

The final Base Capitation Rates for the Agreement Year is found in Appendix 3d, Capitation Rates.

II. Base Capitation Rates for Subsequent Years

A. Initial Schedule of Base Capitation Rates

Annually, the Department will provide an initial Base Capitation rates. The Department will provide the CHC-MCO with information on methodology and data used to develop the initial Base Capitation Rate.

The Department will provide the CHC-MCO with the opportunity for a meeting, in which the Department will consider and respond to questions from the CHC-MCO on development of the initial Base Capitation Rate.

B. Final Schedule of Base Capitation Rates

The Department will provide the CHC-MCO with a final Base Capitation Rate. The rates in Appendix 3e, Capitation Rates, included with this Agreement will remain in effect until agreement is reached on new rates and their effective date. The CHC-MCO must conclude discussion about the rates timely for the purposes of execution of an amendment and the Department's need to obtain approval of the rates from the Centers for Medicare and Medicaid Services (CMS).

APPENDIX 3c

Risk Corridor

This Appendix will be used for a risk corridor arrangement (Arrangement) between the Department and the CHC-MCO. The Arrangement applies collectively to all Community HealthChoices Agreements between the CHC-MCO and the Department.

APPENDIX 3d

Capitation Rates

This Appendix will be used for specifying the capitation rates that will be paid by the Department to the CHC-MCO.

APPENDIX 3e

Overview Of Methodologies for Rate Setting

I. **Rate Setting Methodology #1 – Use of Historical Fee-For-Service Data and Managed Care Encounter Data**

To develop capitation rates on an actuarially sound basis for the Community HealthChoices program using historical fee-for-service (FFS) data and managed care encounter data, the following general steps are performed:

- Summarize the FFS Claims, Managed Care Encounter and Eligibility Data
- Combine the Multiple Years of Data Together, If Applicable
- Project the Base Data Forward
- Include the Effect of Program/Policy Changes
- Adjust the FFS Data to Reflect Managed Care Principles
- Add an Appropriate Administration/Underwriting Gain Load
- Add an Amount for Taxes/Assessments

Summarize the FFS Claims, Managed Care Encounter and Eligibility Data — The Commonwealth provides summarized FFS claims, encounters and eligibility data for the recipients and services to be covered under the Community HealthChoices program. Normally, multiple years of data are made available for rate-setting purposes; although the actuary may choose one or more years of data to base rates upon. This data is then adjusted to account for items not included in the initial data collection process. These adjustments (positive and negative) generally include, but are not limited to: completion factors, legal settlements, gross adjustments, graduate medical education payments, pharmacy rebates, and other adjustments needed to improve the accuracy of the data.

Combine the Multiple Years of Each Data Source Together, If Applicable — To arrive at a single year of each data source to serve as the basis for rate setting, the multiple years of each data source can be combined together if more than one year of data was selected for the base. The blending of the base years of data may be on Participant months or other weighting factors selected by the actuary.

Project the Base Data Forward — The base data is then projected forward to the time period for which the capitation rates are to be paid. Trend factors are used to estimate the future costs of the services for the populations covered by the managed care program. These trend factors normally vary by service and/or population group.

Include the Effect of Program/Policy Changes — Changes from Commonwealth and/or federal policy may occur to the services or populations covered under the Community HealthChoices program (e.g., expands dental care, restricts enrollment). Material program changes are included in the capitation rates by either increasing or decreasing the base data by an appropriate adjustment.

Adjust the FFS Data to Reflect Managed Care Principles — Since Community HealthChoices is a managed care program and not FFS, the projected FFS data

needs to be adjusted to reflect the typical changes that occur when changing from a FFS program to a managed care program. This generally involves increasing the cost/use of preventative services, and decreasing hospital and emergency room cost/use. It may also include increasing the use of community services and transitioning individuals out of nursing facilities, as applicable.

Add an Appropriate Administration/Underwriting Gain Load — After the base data has been trended to the appropriate time period, adjusted for program/policy changes and adjusted to reflect managed care principles, an administration/underwriting gain load will be added to the service claims cost component to determine the overall capitation rates applicable to each population group. The administration/underwriting gain load may be applied as a percentage of the total capitation rate (i.e., percent of premium) and includes all reasonable and appropriate administrative expenses expected for a health plan operating the program in an efficient and effective manner. The underwriting gain component of the load includes consideration for the cost of capital and a risk margin.

Add an Amount for Taxes/Assessments — The final capitation rate, after all other components have been completed, is further adjusted to reflect legislatively mandated taxes/assessments as applicable. These taxes/fees can be applied as a percent of final premium or a PMPM adjustment added to the original final capitation rate. The Department will adjust the payment to the CHC-MCOs for the Medicaid portion of the MCO assessment cost based upon changes to the assessment fee in accordance with Act 92 of 2015.

II. Rate Setting Methodology #2 – Use of Managed Care Data

To develop capitation rates on an actuarially sound basis for the Community HealthChoices program using actual CHC program-specific managed care data, the following general steps are performed:

- Summarize, Analyze, and Adjust the Managed Care Data
- Project the Managed Care Base Data Forward
- Include the Effect of Program/Policy Changes
- Add an Appropriate Administration/Underwriting Gain Load
- Add an Amount for Taxes/Assessments
- Optional Rate Update

Summarize, Analyze, and Adjust the Managed Care Data — The Commonwealth collects data from each of the managed care organizations (MCOs) participating in the Community HealthChoices program. This data is summarized, analyzed, and adjustments (positive and negative) are applied as needed to account for underlying differences between each MCO's management of the Community HealthChoices program. These adjustments can account for items such as collection of TPL/COB, over- or under- reserving of unpaid claims, management efficiency, and Provider contracting relations. After adjusting each MCO's data, each plan's specific service claim costs are aggregated together to arrive at a set of base data for each population group.

Project the Managed Care Base Data Forward — The aggregate base of managed care data is projected forward to the time period for which the capitation

rates are to be paid. Trend factors are used to estimate the future costs of the services that the covered population would generate in the managed care program. These trend factors normally vary by service and/or population group.

Include the Effect of Program/Policy Changes — The Commonwealth occasionally changes or federal laws/regulations will impact the services or populations covered under the Community HealthChoices program (e.g., expands dental care, restricts enrollment). Any new, material program/policy changes that were not already reflected in the managed care data are included in the capitation rates by either increasing or decreasing the managed care data by an appropriate adjustment.

Add an Appropriate Administration/Underwriting Gain Load — After the base data has been trended to the appropriate time period, adjusted for program/policy changes, adjusted to reflect managed care principles, and blended into one data source, an administration/underwriting gain load will be added to the service claim cost component to determine the overall capitation rates applicable to each population group. The administration/underwriting gain load may be applied as a percentage of the total capitation rate (i.e., percent of premium) and includes all reasonable and appropriate administrative expenses expected for a health plan operating the program in an efficient and effective manner. The underwriting gain component of the load includes consideration for the cost of capital and a risk margin.

Add an Amount for Taxes/Assessments — The final capitation rate, after all other components have been completed, is further adjusted to reflect legislatively mandated taxes/assessments as applicable. These taxes/fees can be applied as a percent of final premium or a PMPM adjustment added to the original final capitation rate.

Optional Rate Update — In lieu of rebasing rates on newer experience base data, it is possible to update the prior year's rates for new, material program changes, trend and other adjustments following a similar process outlined above.

III. Rate Setting Methodology #3 – Blending of Prior Year's Rates and Managed Care Data

When updated FFS data is unavailable and actual CHC managed care experience first becomes available, capitation rates for the Community HealthChoices program can be developed on an actuarially sound basis using a blending of both data sources using the following two track approach:

- Project the Prior Year's Rates Forward (Track 1)
- Summarize and Adjust the CHC Managed Care Data (Track 2)
- Include the Effect of New Program/Policy Changes (Track 1 and Track 2)
- Apply Credibility Factors to Each Track and Blend Together
- Add an Appropriate Administration/Underwriting Gain Load
- Add an Amount for Taxes/Assessments

Project the Prior Year's Rates Forward (Track 1) — The first step of Track 1 is to begin with the previous year's capitation rates. This data is projected forward to the time period for which the new capitation rates are to be paid. Trend factors are used to estimate the future costs of the services the covered population would generate under managed care. These trend factors normally vary by service and/or population group.

Include the Effect of New Program/Policy Changes (Track 1) — In Track 1, any new, material program/policy changes implemented by the Commonwealth or required by the federal government, that were not already accounted for in the previous year's rates, are included in the new capitation rates by either increasing or decreasing the rates by an appropriate adjustment.

Summarize and Adjust the CHC Managed Care Data (Track 2) — The more recent managed care data is collected from the MCOs, summarized, and analyzed to support rate setting. Adjustments (positive and negative) are applied to the managed care data as needed to account for underlying differences between each MCO's management of the Community HealthChoices program. These adjustments can account for items such as collection of TPL/COB, over- or under-reserving of unpaid claims, management efficiency, and Provider contracting relations.

Include the Effect of Trend and New Program/Policy Changes (Track 2) — In Track 2, the managed care data is projected forward to the time period the capitation rates are to be paid. Trend factors may vary by service and/or population group, and are used to estimate the future costs of the services that the covered population would generate under managed care. Any new, material program/policy changes that were not already reflected in the managed care data are included in the rates by either increasing or decreasing the data by an appropriate adjustment.

Apply Credibility Factors to Each Track and Blend Together — After separately developing capitation rates using Track 1 and Track 2, the two sets of rates are combined together. This blending involves applying a credibility weight to each track and adding the two components together. The credibility weights may vary between the population groups.

Add an Appropriate Administration/Underwriting Gain Load — After the data has been trended to the appropriate time period, adjusted for program/policy changes, adjusted to reflect managed care principles, and blended into one data source, an administration/underwriting gain load will be added to the service claim cost component to determine the overall capitation rates applicable to each population group. The administration/underwriting gain load may be applied as a percentage of the total capitation rate (i.e., percent of premium) and includes all reasonable and appropriate administrative expenses expected for a health plan operating the program in an efficient and effective manner. The underwriting gain component of the load includes consideration for the cost of capital and a risk margin.

Add an Amount for Taxes/Assessments — The final capitation rate, after all other components have been completed, is further adjusted to reflect legislatively

mandated taxes/assessments as applicable. These taxes/fees can be applied as a percent of final premium or a PMPM adjustment added to the original final capitation rate. The Department will adjust the payment to the CHC-MCOs for the Medicaid portion of the MCO assessment cost based upon changes to the assessment fee in accordance with Act 92 of 2015.

IV. Additional Information on Rate Development

The reimbursement provided under this Agreement is intended for Medically Necessary services covered under the Commonwealth's State Plan. For NFCE individuals, the reimbursement is also intended to cover HCBS services determined necessary based on the individual's assessed need. The MCO has the option to utilize this reimbursement to provide alternatives to the Medically Necessary services covered under the State Plan in order to meet the needs of the individual Participant in the most efficient manner. However, since the capitation rates cannot include these alternative services, an adjustment may be required in the rate development process to incorporate only the cost of state plan and HCBS waiver services which would have been provided in the absence of alternative services. Cost effective in lieu of services may be addressed differently than other non-cost effective in lieu of services. The CHC-MCO may be required to provide documentation, supporting analyses and data related to the provision and justification of non-state plan services.

APPENDIX 3f

Five Percent Capitation Withhold

This appendix provides for capitation withholds if the CHC-MCO has not signed an annual Community HealthChoices Agreement amendment by a specified date.

1. Effective with capitation payments that are payable in December of each calendar year and continuing with capitation amounts that are payable in each month thereafter, the Department will withhold from each monthly capitation payment an amount equal to five percent of the capitation amount it has paid for the August program month in the same calendar year.
2. The Department will not implement this withhold if any of the following apply:
 - a. The Department has received by November 20 of the same calendar year a signed Community HealthChoices Agreement amendment from the CHC-MCO that provides financial terms for the following calendar year; or
 - b. The Deputy Secretary for the Office of Long Term Living decides to waive the monthly capitation payment withhold.
3. If the Department does not withhold an amount from the capitation payment payable in December, and if by December 20 of the same calendar year the Department has not received a signed agreement amendment from the CHC-MCO that provides financial terms for the following calendar year, then effective with monthly capitation payments that are payable in January of the next calendar year and continuing with capitation amounts that are payable in each month thereafter, the Department will withhold from each monthly capitation payment an amount equal to five percent of the capitation amount it has paid for the most recent August program month. The Deputy Secretary of the Office of Long Term Living may elect to waive the monthly capitation payment withhold.
4. If the Department withholds payment per this appendix, the Department will initiate a payment of the total amount that was withheld when the Department receives a signed Community HealthChoices Agreement amendment from the CHC-MCO that provides financial terms for the applicable calendar year for this Community HealthChoices zone.
5. This entire appendix does not apply: (a) if the Department does not provide a detailed financial offer to the CHC-MCO for the following year by September 7 or (b) the CHC-MCO has terminated the Community HealthChoices Agreement.

APPENDIX 3g

Individual Stop Loss Re-Insurance

The Department may contemplate inclusion of an individual stop-loss reinsurance arrangement or another form of risk sharing or risk pools in the CHC-MCO agreements.

APPENDIX 4

Nursing Facility Access to Care Payments

I. DEFINITIONS

For the purposes of this Appendix 4, the term nursing facility means the following:

A. Private Nursing Facility—

- (i) A long-term care nursing facility, that is:
 - (A) Licensed by the Department of Health.
 - (B) Enrolled in the MA Program as a provider of nursing facility services.
 - (C) Owned by an individual, partnership, association or corporation and operated on a profit or nonprofit basis.
- (ii) The term does not include intermediate care facilities for persons with an intellectual disability, Federal or State-owned long-term care nursing facilities, Veteran's homes, county nursing facility, or out-of-state nursing facilities.

B. County nursing facility—

- (i) A long-term care nursing facility, that is:
 - (A) Licensed by the Department of Health.
 - (B) Enrolled in the MA Program as a provider of nursing facility services.
 - (C) Controlled and totally funded by the County Institution District or by the county if no County Institution District exists. "Totally funded," as used in this definition, means that the county funds costs which are not reimbursed by liable third parties, such as MA, Medicare or other health insurance programs. "Controlled," as used in this definition, means that the county government directs the actions and policies of the facility. The term does not include intermediate care facilities for persons with intellectual disabilities controlled or totally funded by a County Institution District or county government.
- (ii) The term does not include intermediate care facilities for persons with an intellectual disability controlled or totally funded by a County Institution District or county government, Federal or State-owned long-term care nursing facilities, Veteran's homes, private nursing facility, or out-of-state nursing facilities.

II. FUNDING BY THE DEPARTMENT TO THE CHC-MCO

A. Private Nursing Facility Access to Care

The rates paid to the CHC-MCO include a Private NF Access to Care component. The Private NF Access to Care component, net of MCO Assessment, is specified in the charts below. The Private NF Access to Care component is subject to the any risk adjustment the department may choose to implement.

RATES TO BE SUPPLIED AT A LATER DATE

B. County Nursing Facility Access to Care

The rates to the CHC-MCO include a County NF Access to Care component. The County NF Access to Care component, net of MCO Assessment, is specified in the charts below. The County NF Access to Care component is subject to any risk adjustment the department may

choose.

RATES TO BE SUPPLIED AT A LATER DATE

III. INCREASED PAYMENTS BY THE CHC-MCO TO NURSING FACILITIES

- A. The CHC-MCO must use the funds received from the Private NF Access to Care component to increase the payments made by the CHC-MCO to private nursing facilities for nursing facility services. CHC-MCO must use the County NF Access to Care component to increase payments made by CHC-MCO to county nursing facilities for nursing facility services.
- B. The CHC-MCO must provide documentation to the Department in a form designated by the Department that all funds received from the Private and County NF Access to Care components are used in accordance with this Appendix.

IV. CLAIMS PROCESSING REQUIREMENTS

- A. A Private or County NF Access to Care payment to a private or county nursing facility by a CHC-MCO is deemed payment of a clean Claim received from a nursing facility for admission and is subject to Section VII.D. of this Agreement.
- B. Unless contract terms between the MCO and nursing facility specify otherwise, the amount of time required to adjudicate this Claim is computed by comparing the date the Private or County NF Access to Care payment was received by the CHC-MCO from the Department with the date the payment is transmitted to the nursing facility.

EXHIBIT A

Managed Long Term Services and Supports Regulatory Compliance Guidelines

Managed Care Organizations participating in Community Health Choices (CHC) must comply with all applicable federal and state laws (including, but not limited to, applicable regulations found in 55 Pa. Code Chapters 52, 1101 through 1249) and policy bulletins issues under those state and federal laws.

As a general manner, regulatory provisions that no longer apply relate to Early and Periodic Screening, Diagnostic, and Treatment requirements (“EPSDT”) and to the calculation of Medical Assistance provider payment rates and fees in place prior to CHC. The following is a non-exhaustive outline of regulations under Title 55 of the Pennsylvania Code and policy bulletins relating to those regulations that do not apply:

Chapter 52. Long-term Living Home and Community-Based Services

- Subsection 52.26 (e) (relating to service coordination entity as Organized Healthcare Delivery System (OHCDs))
- Section 52.27 (relating to service coordinator qualifications and training)
- Subsections 52.28
- Sections 52.41 and 52.42 (relating to billing and payment policies)
- Section 52.45 (relating to fee schedule rate)
- Sections 52.51 and 52.52 (relating to vendor goods and services)
- Section 52.53 (relating to OHCDs)
- Section 52.64 (relating to payment sanctions)

Chapter 1101. General Provisions

- Section 1101.21 (relating to the following definitions: Prior Authorization; Shared Health Facility)
- Subsection 1101.31(b)(13) (relating to dental services)
- Subsection 1101.31(f) (relating to program exception process)
- Subsection 1101.33(a) (relating to recipient eligibility)
- Subsection 1101.33(b) (relating to a single-provider exception)
- Section 1101.51(a) (relating to freedom of choice)
- Section 1101.61 (only as it relates to fees and payments)
- Section 1101.62 (relating to maximum fees)
- Subsections 1101.63(b)(1) through (9) (relating to cost payments)
- Subsection 1101.63(c) (relating to MA deductibles)
- Subsection 1101.64(b) (only as to the reference to rates and fees)
- Section 1101.65 (relating to method of payment)
- Section 1101.67 (relating to prior authorization)
- Section 1101.68 (relating to invoices)
- Section 1101.69 (relating to overpayments and underpayments)
- Section 1101.72 (relating to invoice adjustments)
- Section 1101.83 (relating to restitution and repayment)

Chapter 1121. Pharmaceutical Services

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A-

- Section 1121.2 (relating to the definitions of: CAP; Compounded Prescription; Pricing Service; Federal Upper Limit; CMS Multisource Drug; State MAC; and Usual and Customary Charge)
- Subsections 1121.52(a)(6) and (b) (relating to payment conditions)
- Subsections 1121.53(a), (b)(1), (b)(2), (c), and (f) (relating to limitations on payment)
- Section 1121.55 (relating to the Department's payment to pharmacies)
- Section 1121.56 (relating to Drug Cost Determination)

Chapter 1123. Medical Supplies

- Section 1123.1 (only as to the reference to MA Fee Schedule)
- Subsections 1123.13(a) and (b) (relating to inpatient services)
- Subsection 1123.22(1) and (2) (relating to medical supplies which have been prescribed through the school medical program and EPSDT)
- Section 1123.51 (only as to the reference to MA Fee)
- Section 1123.53 (related to hemophilia products)
- Section 1123.54 (related to Orthopedic shoes)
- Section 1123.55 (related to oxygen and related equipment)
- Section 1123.56 (related to vision aides)
- Section 1123.57 (relating to hearing aids)
- Subsections 1123.58 (related to prostheses and orthoses)
- Section 1123.60 (related to limitations on payment)
- Section 1123.61 (related to non-compensable services and items)
- Section 1123.62 (related to method of payment)
- MA Bulletin 05-86-02
- MA Bulletin 05-87-02
- MA Bulletin 1123-91-01

Chapter 1126. Ambulatory Surgical Center and Hospital Short Procedure Unit Services

- Subsections 1126.51(f) through (h) and (k) through (m) (relating to payment for same-day surgical services)
- Subsections 1126.52 (related to maximum reimbursement and developed fees)
- Subsection 1126.53(b) (related to limitations on covered procedures)
- Subsection 1126.54(a)(7) (related to sex reassignment)
- Subsections 1126.54 (b) (related to non-compensable services and items)

Chapter 1127. Birth Center Services

- Subsection 1127.51(d) (related to claims submissions)
- Subsections 1127.52(a) through (c) (related to fees and payment methodology)
- Subsection 1127.52(d) (related to termination of birth center services during prenatal care)
- Subsection 1127.52(e) (related to payment if complications develop during labor and patient is transferred to a hospital)
- Subsection 1127.53(c) (related to limitations on payment)

Chapter 1128. Renal Dialysis Facilities

- Subsection 1128.51(a) – (d) (only as it relates to payment provisions)
- Subsection 1128.51(f) through (m) (only as it relates to fees)
- Subsection 1128.51(n) (related to payment to Out-of-State dialysis facilities)
- Section 1128.52 (related to payment criteria)
- Subsection 1128.53(a) through (e) (related to limitations on payment)
- Subsection 1128.53(f) (only as it relates to payment for back up visits)
- Subsection 1128.53(g) (related to limitations on payment)

Chapter 1129. Rural Health Clinic Services

- Subsection 1129.51(b) and (c) (only as it relates to billings to, and payments from, the Department to payment to Rural Health Clinics)
- Sections 1129.52 and 1129.53 (related to payment policies for Rural Health Clinics)

Chapter 1130. Hospice Services

- Subsections 1130.22(4), 1130.41(a), 1130.41(c) and Subsection 1130.42(a) (only as it relates to the use of the specific form; however, the provider must have a form that is substantively the same)
- Subsection 1130.63(b) (related to limitations on coverage)
- Subsection 1130.63 (c) (to the extent it provides that bereavement counseling is not reimbursable)
-
- Subsection 1130.63(e) (related to limitations on coverage)
- Subsection 1130.71(d) through (h) (as those provisions relates to MA payments process)
- Section 1130.72 (related to services performed by hospice physicians)
- Section 1130.73 (related to additional payment to nursing facility residents)

Chapter 1140. Healthy Beginnings Plus Program

- Subsections 1140.52(2), 1140.53 and 1140.54(1) (as those provisions related to billing, payment process and non-compensable services and items)

Chapter 1141. Physicians' Services

- Subsection 1141.53(a) through (c) (Relating to payment made in an approved SPU only if the service could not appropriately and safely be performed in the physician's office, clinic or ER of a hospital; prior authorization requirements for specialists' examinations and consultations; and services provided to recipients in skilled and intermediate care facilities by the physician administrator or medical director.)
- Subsection 1141.53(f) and (g) (Relating to all covered outpatient physicians' services billed to the Department shall be performed by such physician personally or by a registered nurse, physician's assistant, or a midwife under the physician's direct supervision; and payment by the Department of a \$10 per month fee to physicians who are approved by the Department to participate in the restricted recipient program.)
- Subsection 1141.54(a) (1) through (3) (Relating to when a physician is eligible to bill the Department for services provided to a hospitalized recipient.)
- Subsection 1141.54(f) (Relating to inpatient physicians' services billed to the Department shall be performed by the physician, an RN, PA or midwife under the physician's direct supervision.)
- Subsection 1141.55(b)(1) (only as it relates to the Department's forms)

- Subsections 1141.55(c), 1141.55(c)(2) and Subsection 1141.55(c)(3) and 1141.56(a)(3) (to the extent those provisions referenced the Provider Handbook)
- Subsection 1141.57(a)(2) (only to the extent that the incident must be reported within 72 hours)
- Subsection 1141.57(a)(1)(i) (to the extent of the invoice and report)
- Subsection 1141.57(a)(2)(i) (to the extent of the invoice and report)
- Subsections 1141.59(1) through (5), 1141.59(7) and (8), and 1141.59(10) and (11) and 1141.59 (14) through (16) (related to non-compensable services)
- Section 1141.60 (related to Payment for medications dispensed or ordered in the course of an office visit)

Chapter 1142. Midwives' Services

- Section 1142.51 (only as to MA payment fees)
- Subsection 1142.52(2) (only as to MA billing)
- Subsection 1142.55 (related to non-compensable services)

Chapter 1143. Podiatrists' Services

- Section 1143.2 (only as to the definition of Medically-Necessary)
- Section 1143.51 (only as to the MA fee schedule)
- Section 1143.53 (related to Payment conditions for outpatient services)
- Section 1143.54 (related to payment conditions for inpatient hospital services.)
- Subsection 1143.55 Payment relating to Payment Conditions for Diagnostic Services
- Section 1143.56 (related to payment conditions for orthopedic shoes, molded shoes and shoe inserts)
- Section 1143.57 (related to limitations on payment for podiatrist visits and x-rays)
- Subsection 1143.58(a)(1) through (12) (related to non-compensable services and items for podiatry services)
- Subsection 1143.58 (b) (Relating to non-compensable services and items)

Chapter 1144. Certified Registered Nurse Practitioner Services

- Subsection 1144.42(b) (only as to the reference to the Department)
- Subsection 1144.52 (Relating to payment conditions)
- Subsection 1144.53 (related to non-compensable services)

Chapter 1145. Chiropractor's Services

- Subsections 1145.11 through 1145.14 (related to services and payment limitations)
- Section 1145.51 (only as to the MA fee schedules and billing)
- Section 1145.54 (related to non-compensable services)

Chapter 1147. Optometrists' Services

- Section 1147.2 (only as to remove "untinted" from the definition "Eyeglasses")
- Section 1147.11 (only as to MA)
- Section 1147.12 (only as to MA fee schedules)
- Section 1147.13 (only as to MA fee Schedules)
- Subsection 1147.14(1) (related to orthoptic training)
- Section 1147.23 (to the extent of "only" and "They are not eligible for eyeglasses, low vision aids or eye prostheses. However, State Blind Pension recipients are eligible for eye prostheses if they are also categorically needy.")

- Section 1147.51 (relating to limitations on payment; and non-compensable services and items)” and “and the Medical Assistance Program fee schedule” and "Optometric services shall be billed in the name of the optometrist providing the service.")
- Section 1147.53 (related to limitations on payments for optometric services)
- Section 1147.54 (related to non-compensable optometric services and items)

Chapter 1149. Dentists’ Services

- Section 1149.1 (only as to MA fees)
- Subsection 1149.43(6) (related to radiographs are requested by the Department for prior authorization purposes)
- Subsection 1149.43(9) through (11) (related to pathology reports are required for surgical excision services; pre-operative X-rays are required for surgical services; and postoperative X-rays are required for endodontic procedures)
- Section 1149.51 (Relating to general payment policy)
- Section 1149.52 (related to payment conditions for various dental services)
- Section 1149.54 (Relating to Payment Policies for Orthodontic Services)
- Subsection 1149.55(1) and Subsections 1149.55(5) through (8) (related to payment policies for orthodontic services)
- Section 1149.56 (related to payment limitations for orthodontic services)
- Section 1149.57 (related to non-compensable dental services and items)

Chapter 1150. Medical Assistance Program Payment Policies

- Section 1150.2 (only as to definitions of PSR and Second Opinion program)
- Subsections 1150.51 (related to general Medical Assistance Program payment policies)
- Section 1150.52 (related to payment for Anesthesia services)
- Section 1150.54 (related to payment for surgical services)
- Section 1150.55 (related to payment for obstetrical services)
- Section 1150.56 (related to payment for medical services)
- Section 1150.56a (related to payment policy for consultations)
- Section 1150.57 (related to payment for diagnostic services and radiation therapy)
- Section 1150.58 (related to prior authorization)
- Section 1150.59 (related to the PSR Program)
- Section 1150.60 (related to the Second Opinion Program)
- Section 1150.61 (related to guidelines for fee schedule changes)
- Section 1150.62 (related to payment levels and notices of rate setting changes)
- Section 1150.63 (only as to references to the Department and CAO)

Chapter 1151. (relating to inpatient psychiatric services)

Chapter 1153. (relating to outpatient psychiatric services)

Chapter 1163. Inpatient Hospital Services, Subchapter A, Acute Care General Hospitals under the Prospective Payment System

- Section 1163.32 (related to hospital Units excluded from the DRG prospective payment system)
- Subsections 1163.51 relating to payment for hospital services)

- Sections 1163.52 through 1153.59 (related to prospective payment methodology, assignment of DRG, prospective capital reimbursement system, payments for direct medical education, outliers, payment policy for readmissions and transfers, and non-compensable services and items and outlier days)
- Subsection 1163.60(b)(1), Subsection 1163.60(c)(2), and Subsection 1163.60(c)(3) (only as to references to the Provider Handbook)
- Subsections 1163.62 (a) (2) through 1163.65 (related to payment conditions for abortions , billing, cost reports and payment for out of state services)
- Subsection 1163.66 (b) through (g) (relating to third-party liability)
- Section 1163.67 (related to disproportionate share payments)
- Sections 1163.70 (related to changes of ownership or control)
- Subsections 1163.72 (a), (c) through (g) (related to general utilization review, admissions, day and cost outliers)
- Sections 1163.73 (relating to hospital utilization review plan)
- Subsections 1163.75 (6) and (12) (related to , the department’s forms and manual)
- Sections 1163.76 through 1163.77 (only as to the written plan of care within 2 days of admission and Admission review requirements within 24 hours of admission)
- Section 1163.78a and 1163.78b (related to review requirements for day outliers and cost outliers)
- Subsections 1163.92 (a) through (f) (related to administrative sanctions)
- Subsection 1163.101 (a) (relating to right to appeal under Chapter 1101 (relating to general provisions)
- Section 1163.122 (related to determination of DRG relative values)
- Section 1163.126 (related to computation of hospital specific computation rates)

Chapter 1163. Inpatient Hospital Services, Subchapter B, Hospitals and Hospital Units Under Cost Reimbursement Principles

- Section 1163.402 (only as to definition of “certified day”)
- Subsections 1163.451 relating to general payment policies)
- Section 1163.452 (related to payment methods and rates)
- Subsections 1163.453 (a) and (c) (related to allowable and non-allowable costs, allowable costs for inpatient services, payment not higher than hospital’s customary charge)
- Subsections 1163.453 (d) (2) through (9) (related to costs not allowable under the Medical Assistance Program)
- Subsections 1163.453(e) and (f) (related to allowable costs)
- Section 1163.454 (related to limitations on payment)
- Subsection 1163.455 (a)(1) through (5) and (7) through (16) (related to non-compensable inpatient services)
- Subsection 1163.455 (b) and (c) (related to non-compensable inpatient services)
- Section 1163.457 (related to payment policies relating to out-of-state hospitals)
- Section 1163.458 (related to payment policies relating to same calendar day admissions and discharges)
- Section 1163.459 (related to disproportionate share payments)
- Section 1163.472 (relating to concurrent hospital review)
- Section 1163.476 and 1163.477 (only as to the written plan of care within 2 days of admission and Admission review requirements within 24 hours of admission)
- Subsection 1163.481(b) and (c) (related to utilization review sanctions)
- Section 1163.501 (relating to provider right to appeal)
- Section 1163.511 (related to change of ownership or control)

Chapter 1181. Nursing Facility Care

Chapter 1187. Private Nursing Facility Services

- Section 1187.2 (for definitions relating to payment calculation)
- Subsection 1187.21(4) ("Payment will be based on criteria found in § 1187.101(b) (relating to general payment policy)" does not apply)
- Subsection 1187.22(6) (Assure and verify that the information contained on the quarterly CMI report is accurate for the picture date)
- Subsection 1187.22(12) (File an acceptable cost report with the Department within the time limit specified in § 1187.73 or § 1187.75 (relating to annual reporting; and final reporting))
- Section 1187.23 (related to nursing facility incentives and adjustments)
- Subsection 1187.33(a)(5) (related to requirements relating to the correction, verification and submission of the CMI report to the Department)
- Subsections 1187.33(a)(6) (i)-(iii) (related to contents of CMI report)
- Subsections 1187.33(b)(1)-(3) (related to sanctions)
- Subchapter E (related to allowable program cost policies)
- Subchapter F, except for 1187.78 (relating to accountability requirements related resident personal fund management) and 1187.79 (relating to auditing requirements related to resident personal fund management)
- Subchapter G
- Subsection 1187.102(e) (only as to reporting allowable Medicare Part B-type costs)
- Section 1187.103 (relating to cost finding and allocation of costs)
- Section 1187.104 (only as to payment rates - hospital reserved days and therapeutic leave days are covered benefits. CHC MCOs must provide at least up to the FFS 15 consecutive day per hospitalization for hospital reserved days, and at least up to the FFS 30 calendar day for therapeutic leave days if included in Participant's care plan and ordered by a physician)
- Section 1187.105 (related to limitations on payment for prescription drugs)
- Section 1187.106 (related to Limitations on payment during strike or disaster situations requiring resident evacuation - MCO must make payment arrangements for alternative care in the event NF residents must be relocated due to strike or disaster situation)
- Sections 1187.107 through 1187.117, including statements of policy at 1187.113a and 1187.113b (related to payment provisions)
- Subchapter J (related to nursing facility right of appeal)
- Subchapter K (related to exceptional payments for nursing facility services)

Chapter 1189. County Nursing Facility Services

- Sections 1189.1 and 1189.2 (related to policy and definitions)
- Subchapter B (related to allowable program costs and policies)
- Subchapter C, except for 1189.73 (relating to accountability requirements related resident personal fund management) and 1189.74 (relating to auditing requirements related to resident personal fund management)
- Subchapter D (related to rate setting)
- Subsection 1189.102(e) (related to reporting allowable Medicare Part B-type costs)

- Section 1189.103 (only as to payment rates - hospital reserved days and therapeutic leave days are covered benefits. CHC MCOs must provide at least up to the FFS 15 consecutive day per hospitalization for hospital reserved days, and at least up to the FFS 30 calendar day for therapeutic leave days if included in Participant's care plan and ordered by a physician)
- Section 1189.104 (related to related to Limitations on payment during strike or disaster situations requiring resident evacuation - MCO must make payment arrangements for alternative care in the event NF residents must be relocated due to strike or disaster situation)
- Section 1189.105 (related to incentive payments)
- Section 1189.106 (relating to adjustments relating to sanctions and fines)
- Section 1189.107 (relating to adjustment relating to errors and corrections of nursing facility payments)
- Section 1189.108 (related to supplemental payments)
- Subchapter F (related to county facility right of appeal)

Chapter 1221. Clinic and Emergency Room Services

- Sections 1221.43 through 1221.44 (related to participation requirements for hospital clinics and emergency rooms for higher reimbursement rate, and additional participation requirements for independent clinics,)
- Sections 1221.51 and 1221.52 (related to general payment policy for clinic and emergency room services and payment conditions for various services)
- Subsections 1221.55(b)(1) (except that an informed consent form is required)
- Subsections 1221.57(a)(2) and 1221.57(c) (except that CHC-MCO must comply with Medical Assistance Bulletin 99-95-09)
- Sections 1221.58 and 1221.59 (related to limitations on payments and non-compensable services and items)
- MA Bulletin 11-95-04
- MA Bulletin 11-95-10
- MA Bulletin 11-95-12

Chapter 1223. Outpatient Drug and Alcohol Clinic Services

Chapter 1225. Family Planning Clinic Services

- Sections 1225.1 and 1225.51 (only as to MA fees)
- Subsection 1225.54(2) (related to non-compensable family planning services)

Chapter 1230. Portable X-Ray Services

- Sections 1230.1, 1230.51 and 1230.52(b) (only as to MA fees)
- Subsection 1230.53 (related to portable x-ray services, provider maximum payment, payment for transportation of portable x-ray equipment and electrocardiogram services)
- Subsection 1230.54 (related to non-compensable)

Chapter 1239. Medical Assistance Case Management Services for Recipients under the Age of 21

- MA Bulletin 99-94-08

Chapter 1241. Early and Periodic Screening, Diagnosis, and Treatment Program

Chapter 1243. Outpatient Laboratory Services

- Section 1243.1 and 1243.51 (only as to MA fees)

- Subsection 1243.52(b) (only as to billing)
- Subsection 1243.53(a) (related to limitations on payment)
- Subsection 1243.54(1)(2) (related to non-compensable services)

Chapter 1245. Ambulance Transportation

- Section 1245.1 (only as to MA fees)
- Subsection 1245.52(1) (related to payment conditions for ambulance services)
- Subsections 1245.52(3) through (5) (related to transportation to the nearest appropriate medical facility and medical services/supplies invoice)
- Section 1245.53 (related to limitations on payment for ambulance service when more than one patient is transported. Payment is made for transportation of the patient whose destination is the greatest distance. No additional payment is allowed for the additional person)
- Subsections 1245.54(1) through (7) (related to non-compensable services)

Chapter 1249. Home Health Agency Services

- Section 1249.1 and 1249.51 (only as to MA fees)
- Section 1249.52 (Payment conditions for various services.)
- Subsection 1249.55 (a) (only as to MA Fee Schedule) and (b) (
- Section 1249.57 (a) (related to payment conditions for maternal/child services) and 1249.57 (b).
- Section 1249.58 (related to payment conditions for travel costs)
- Section 1249.59 (related to limitations on payment)

EXHIBIT B

CHC-MCO Pay For Performance Program

The Department may implement a Pay for Performance Incentive to CHC-MCOs that help Participants successfully complete the financial eligibility redetermination process with their local CAOs. The Department may implement additional Pay for Performance incentives in later years.

EXHIBIT C

CHC-MCO Requirements For Provider Terminations

The CHC-MCO must comply with the requirements outlined in this Exhibit when they terminate a Provider from the Network. The requirements have been delineated to identify the requirements for terminations that are initiated by the CHC-MCO and terminations that are initiated by the Provider. Also provided in this Exhibit are the requirements for submission of work plans and supporting documentation that is to be submitted to the Department for hospital terminations, terminations of a specialty unit within a facility and terminations with large Provider groups, which would negatively impact the ability of Participants to access services.

1. Termination by the CHC-MCO

A. Notification to Department

The CHC-MCO must notify the Department in writing of its intent to terminate a Network Provider and services provided by a Network Provider (which includes but is not limited to a home care agency, nursing facility, hospital, specialty unit within a facility, and/or a large Provider group) ninety (90) days prior to the effective date of the termination.

The CHC-MCO must submit a Provider termination work plan and supporting documentation within ten (10) business days of the CHC-MCO notifying the Department of the termination and must provide weekly updates to this information. The requirements for the work plan and supporting documentation are found in this Exhibit, under 3. Work plans and Supporting Documentation.

B. Continuity of Care

The CHC-MCO must comply with both this section and the PA Department of Health (DOH) requirements found at 28 PA Code §9.684.

Unless the Provider is being terminated for cause as described in 40 P.S. § 991.2117(b), the CHC-MCO must allow a Participant to continue an ongoing course of treatment from the Provider for up to sixty (60) days from the date the Participant is notified by the CHC-MCO of the termination or pending termination of the Provider, or for up to sixty (60) days from the date of Provider termination, whichever is greater. A Participant is considered to be receiving an ongoing course of treatment from a Provider if during the previous twelve (12) months the Participant was treated by the Provider for a condition that requires follow-up care or additional treatment or the services have been Prior Authorized. Any adult Participant with a previously scheduled appointment shall be determined to be in receipt of an ongoing course of treatment from the Provider, unless the appointment is for a well adult check-up. Per Department of Health regulation Title 28, §9.684(d), the transitional period may be extended by the CHC-MCO if the

extension is determined to be clinically appropriate. The CHC-MCO shall consult with the Participant and the healthcare Provider in making the determination. The CHC-MCO must also allow a Participant who is pregnant to continue to receive care from the Provider that is being terminated through the completion of the Participant's postpartum care.

For a Participant who is receiving LTSS but whose LTSS Provider leaves the CHC-MCO Provider Network, the CHC-MCO must continue to allow the Participant to receive services for a 60 day period and must pay that Provider until such time as an alternative Network Provider can be identified and begins to deliver the same LTSS services as the former Provider.

The CHC-MCO must review each request to continue an ongoing course of treatment and notify the Participant of the decision as expeditiously as the Participant's health condition requires, but no later than 2 business days. If the CHC-MCO determines what the Participant is requesting is not an ongoing course of treatment, the CHC-MCO must issue the Participant a denial notice using the template notice titled C(4) Continuity of Care Denial Notice found on the intranet supporting CHC.

The CHC-MCO must also inform the Provider that to be eligible for payment for services provided to a Participant after the Provider is terminated from the Network, the Provider must agree to meet the same terms and conditions as Network Providers.

C. Notification to Participants

If the Provider that is being terminated from the Network is a PCP, the CHC-MCO, using the template notice titled C(1) Provider Termination Template For PCPs found on the intranet supporting CHC, must notify all Participants who receive primary care services from the Provider forty-five (45) days prior to the effective date of the Provider's termination. Participants who are receiving an ongoing course of treatment from the Provider may continue to receive this treatment for up to sixty (60) days from the date the Participant is notified of the termination or pending termination of the Provider, or for up to sixty (60) days from the date of Provider termination, whichever is greater.

If the Provider that is being terminated from the Network is not a PCP or a hospital, the CHC-MCO, using the template notice titled C(3) Provider Termination Template for Specialist and FQHC Providers Who Are Not PCPs, found on the intranet supporting CHC, must notify all Participants who have received services from the Provider during the previous twelve (12) months, as identified through referral and claims data; all Participants who are scheduled to receive services from the Provider; and all Participants who have a pending or approved Prior Authorization request for services from the Provider forty-five (45) days prior to the effective date of the Provider's termination. Participants who are receiving an ongoing course of treatment from the Provider may continue to receive this

treatment for up to sixty (60) days from the date the Participant is notified of the termination or pending termination of the Provider, or for up to sixty (60) days from the date of Provider termination, whichever is greater.

If the Provider that is being terminated from the Network is a hospital (including a specialty unit within a facility or hospital), the CHC-MCO, using the template notice titled C(2) Hospital/Specialty Unit Within a Facility or Hospital Termination found on the Intranet supporting CHC, must notify all Participants assigned to a PCP with admitting privileges at the hospital, all Participants assigned to a PCP that is owned by the hospital, and all Participants who have utilized the hospital's services within the past twelve (12) months forty-five (45) days prior to the effective date of the hospital's termination. The MCO must utilize claims data to identify these Participants.

If the CHC-MCO is terminating a specialty unit within a facility or hospital, the Department may require the CHC-MCO to provide forty-five (45) day advance written notice to a specific Participant population or to all of its Participants, based on the impact of the termination.

The Department, at its sole discretion, may allow exceptions to the forty-five (45) day advance written notice depending upon verified status of contract negotiations between the CHC-MCO and Provider.

The Department, in coordination with DOH, may require the CHC-MCO to include additional information in the notice of a termination to Participants.

The forty-five (45) day advance written notice requirement does not apply to terminations by the CHC-MCO for cause in accordance with 40 P.S. Section 991.2117(b). The CHC-MCO must notify Participants within five (5) business days using the template notice titled C(1) Provider Termination Template For PCPs, found on the intranet supporting CHC.

The CHC-MCO must update hard copy and web-based Provider directories to reflect changes in the Provider Network as required in Section V.O.17, Provider Directories, of this agreement.

2. Termination by the Provider

A. Notification to Department

If the CHC-MCO is informed by a Provider that the Provider intends to no longer participate in the CHC-MCO's Network, the CHC-MCO must notify the Department in writing ninety (90) days prior to the date the Provider will no longer participate in the CHC-MCO's Network. If the CHC-MCO receives less than ninety (90) days notice that a Provider will no longer participate in the CHC-MCO's Network, the CHC-MCO must notify the Department by the next Business Day after receiving notice from the Provider.

The CHC-MCO must submit a Provider termination work plan within ten (10) business days of the CHC-MCO notifying the Department of the termination and must provide weekly status updates to the work plan. The requirements for the work plan are found in this Exhibit, under 3. Work plans and Supporting Documentation.

The CHC-MCO must comply with both this section and the PA Department of Health (DOH) requirements found in 28 Pa. Code §9.684.

B. Notification to Participants

If the Provider that is terminating its participation in the Network is a PCP, the CHC-MCO, using the template notice titled C(1) Provider Termination Template For PCPs, found on the intranet supporting CHC, must notify all Participants who receive primary care services from the Provider.

If the Provider that is terminating its participation in the Network is not a PCP or a hospital, the CHC-MCO, using the template notice titled C(3) Provider Termination Template for Specialist and FQHC Providers Who Are Not PCPs, found on the intranet supporting CHC, must notify all Participants, who have received services from the Provider during the previous twelve (12) months, all Participants who were scheduled to receive services from the terminating Provider, and all Participants who have a pending or approved Prior Authorization request for services from the Provider forty-five (45) days prior to the effective date of the Provider's termination. The CHC-MCO must use referral and claims data to identify these Participants.

If the Provider that is terminating its participation in the Network is a hospital or specialty unit within a facility, the CHC-MCO, using the template notice titled C(2) Hospital/Specialty Unit Within a Facility or Hospital Termination, found on the intranet supporting CHC, must, forty-five (45) days prior to the effective date of the hospital's termination, notify all Participants assigned to a PCP with admitting privileges at the hospital, all Participants assigned to a PCP that is owned by the hospital, and all Participants who have utilized the terminating hospital's services within the past twelve (12) months. The MCO must use referral and claims data to identify these Participants.

If the Provider that is terminating its participation in the Network is a specialty unit within a facility or hospital, the Department may require the CHC-MCO to provide forty-five (45) days advance written notice to a specific Participant population or to all of its Participants, based on the impact of the termination.

The Department, in coordination with DOH, may require additional information be included in the notice of a termination to Participants.

The CHC-MCO must update hard copy and web-based Provider directories to reflect changes in the Provider Network as required in Section V.O.17, Provider Directories, of this agreement.

3. Work plans and Supporting Documentation

A. Workplan Submission

The CHC-MCO must submit a Provider termination work plan within ten (10) business days of the CHC-MCO notifying the Department of the termination and must provide weekly updates to the work plan. The work plan must provide detailed information on the tasks that will take place to ensure the termination is tracked from the time it is first identified until the termination effective date. The work plan should be organized by task, responsible person(s), target dates, completed dates, and status. The work plan should define the steps within each of the tasks. The tasks may include, but are not limited to:

- Commonwealth Notifications (DHS and DOH).
- Provider Impact and Analysis.
- Provider Notification of the Termination.
- Participant Impact and Analysis.
- Participant Notification of the Termination.
- Participant Transition.
- Participant Continuity of Care.
- Systems Changes.
- Provider Directory Updates for IEE (include date when all updates will appear on Provider files sent to enrollmentbroker).
- CHC-MCO Online Directory Updates.
- Participant Service and Provider Service Script Updates.
- Submission of Required Documents to the Department (Participant notices and scripts for prior approval).
- Submission of Final Participant Notices to the Department (also include date that DOH received the final notices).
- Communication with the Public Related to the Termination.
- Termination Retraction Plan, if necessary.

B. Supporting Documentation

The Department is also requesting that the CHC-MCO submit the following supporting documentation, in addition to the work plan, within ten (10) business days of the CHC-MCO notifying the Department of the termination and must provide weekly updates as appropriate. The Department is not prescribing the format for the supporting documentation, but electronic means is preferable.

- 1) Background Information
 - a) Submit a summary of issues/reasons for termination.
 - b) Submit information on negotiations or outreach that has occurred between the CHC-MCO and the Provider including dates, parties present, and outcomes.

2) Participant Access to Provider Services

- a) Submit information that identifies Providers remaining in the Network by Provider type and location that would be available within the appropriate travel times for those Participants once the termination is effective. Provide the travel times for the remaining Providers based upon the travel standards outlined in Exhibit BB of the contract. For PCPs also list current panel sizes and the number of additional Participants that are able to be assigned to those PCPs.
- b) Submit geographic access reports and maps documenting that all Participants currently accessing terminating Providers can access services being provided by the terminating Provider from remaining Network Providers who are accepting new Participants. This documentation must be broken out by Provider type.
- c) Submit a comprehensive list of all Providers, broken out by Provider type, who are affected by the termination and that also indicates the current number of Participants either assigned (for PCPs) or utilizing these Providers.
- d) Submit information that includes the admitting privileges at other hospitals or facilities for each affected Provider and whether each affected Provider can serve the CHC-MCO's Participants at another hospital or facility.
- e) Submit a copy of the final Provider notices to the Department.

3) Participant Identification and Notification Process

- a) Submit information that identifies the total number of Participants affected by the termination, i.e., assigned to an owned/affiliated PCP or utilizing the hospital or owned/affiliated Provider within the twelve (12) months preceding the termination date, broken down by Provider.
- b) Submit information on the number of Participants with prior authorizations in place that will extend beyond the Provider termination date.
- c) Submit draft and final Participant notices, utilizing the templates included as C(1) – C(4), Provider and Hospital Termination Templates and Continuity of Care Denial Notice, found on the intranet supporting CHC, as appropriate, for Department review and prior approval.

4) Participant Services

- a) Submit for Department prior approval, the call center script to be used to respond to inquiries regarding the termination.
- b) Identify a plan for handling increased call volume in the call center while maintaining call center standards.
- c) Submit to the Department a call center report for the reporting of summary call center statistics, if requested as part of the termination. This call center report should include, at a minimum, the following elements:
 - Total Number of Inbound Participant services calls (broken out by PCP, Specialist, and Hospital).

- Termination call reasons (broken out by Inquiries, PCP Change, Opt Out/Plan Change).

5) Affected Participants in Service Coordination

- Submit the total number of Participants in Service Coordination affected by the termination.
- Submit the criteria to the Department that the CHC-MCO will utilize for continuity of care for Participants affected by the termination.
- Submit an outreach plan and outreach script to the Department for prior approval if outbound calls are to be made to inform Participants in care management about the termination.

6) Participants Affected by Home Care Agency Termination:

- Submit the total number of Participants in the home care agency affected by the termination.
- Submit the criteria to the Department that the CHC-MCO will utilize for continuity of care for Participants affected by the termination.
- Submit an outreach plan and outreach script to the Department for prior approval if outbound calls are to be made to inform Participants about the termination.

7) Participants Affected by Nursing Facility Termination

- Submit the total number of Participants affected by the termination.
- Submit the criteria to the Department that the CHC-MCO will utilize for continuity of care for Participants affected by the termination.

Submit an outreach plan and outreach script to the Department for prior approval if outbound calls are to be made to inform Participants in care management about the termination.

8) Enrollment Services

- Submit final, approved Participant notices to the Department, the Participant notices should be on CHC-MCO letterhead.

9) News Releases

Any news releases related to the termination must be submitted to the Department for prior approval.

10) Website Update

Indicate when the CHC-MCO's web-based Provider directories will be updated, and what, if any, additional information will be posted to the CHC-MCO website.

EXHIBIT D STANDARD TERMS AND CONDITIONS

1. TERM

The term of the Agreement shall commence on the Effective Date and shall end on the Expiration Date identified in the Agreement, subject to the other provisions of the Agreement. The Agreement shall not be a legally binding Agreement until fully executed by the CHC-MCO and by the Commonwealth and all approvals required by Commonwealth and federal procurement procedures have been obtained. No agency employee has the authority to verbally direct the commencement of any work under this Agreement. The Commonwealth may, upon notice to the CHC MCO, extend the term of the Agreement for up to three (3) months upon the same terms and conditions, which will be utilized to prevent a lapse in Agreement coverage and only for the time necessary, up to three (3) months, to enter into a new Agreement.

2. Reserved.

3. Reserved.

4. ENVIRONMENTAL PROVISIONS

In the performance of the Agreement, the CHC-MCO shall minimize pollution and shall strictly comply with all applicable environmental laws and regulations.

5. Reserved.

6. COMPENSATION/EXPENSES

The CHC-MCO shall be required to perform the specified services at the prices provided for in the Agreement. All services shall be performed within the time periods specified in the Agreement. The CHC-MCO shall be compensated only for work performed to the satisfaction of the Commonwealth. The CHC MCO shall not be paid travel or per diem expenses.

7. Reserved.

8. PAYMENT

The CHC-MCO agrees that the Commonwealth may set off the amount of any state tax liability or other obligation of the CHC-MCO or its subsidiaries to the Commonwealth against any payments due the CHC-MCO under any Agreement with the Commonwealth.

9. TAXES

The Commonwealth is exempt from all excise taxes imposed by the Internal Revenue Service and has accordingly registered with the Internal Revenue Service to make tax free purchases under Registration No. 23740001-K. With the exception of purchases of the following items, no exemption certificates are required and none will be issued: undyed diesel fuel, tires, trucks, gas guzzler emergency vehicles, and sports fishing equipment. The Commonwealth is also exempt from Pennsylvania state sales tax, local sales tax, public transportation assistance taxes and fees and vehicle rental tax. The Department of Revenue regulations provide that exemption certificates are not required for sales made to governmental entities and none will be issued. Nothing in this paragraph is meant to exempt a construction Contractor 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 Contract.

10. WARRANTY

The CHC-MCO warrants that all services performed by the CHC MCO, its agents and subcontractor shall be performed in a professional and workmanlike manner and in accordance with prevailing professional and industry standards. Unless otherwise stated in the Agreement, all services are warranted for a period of one year following completion of performance by the CHC-MCO and acceptance by the Commonwealth. The CHC-MCO shall correct any problem with the service without any additional cost to the Commonwealth.

11. PATENT, COPYRIGHT, AND TRADEMARK INDEMNITY

The CHC-MCO 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 Agreement 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. The CHC-MCO 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 Agreement. 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 CHC-MCO's written request, it shall be at the CHC-MCO's expense, but the responsibility for such expense shall be only that within the CHC-MCO's written authorization. The CHC-MCO shall indemnify and hold the Commonwealth harmless from all damages, costs, and expenses, including attorney's fees that the CHC-MCO 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 Agreement. If any of the products provided by the CHC-MCO in such suit or proceeding are held to constitute infringement and the use is enjoined, the CHC-MCO 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 CHC-MCO is unable to do any of the preceding, it will 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 CHC-MCO under this paragraph continue without time limit. No costs or expenses shall be incurred for the account of the CHC-MCO without its written consent.

12. OWNERSHIP RIGHTS

The Commonwealth shall have unrestricted authority to reproduce, distribute, and use any submitted report, data, or material, and any software or modifications and any associated documentation that is designed or developed and delivered to the Commonwealth as part of the performance of the Agreement.

13. ASSIGNMENT OF ANTITRUST CLAIMS

The CHC-MCO and the Commonwealth recognize that in actual economic practice, overcharges by the CHC-MCO'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 Agreement, the CHC-MCO assigns to the Commonwealth all right, title and interest in and to any claims the CHC-MCO now has, or may acquire, under state or federal antitrust laws relating to the products and services which are the subject of this Agreement.

14. HOLD HARMLESS PROVISION

The CHC-MCO 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 CHC-MCO and its employees and agents under this Agreement 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

In addition to its other audit requirements, 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 CHC-MCO to the extent that the books, documents and records relate to costs or pricing data for the Agreement. The CHC-MCO will maintain records which will support the prices charged and costs incurred for the Agreement. The CHC-MCO shall preserve books, documents, and records that relate to costs or pricing data for the Agreement for a period of five (5) years from date of final payment. The CHC-MCO shall give full and free access to all records to the Commonwealth and its 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 Agreement, declare the CHC-MCO in default by written notice to the CHC-MCO, and terminate as provided in Paragraph 18, Termination Provisions, the whole or any part of this Agreement for any of the following reasons:
 - 1) Failure to begin services within the time specified in the Agreement or as otherwise specified;
 - 2) Failure to perform the services with sufficient labor, equipment, or material to insure the completion of the specified work in accordance with the Agreement terms;
 - 3) Unsatisfactory performance of services;
 - 4) Discontinuance of services without approval;
 - 5) Failure to resume services, which has been discontinued, within a reasonable time after notice to do so;
 - 6) Insolvency or bankruptcy;
 - 7) Assignment made for the benefit of creditors;
 - 8) Failure or refusal within 10 days after written notice, 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;
 - 9) Failure to protect, to repair, or to make good any damage or injury to property;
 - 10) Theft or fraud involving the Commonwealth or the federal government;

- 11) An adverse material change in circumstances as describe in Section IX of the Agreement;
 - 12) Notification by PID or DOH that the CHC-MCO's authority to operate has been suspended, limited or revoked or has expired and will not be renewed;
 - 13) Failure to obtain NCQA certification; or
 - 14) Breach of any provision of the Agreement.
- b. In the event that the Commonwealth terminates this Agreement in whole or in part, the Commonwealth may procure, upon such terms and in such manner as it determines, services similar or identical to those so terminated, and the CHC-MCO shall be liable to the Commonwealth for any reasonable excess costs for such similar or identical services included within the terminated part of the Agreement.
 - c. If the Agreement is terminated, the Commonwealth, in addition to any other rights provided in this paragraph, may require the CHC-MCO to transfer title and deliver immediately to the Commonwealth in the manner and to the extent directed by the Department, such partially completed work, including, where applicable, reports, working papers and other documentation, as the CHC-MCO has specifically produced or specifically acquired for the performance of such part of the Agreement as has been terminated. Except as provided below, payment for completed work accepted by the Commonwealth shall be at the Agreement 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 CHC-MCO and the Department. The Commonwealth may withhold from amounts otherwise due the CHC-MCO for such completed or partially completed works, such sum as the Department determines to be necessary to protect the Commonwealth against loss.
 - d. The rights and remedies of the Commonwealth provided in this paragraph are not exclusive and are in addition to any other rights and remedies provided by law or under the Agreement.

17. FORCE MAJEURE

Neither party will incur any liability to the other if its performance of any obligation under this Agreement is prevented or delayed by causes beyond its control and without the fault or negligence of either party. Causes beyond a party's control may include, but aren't limited to, acts of God or war, changes in controlling law, regulations, orders or the requirements of any governmental entity, severe weather conditions, civil disorders, natural disasters, fire, epidemics and quarantines, general strikes throughout the trade, and freight embargoes.

The CHC-MCO shall notify the Commonwealth orally within five (5) days and in writing within ten (10) days of the date on which the CHC-MCO 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 Agreement is prevented or delayed and (iii) if performance is delayed, state a reasonable estimate of the duration of the delay. The CHC-MCO 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 Agreement or to extend the time for performance as reasonably necessary to compensate for the

delay.

In the event of a declared emergency by competent governmental authorities, the Commonwealth by notice to the CHC-MCO, may suspend all or a portion of the Agreement.

18. TERMINATION PROVISIONS

a. The Commonwealth has the right to terminate the Agreement for any of the following reasons. Termination shall be effective upon written notice to the CHC-MCO and in accordance with the Agreement terms.

- 1) **TERMINATION FOR CONVENIENCE:** Upon 120 days written notice, the Commonwealth may terminate the Agreement for its convenience if the Commonwealth determines termination to be in its best interest. The effective date of the termination will be the last day of the month in which the 120th day fall. The CHC-MCO shall be paid for services satisfactorily completed prior to the effective date of the termination, but in no event shall the CHC-MCO be entitled to recover loss of profits.
- 2) **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 Agreement. The CHC MCO 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 Agreement. 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
- 3) **TERMINATION FOR CAUSE:** The Commonwealth may terminate the Agreement for default under Paragraph 16, Default or other cause as specified in the Agreement or by law, by providing written notice of default to the CHC-MCO. Except as provided in Section X.A.2 of the Agreement, the Commonwealth will provide forty-five (45) days written notice setting forth the grounds for termination and provide the CHC-MCO with forty five (45) or such longer time as approved by the Commonwealth in which to implement a corrective action plan and cure the deficiency. If corrective action is not implemented to the satisfaction of the Commonwealth within the approved cure period, the termination shall be effective at the expiration of the approved cure period. If it is later determined that the Commonwealth erred in terminating the Agreement for cause, then, at the Commonwealth's discretion, the Agreement shall be deemed to have been terminated for convenience under the Subparagraph 18.a.

b. TERMINATION BY THE CHC-MCO. The CHC-MCO may terminate this Agreement upon 120 days advance written notice to the Commonwealth. The effective date of the termination will be the last day of the month in which the 120th days falls.

19. Reserved.

20. ASSIGNABILITY AND SUBGRANTING

- a. Subject to the terms and conditions of this Paragraph 20, this Agreement shall be binding upon the parties and their respective successors and

- assigns.
- b. The CHC-MCO shall not subcontract with any person or entity to perform all or any part of the services to be performed without the prior written consent of the Department, which consent may be withheld at the sole and absolute discretion of the Department.
 - c. The CHC-MCO may not assign, in whole or in part, the Agreement or its rights, duties, obligations, or responsibilities hereunder without the prior written consent of the Department, which consent may be withheld at the sole and absolute discretion of the Department.
 - d. The CHC-MCO may, without the consent of the Department, assign its rights to payment to be received under the Agreement, provided that the CHC-MCO provides written notice of such assignment to the Department together with a written acknowledgement from the assignee that any such payments are subject to all of the terms and conditions of the Agreement.
 - e. For the purposes of this Agreement, 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 CHC-MCO 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 Department shall be evidenced by a written assignment agreement executed by the CHC-MCO and its assignee in which the assignee agrees to be legally bound by all of the terms and conditions of the Agreement and to assume the duties, obligations, and responsibilities being assigned.
 - g. A change of name, following which the CHC-MCO's federal identification number remains unchanged, shall not be considered to be an assignment. The CHC-MCO shall give the Department written notice of any such change of name.

21. NONDISCRIMINATION/SEXUAL HARASSMENT CLAUSE

During the term of the Agreement, the CHC-MCO 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 agreement or any subgrant, contract, or subcontract, the CHC-MCO, a subgrantee, a contractor, a subcontractor, or any person acting on behalf of the CHC-MCO shall not discriminate in violation of the Pennsylvania Human Relations Act (PHRA) and applicable federal laws against any citizen of this Commonwealth who is qualified and available to perform the work to which the employment relates.
- b. The CHC-MCO, any subgrantee, contractor or any subcontractor or any person on their behalf shall not in any manner discriminate in violation of the PHRA and applicable federal laws against or intimidate any of its employees.
- c. The CHC-MCO, any subgrantee, contractor or any subcontractor shall establish and maintain a written nondiscrimination and sexual harassment policy and shall inform their employees of the policy. The policy must contain a provision that sexual harassment will not be tolerated and employees who practice it will be disciplined. Posting this Nondiscrimination/Sexual Harassment Clause conspicuously in easily-accessible and well-lighted places customarily frequented by employees and at or near where the grant services are performed shall satisfy this requirement.
- d. The CHC-MCO, any subgrantee, contractor or any subcontractor shall not discriminate in violation of the PHRA and applicable federal laws against any subgrantee, contractor, subcontractor or supplier who is qualified to perform the work to which the Agreement relates.

- e. The CHC-MCO and each subgrantee, contractor and subcontractor represents that it is presently in compliance with and will maintain compliance with all applicable federal, state, and local laws and regulations relating to nondiscrimination and sexual harassment. The CHC-MCO and each subgrantee, contractor and subcontractor further represents that it has filed a Standard Form 100 Employer Information Report (“EEO-1”) with the U.S. Equal Employment Opportunity Commission (“EEOC”) and shall file an annual EEO-1 report with the EEOC as required for employers subject to Title VII of the Civil Rights Act of 1964, as amended, that have 100 or more employees and employers that have federal government contracts or first-tier subcontracts and have 50 or more employees. The CHC-MCO, any subgrantee, any contractor or any subcontractor shall, upon request and within the time periods requested by the Commonwealth, furnish all necessary employment documents and records, including EEO-1 reports, and permit access to their books, records, and accounts by the granting agency and the Bureau of Small Business Opportunities (BSBO), for the purpose of ascertaining compliance with the provisions of this Nondiscrimination/Sexual Harassment Clause.
- f. The CHC-MCO, any subgrantee, contractor or any subcontractor shall include the provisions of this Nondiscrimination/Sexual Harassment Clause in every agreement, contract or subcontract so that those provisions applicable to subgrantees, contractors or subcontractors will be binding upon each subgrantee, contractor or subcontractor.
- g. The CHC-MCO’s and each subgrantee’s, contractor’s and subcontractor’s obligations pursuant to these provisions are ongoing from and after the effective date of the agreement through the termination date thereof. Accordingly, the CHC-MCO and each subgrantee, contractor and subcontractor shall have an obligation to inform the Commonwealth if, at any time during the term of the agreement, it becomes aware of any actions or occurrences that would result in violation of these provisions.
- h. The Commonwealth may cancel or terminate the agreement and all money due or to become due under the agreement may be forfeited for a violation of the terms and conditions of this Nondiscrimination/Sexual Harassment Clause. In addition, the Department may proceed with debarment or suspension and may place the CHC-MCO, subgrantee, contractor, or subcontractor in the Contractor Responsibility File.

22. INTEGRITY PROVISIONS

It is essential that those who have agreements 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 contracting and procurement process.

1. **DEFINITIONS.** For purposes of these Integrity Provisions, the following terms shall have the meanings found in this Section:
 - a. **“Affiliate”** means two or more entities where (a) a parent entity owns more than fifty percent of the voting stock of each of the entities; or (b) a common shareholder or group of shareholders owns more than fifty percent of the voting stock of each of the entities; or c) the entities have a common proprietor or general partner.
 - b. **“Consent”** means written permission signed by a duly authorized officer or employee of the Commonwealth, provided that where the material facts have

been disclosed, in writing, by prequalification, bid, proposal, or contractual terms, the Commonwealth shall be deemed to have consented by virtue of the execution of this contract.

- c. **“Contractor”** means the individual or entity, that has entered into this Agreement with the Commonwealth.
 - d. **“Contractor Related Parties”** means any affiliates of the Contractor and the Contractor’s executive officers, Pennsylvania officers and directors, or owners of 5 percent or more interest in the Contractor.
 - e. **“Financial Interest”** means either:
 - (1) Ownership of more than a five percent interest in any business; or
 - (2) Holding a position as an officer, director, trustee, partner, employee, or holding any position of management.
 - f. **“Gratuity”** means tendering, giving, or providing anything of more than nominal monetary value including, but not limited to, cash, travel, entertainment, gifts, meals, lodging, loans, subscriptions, advances, deposits of money, services, employment, or contracts of any kind. The exceptions set forth in the Governor’s Code of Conduct, Executive Order 1980-18, the 4 Pa. Code §7.153(b), shall apply.
 - g. **“Non-bid Basis”** means an agreement awarded or executed by the Commonwealth with Contractor without seeking bids or proposals from any other potential bidder or offeror.
2. In furtherance of this policy, Contractor agrees to the following:
- a. Contractor shall maintain the highest standards of honesty and integrity during the performance of this Agreement and shall take no action in violation of state or federal laws or regulations or any other applicable laws or regulations, or other requirements applicable to Contractor or that govern procurement with the Commonwealth.
 - b. Contractor shall establish and implement a written business integrity policy, which includes, at a minimum, the requirements of these provisions as they relate to the Contractor activity with the Commonwealth and Commonwealth employees and which is made known to all Contractor employees. Posting these Integrity Provisions conspicuously in easily-accessible and well-lighted places customarily frequented by employees and at or near where the services are performed shall satisfy this requirement.
 - c. Contractor, its affiliates, agents, employees and anyone in privity with Contractor shall not accept, agree to give, offer, confer, or agree to confer or promise to confer, directly or indirectly, any gratuity or pecuniary benefit to any person, or to influence or attempt to influence any person in violation of any federal or state law, regulation, executive order of the Governor of Pennsylvania, statement of policy, management directive or any other published standard of the Commonwealth in connection with performance of work under this Agreement except as provided in this Agreement.

- d. Contractor shall not have a financial interest in any other contractor, subcontractor, or supplier providing services, labor, or material under this Agreement, unless the financial interest is disclosed to the Commonwealth in writing and the Commonwealth consents to Contractor's financial interest prior to Commonwealth execution of the Agreement. Contractor shall disclose the financial interest to the Commonwealth at the time of proposal submission, or if no bids or proposals are solicited, no later than Contractor's submission of the Agreement signed by Contractor.
- e. Contractor certifies to the best of its knowledge and belief that within the last five (5) years Contractor or Contractor Related Parties have not:
 - (1) been indicted or convicted of a crime involving moral turpitude or business honesty or integrity in any jurisdiction;
 - (2) been suspended, debarred or otherwise disqualified from entering into any contract with any governmental agency;
 - (3) had any business license or professional license suspended or revoked;
 - (4) had any sanction or finding of fact imposed as a result of a judicial or administrative proceeding related to fraud, extortion, bribery, bid rigging, embezzlement, misrepresentation or anti-trust; and
 - (5) been, and is not currently, the subject of a criminal investigation by any federal, state or local prosecuting or investigative agency and/or civil anti-trust investigation by any federal, state or local prosecuting or investigative agency.

If Contractor cannot so certify to the above, then it must submit along with its bid, proposal or agreement a written explanation of why such certification cannot be made and the Commonwealth will determine whether an Agreement may be entered into with the Contractor. The Contractor's obligation pursuant to this certification is ongoing from and after the effective date of the Agreement through the termination date thereof. Accordingly, the Contractor shall have an obligation to immediately notify the Commonwealth in writing if at any time during the term of the Agreement it becomes aware of any event which would cause the Contractor's certification or explanation to change. Contractor acknowledges that the Commonwealth may, in its sole discretion, terminate the Agreement for cause if it learns that any of the certifications made herein are currently false due to intervening factual circumstances or were false or should have been known to be false when entering into the Agreement.

Contractor shall comply with the requirements of the *Lobbying Disclosure Act (65 Pa.C.S. §13A01 et seq.)* regardless of the method of award. If this Agreement was awarded on a Non-bid Basis, Contractor must also comply with the requirements of the *Section 1641 of the Pennsylvania Election Code (25 P.S. §3260a)*.

- f. When Contractor has reason to believe that any breach of ethical standards as set forth in law, the Governor's Code of Conduct, or these Integrity Provisions has occurred or may occur, including but not limited to contact by a Commonwealth officer or employee which, if acted upon, would violate such ethical standards, Contractor shall immediately notify the project officer or the Office of the State

Inspector General in writing.

- g. Contractor, by submission of its proposal and/or execution of this Agreement and by the submission of any bills, invoices or requests for payment pursuant to the Agreement, certifies and represents that it has not violated any of these Integrity Provisions in connection with the submission of the proposal, during any negotiations or during the term of the Agreement, to include any extensions thereof. Contractor shall immediately notify the Commonwealth in writing of any actions for occurrences that would result in a violation of these Integrity Provisions. Contractor agrees to reimburse the Commonwealth for the reasonable costs of investigation incurred by the Office of the State Inspector General for investigations of the Contractor's compliance with the terms of this or any other agreement between the Contractor and the Commonwealth that results in the suspension or debarment of the Contractor. Contractor shall not be responsible for investigative costs for investigations that do not result in the Contractor's suspension or debarment.
- h. Contractor shall cooperate with the Office of the State Inspector General in its investigation of any alleged Commonwealth agency or employee breach of ethical standards and any alleged Contractor non-compliance with these Integrity Provisions. Contractor agrees to make identified Contractor employees available for interviews at reasonable times and places. Contractor, upon the inquiry or request of an Inspector General, shall provide, or if appropriate, make promptly available for inspection or copying, any information of any type or form deemed relevant by the Office of the State Inspector General to Contractor's integrity and compliance with these provisions. Such information may include, but shall not be limited to, Contractor's business or financial records, documents or files of any type or form that refer to or concern this contract. Contractor shall incorporate this paragraph in any agreement, contract or subcontract it enters into in the course of the performance of this agreement solely for the purpose of obtaining subcontractor compliance with this provision. The incorporation of this provision in a subcontract shall not create privity of contract between the Commonwealth and any such subcontractor, and no third party beneficiaries shall be created thereby.
- i. For violation of any of these Integrity Provisions, the Commonwealth may terminate this and any other Agreement with Contractor, claim liquidated damages in an amount equal to the value of anything received in breach of these Provisions, claim damages for all additional costs and expenses incurred in obtaining another contractor to complete performance under this Agreement, and debar and suspend Contractor from doing business with the Commonwealth. These rights and remedies are cumulative, and the use or non-use of any one shall not preclude the use of all or any other. These rights and remedies are in addition to those the Commonwealth may have under law, statute, regulation, or otherwise.

23. RESPONSIBILITY PROVISIONS

- a. The CHC-MCO certifies, for itself and all its subgrantees and subcontractors, that as of the date of its execution of this Agreement, that neither it, nor any subgrantees, subcontractors nor any suppliers are under suspension or debarment by the Commonwealth or any governmental entity, instrumentality, or authority and, if the CHC-MCO cannot so certify, then it agrees to submit, along with its Proposal, a written explanation of why such certification

cannot be made.

b. The CHC-MCO also certifies, that as of the date of its execution of the Agreement, it has no tax liabilities or other Commonwealth obligations.

c. The CHC-MCO's obligations pursuant to these provisions are ongoing from and after the effective date of the Agreement through the termination date thereof. Accordingly, the CHC-MCO shall have an obligation to inform the Commonwealth if, at any time during the term of the Agreement, it becomes delinquent in the payment of taxes, or other Commonwealth obligations, or if it or any of its subgrantees or subcontractors are suspended or debarred by the Commonwealth, the federal government, or any other state or governmental entity. Such notification shall be made within 15 days of the date of suspension or debarment.

d. The failure of the CHC-MCO 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.

e. The CHC-MCO agrees to reimburse the Commonwealth for the reasonable costs of investigation incurred by the Office of State Inspector General for Investigations of the its compliance with the terms of this or any other agreement between the CHC-MCO and the Commonwealth, which results in the suspension or debarment of the CHC-MCO. 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 CHC-MCO shall not be responsible for investigative costs for investigations that do not result in the CHC-MCO's suspension or debarment.

f. The CHC-MCO may obtain a current list of suspended and debarred Commonwealth entities by either searching the internet at <http://www.dgs.pa.gov> 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 CHC-MCO understands and agrees that it shall not cause any individual with a disability to be excluded from participation in this Agreement or from activities provided for under the Agreement on the basis of the disability. As a condition of accepting this Agreement, the CHC-MCO 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 Agreements with outside entities.

b. The CHC-MCO 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 CHC-MCO's failure to comply with the provisions of subparagraph (a) above.

25. Reserved.

26. COVENANT AGAINST CONTINGENT FEES

The CHC-MCO warrants that no person or selling agency has been employed or retained to solicit or secure the Agreement 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 CHC-MCO for the purpose of securing business. For breach or violation of this warranty, the Commonwealth may terminate the Agreement without liability or in its discretion to deduct from the Agreement price or consideration, or otherwise recover the full amount of such commission, percentage, brokerage, or contingent fee.

27. APPLICABLE LAW

This Agreement shall be governed by and interpreted and enforced in accordance with the laws of the Commonwealth of Pennsylvania (without regard to any conflict of law's provisions) and the decisions of the Pennsylvania courts. The CHC-MCO 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 CHC-MCO 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 Agreement, including all referenced documents, constitutes the entire agreement between the parties. No agent, representative, employee or officer of either the Commonwealth or the CHC-MCO has authority to make, or has made, any statement, agreement or representation, oral or written, in connection with the Agreement, 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 Agreement. No modifications, alterations, changes, or waiver to the Agreement or any of its terms shall be valid or binding unless accomplished by a written amendment signed by both parties.

29. CHANGE ORDERS

The Commonwealth may issue change orders at any time during the term of the Agreement or any renewals or extensions thereof: 1) to increase or decrease the quantities resulting from variations between any estimated quantities in the Agreement and actual quantities; 2) to make changes to the services within the scope of the Agreement; 3) to notify the CHC-MCO that the Commonwealth is exercising any renewal or extension option; or 4) to modify the time of performance that does not alter the scope of the Agreement to extend the completion date beyond the Expiration Date of the Agreement or any renewals or extensions thereof. Any such change order shall be in writing signed by the Project 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 Agreement, nor, if performance security is being furnished in conjunction with the Agreement release the security obligation. The CHC-MCO will provide the service in accordance with the

change order.

30. RIGHT TO KNOW LAW 8-K-1580

- a. The CHC-MCO and its subgrantees and subcontractors understands that this Agreement and records related to or arising out of the 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 Department.

- c. If the Commonwealth needs the CHC-MCO, subgrantee or subcontractor’s assistance in any matter arising out of the RTKL related to this Agreement, it shall notify the CHC-MCO, subgrantee, or subcontractor using the legal contact information provided in the Agreement. The CHC-MCO, subgrantee, or subcontractor at any time, may designate a different contact for such purpose upon reasonable prior written notice to the Commonwealth.

- d.
 - c. Upon written notification from the Commonwealth that it requires assistance in responding to a request under the RTKL for information related to this Agreement that may be in the CHC-MCO, a subgrantee or subcontractor’s possession, constituting, or alleged to constitute, a public record in accordance with the RTKL (“Requested Information”), CHC-MCO 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 the CHC-MCO, subgrantee or subcontractor’s possession arising out of this 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 Agreement.

 - d. If the CHC-MCO, subgrantee or subcontractor 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 the CHC-MCO, subgrantee or subcontractor considers exempt from production under the RTKL, the CHC-MCO, subgrantee or subcontractor must notify the Commonwealth and provide, within seven (7) calendar days of receiving the written notification, a written statement signed by a representative of the CHC-MCO, subgrantee or subcontractor explaining why the requested material is exempt from public disclosure under the RTKL.

 - e. The Commonwealth will rely upon the written statement 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, the CHC-MCO, subgrantee or subcontractor shall provide the Requested Information within five (5) business days of receipt of written notification of the Commonwealth’s determination.

 - f. If the CHC-MCO, subgrantee or subcontractor fails to provide the Requested Information within the time period required by these provisions, the CHC-MCO shall indemnify and hold the Commonwealth harmless for any damages, penalties, costs, detriment or harm that the Commonwealth may incur as a result of the failure, including any statutory damages assessed against the Commonwealth.

- g. The Commonwealth will reimburse the CHC-MCO, subgrantee or subcontractor 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. The CHC-MCO, subgrantee or subcontractor 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, the CHC-MCO, subgrantee or subcontractor 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 the CHC-MCO, subgrantee or subcontractor's failure, including any statutory damages assessed against the Commonwealth, regardless of the outcome of such legal challenge. As between the parties, the CHC-MCO, subgrantee and subcontractor 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 CHC-MCO, subgrantee and subcontractor's duties relating to the RTKL are continuing duties that survive the expiration of this Agreement and shall continue as long as the Requested Information in its possession.

Exhibit E

Specific Federal Regulatory Cites for Managed Care Agreements

Citation	Requirement
1903(m)(4)(B)	The CHC-MCO will make reports of any transactions between the CHC-MCO and parties in interest that are provided to the State or other agencies pursuant to Section 1903(m)(4)(A) of the Act available to CHC-MCO Participants upon reasonable request.
Citation	Requirement
42 CFR 438.6(f)(2)(ii)	The CHC-MCO will report all identified provider-preventable conditions in a form or frequency, which may be specified by the State.
ARRA 5006(a) State Medicaid Director Letter SMD #10-001 01/22/2010	The CHC-MCO is prohibited from imposing enrollment fees, premiums, or similar charges on Indians served by an Indian health care provider; Indian Health Service (IHS); an Indian Tribe, Tribal Organization, or Urban Indian Organization (I/T/U) or through referral under contract health services (CHS).
ARRA 5006(d) SMD 10-001	The CHC-MCO must permit any Indian who is enrolled in a non-Indian MCO and eligible to receive services from a participating I/T/U provider to choose to receive Covered Services from that I/T/U provider and if that I/T/U provider participates in the network as a primary care provider, to choose that I/T/U as his or her primary care provider, as long as that provider has capacity to provide the services.
ARRA 5006(d) SMD 10-001	The CHC-MCO must demonstrate that there are sufficient I/T/U providers in the network to ensure timely access to services available under the Agreement for Indian Participants who are eligible to receive services from such providers.

<p>ARRA 5006(d) SMD 10-001</p>	<p>The CHC-MCO must pay I/T/U providers, whether participating in the network or not, for covered Medicaid or CHIP managed care services provided to Indian Participants who are eligible to receive services from such providers either at a rate negotiated between the CHC-MCO and the I/T/U provider, or if there is no negotiated rate, at a rate no less than the level and amount of payment that would be made if the provider were not an I/T/U</p>
<p style="text-align: center;">Citation</p>	<p style="text-align: center;">Requirement</p>
<p>42 CFR 438.6(f)(2)(i) 42 CFR 434.6(a)(12)(i) 42 CFR 447.26(b)</p>	<p>The CHC-MCO is prohibited from making payment to a Provider for provider- preventable conditions that meet the following criteria:</p> <ul style="list-style-type: none"> (i) Is identified in the State Plan (ii) Has been found by the State, based upon a review of medical literature by qualified professionals, to be reasonably preventable through the application of procedures supported by the evidence-based guidelines (iii) Has a negative consequence for the beneficiary (iv) Is auditable (v) Includes, at a minimum, wrong surgical or other invasive procedure performed on a patient; surgical or other invasive procedure performed on the wrong body part; surgical or other invasive procedure performed on the wrong patient.
<p>42 CFR 438.6(f)(2)(ii) 42 CFR 434.6(a)(12)(ii)</p>	<p>The CHC-MCO must require all Providers to report provider-preventable conditions associated with claims for payments or Participant treatments for which payment would otherwise be made.</p>
<p>1916(a)(2)(D) 1916(b)(2)(D) 42 CFR 438.108 42 CFR 447.50-57 State Medicaid Director Letter SMDL #06-015 6/16/2006</p>	<p>Any cost sharing imposed by the CHC-MCO on Participants is in accordance with Medicaid fee for service requirements at 42 CFR 447.50 through 42 CFR 447.57</p>

<p>1903(i) final sentence 1903(i)(2)(A)</p>	<p>The CHC-MCO is prohibited from paying for an item or service (other than an emergency item or service, not including items or services furnished in an emergency room of a hospital) furnished under the plan by any individual or entity during any period when the individual or entity is excluded from participation under title V, XVIII, or XX or under this title pursuant to section 1128, 1128A, 1156, or 1842(j)(2).</p>
Citation	Requirement
<p>1903(i) final sentence 1903(i)(2)(B)</p>	<p>The CHC-MCO is prohibited from paying for an item or service (other than an emergency item or service, not including items or services furnished in an emergency room of a hospital) furnished at the medical direction or on the prescription of a physician, during the period when such physician is excluded from participation under title V, XVIII, or XX or under this title pursuant to section 1128, 1128A, 1156, or 1842(j)(2) and when the person furnishing such item or service knew, or had reason to know, of the exclusion (after a reasonable time period after reasonable notice has been furnished to the person).</p>
<p>1903(i) final sentence 1903(i)(2)(C)</p>	<p>The CHC-MCO is prohibited from paying for an item or service (other than an emergency item or service, not including items or services furnished in an emergency room of a hospital) furnished by an individual or entity to whom the State has failed to suspend payments under the plan during any period when there is a pending investigation of a credible allegation of fraud against the individual or entity, as determined by the State in accordance with regulations promulgated by the Secretary for purposes of Section 1862(o) of the Act and this subparagraph unless the State determines in accordance with such regulations that there is good cause not to suspend payments.</p>
<p>1903(i) final sentence 1903(i)(16)</p>	<p>The CHC-MCO shall not make payment with respect to any amount expended for which funds may not be used under the Assisted Suicide Funding Restriction Act</p>

<u>1903(i) final sentence</u> <u>1903(i)(17)</u>	The CHC-MCO shall not make payment with respect to any amount expended for roads, bridges, stadiums, or any other item or service not covered under the Medicaid State Plan.
Citation	Requirement
<u>1903(i) final sentence</u> <u>1903(i)(18)</u>	The CHC-MCO shall not make payment with respect to any amount expended for home health care services provided by any agency or organization, unless the agency or organization provides the State with a surety bond as specified in Section 1861(o)(7) of the Act.
<u>1903(t)</u> <u>42 CFR 495.332 (d)(2)</u> <u>42 CFR 438.6(c)(5)(iii)</u> <u>42 CFR 495.332 (d)(2)</u> <u>42 CFR 438.6(c)(5)(iii)</u> <u>42 CFR 495.304</u> <u>42 CFR 495.310(c)</u> <u>42 CFR 447.253(e)</u> <u>42 CFR 495.370(a)</u> <u>SMD# 09-006, Attachment A</u> <u>1903(t)(6)(A)(ii)</u>	If the CHC-MCO is required by the State to disburse electronic health records (EHR) incentive payments to eligible professionals, the agreement establishes a methodology for verifying that this process does not result in payments that exceed 105 percent of the capitation payment, in accordance with 42 CFR 438.6(c)(5)(iii).
<u>1903(t)(6)(A)(ii)</u> <u>495.310(k)</u> <u>495.332(c)(9)</u>	If the CHC-MCO is required by the State to disburse EHR incentive payments to eligible professionals, the agreement between the CHC-MCO and the State includes a description of the process and methodology for ensuring and verifying that incentive payments are paid directly to the eligible professional (or to an employer or facility to which such Provider has assigned payments) without any deduction or rebate.
Citation	Requirement

1124(a)(2)(A)
1903(m)(2)(A)(viii)
1903(t)(6)(A)(ii)
42 CFR 455.100-103
42 CFR 455.104(b)

In accordance with Section 1903(t)(6)(A)(ii) of the Act and the regulations implementing such section, the CHC-MCO must disclose the following information to the state for any person or corporation with ownership or control interest in the CHC-MCO:

- Name and address (the address for corporate entities must include as applicable primary business address, every business location, and P.O. Box address.)
- Date of birth and Social Security Number (in the case of an individual)
- Other tax identification number (in the case of a corporation)
- Whether the person (individual or corporation) with an ownership or control interest in the CHC-MCO or a CHC-MCO subcontractor is related to another person with ownership or control interest in the CHC-MCO as a spouse, parent, child, or sibling.
- The name of any other Medicaid Provider or fiscal agent in which the person or corporation has an ownership or control interest.
- The name, address, date of birth and Social Security Number of any managing employee of the CHC-

Exhibit E(1)

DEPARTMENT OF HUMAN SERVICES **ADDENDUM TO STANDARD CONTRACT TERMS AND CONDITIONS**

A. APPLICABILITY

This Addendum is intended to supplement the Standard Terms and Conditions. To the extent any of the terms contained herein conflict with terms contained in the Standard Contract Terms and Conditions, the terms in the Standard Contract Terms and Conditions shall take precedence. Further, it is recognized that certain terms contained herein may not be applicable to all the services which may be provided through Department contracts.

B. CONFIDENTIALITY

The parties shall not use or disclose any information about a Participant of the services to be provided under this Agreement for any purpose not connected with the parties' Agreement responsibilities except with written consent of such Participant, Participant's attorney, or Participant's parent or legal guardian.

C. INFORMATION

During the period of this Agreement, all information obtained by the CHC-MCO through work on the project will be made available to the Department immediately upon demand. If requested, the CHC-MCO shall deliver to the Department background material prepared or obtained by the CHC-MCO incident to the performance of this agreement. Background material is defined as original work, papers, notes and drafts prepared by the CHC-MCO 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

CHC-MCO agrees to obtain all licenses, certifications and permits from Federal, State and Local authorities permitting it to carry on its activities under this Agreement.

E. PROGRAM SERVICES

Definitions of service, eligibility of recipients of service and other limitations in this Agreement are subject to modification by amendments to Federal, State and Local laws, regulations and program requirements without further notice to the CHC-MCO hereunder.

F. CHILD PROTECTIVE SERVICE LAWS

In the event that the Agreement calls for services to minors, the CHC-MCO 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 CHC-MCO agrees to comply with the requirements of the Pro-Children Act of 1994; Public Law 103- 277, Part C-Environment Tobacco Smoke (also known as the Pro-Children Act of 1994) requires that smoking not be permitted in any portion of any indoor facility owned or leased or contracted by an entity and used routinely or regularly for the provision of health care services, day care and education to children under the age of 18, if the services are funded by Federal programs whether directly or through State and Local governments. Federal programs include grants, cooperative agreements, loans or loan guarantees and contracts. The law does not

apply to children's services provided in private residences, facilities funded solely by Medicare or Medicaid funds, and portions of facilities used for inpatient drug and alcohol treatment.

H. MEDICARE/MEDICAID REIMBURSEMENT

1. To the extent that services are furnished by contractors, subcontractors, or organizations related to the CHC-MCO and such services may in whole or in part be claimed by the Commonwealth for Medicare/Medicaid reimbursements, CHC-MCO 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 Agreement.
 - b. Full and free access to (i) the Commonwealth, (ii) the U.S. Comptroller General, (iii) the U.S. Department of Health and Human Services, and their authorized representatives.
2. Your signature on the proposal certifies under penalty of law that you have not been suspended/terminated from the Medicare/Medicaid Program and will notify the contracting DHS Facility or DHS Program Office immediately should a suspension/termination occur during the Agreement period.

I. TRAVEL AND PER DIEM EXPENSES

The CHC-MCO shall not be allowed or paid travel or per diem expenses except as provided for in CHC-MCO's Budget and included in the Agreement amount. Any reimbursement to the CHC-MCO for travel, lodging or meals under this Agreement shall be at or below state rates as provided in Management Directive 230.10, Commonwealth Travel Policy, as may be amended, unless the CHC-MCO has higher rates which have been established by its offices/officials, and published prior to entering into this Agreement. 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 CHC-MCO 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 Agreement. As required by law, an independent contractor is responsible for Malpractice Insurance for health care personnel. CHC-MCO shall provide insurance Policy Number and Provider" Name, or a copy of the policy with all renewals for the entire Agreement period.
2. The CHC-MCO shall, at its expense, procure and maintain during the term of the Agreement, 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 CHC-MCO'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 CHC-MCO, 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 Agreement or the failure to perform under this Agreement whether such performance or nonperformance be by the CHC-MCO, 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 Agreement and during the term of the Agreement, the CHC-MCO 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. The CHC-MCO agrees to obtain all supplies and equipment for use in the performance of this Agreement 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. The CHC-MCO has title to all personal property acquired by the CHC-MCO, including purchase by lease/purchase agreement, for which the CHC-MCO is to be reimbursed under this Agreement. Upon cancellation or termination of this Agreement, disposition of such purchased personal property which has a remaining useful life shall be made in accordance with the following provisions.
 - a. The CHC-MCO 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 CHC-MCO receiving the property and will be reimbursed by the Department. Title to all transferred property shall vest in the designated CHC-MCO. The Department will reimburse the CHC-MCO 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 CHC-MCO 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 CHC-MCO shall reimburse the Department in the amount determined from the tables.
 - c. When authorized by the Department in writing, the CHC-MCO 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 CHC-MCO, including purchase by lease-purchase contract, for which the CHC-MCO is to be reimbursed under this Agreement shall be deemed "Department Property" for the purposes of subsection 5, 6 and 7 of this section.
5. The CHC-MCO 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 Agreement.
7. In the event that the CHC-MCO 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 Agreement, or shall reimburse the Department, at the Department's direction.

L. DISASTERS

If, during the terms of this Agreement, 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 CHC-MCO hereunder during the period of time there is no need for the services provided by the CHC-MCO except to render compensation which the CHC-MCO was entitled to under this agreement prior to such damage.

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 CHC-MCO warrants that no person or selling agency has been employed or retained to solicit or secure this Agreement 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 CHC-MCO for the purpose of securing business). For breach or violation of this warranty, the Department shall have the right to annul this Agreement without liability or, in its discretion, to deduct from the consideration otherwise due under the Agreement, or otherwise recover, the full amount of such commission, percentage, and brokerage or contingent fee.

O. CHC-MCO'S CONFLICT OF INTEREST

The CHC-MCO hereby assures that it presently has no interest and will not acquire any interest, direct or indirect, which would conflict in any manner or degree with the performance of its services hereunder. The CHC-MCO further assures that in the performance of this Agreement, it will not knowingly employ any person having such interest. CHC-MCO hereby certifies that no member of the Board of the CHC-MCO 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 Agreement, shall participate in any decision relating to this Agreement 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 Agreement or the proceeds thereof.

**Q. CONTRACTOR RESPONSIBILITY TO EMPLOY WELFARE CLIENTS
(Applicable to contracts \$25,000 or more)**

1. The CHC-MCO, within 10 days of receiving the notice to proceed, must contact the Department of Human Services's Contractor Partnership Program (CPP) to present, for review and approval, the CHC-MCO'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 Agreement. If no employment opportunities arise as a result of this Agreement, the CHC-MCO must identify other employment opportunities available within the organization that are not a result of this Agreement. 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 Agreement.
2. The CHC-MCO's CPP approved recruiting and hiring plan shall be maintained throughout the term of the Agreement and through any renewal or extension of the Agreement. Any proposed change must be submitted to the CPP Division which will make a recommendation to the Contracting Officer regarding course of action. If an Agreement is assigned to another CHC-MCO, the new CHC-MCO must maintain the CPP recruiting and hiring plan of the

original Agreement.

3. The CHC-MCO, within 10 days of receiving the notice to proceed, must register in the Commonwealth Workforce Development System (CWDS). In order to register the selected CHC-MCO 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 CHC-MCO will receive written notice (via the pink CHC-MCO'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 CHC-MCO to the Central Office of Employment and Training – CPP Division. A copy of the submitted Form PA-1540 must also be submitted (by the CHC-MCO) to the DHS Contract Monitor (i.e. Contract Officer). The reports must be submitted on the DHS Form PA- 1540. The form may not be revised, altered, or re-created.
5. If the CHC-MCO is non-compliant, CPP Division will contact the Contract Monitor to request corrective action. The Department may cancel this Agreement upon thirty (30) days written notice in the event of the CHC-MCO'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 CHC-MCO 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 CHC-MCO 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 CHC-MCO

CHC-MCO 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 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 confidentiality 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 CHC-MCO shall apply for clearance using the State Police Background Check (SP4164) at its 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 Agreement.

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 CHC-MCO will be required to complete and return a "Lobbying Certification Form" and a "Disclosure of Lobbying Activities form" with their signed Agreement, which forms will be made attachments to the Agreement.

U. AUDIT CLAUSE

(applicable to Agreements \$100,000 or more)

This Agreement is subject to audit in accordance with the Audit Clause attached hereto and incorporated herein.

EXHIBIT F

FAMILY PLANNING SERVICES PROCEDURES

In addition to family planning services in the Agreement, the CHC-MCO must provide the following procedures:

- Insertion, implantable contraceptive capsules.
- Implantation of contraceptives, including device (e.g., Norplant) (once every five years) (females only).
- Removal, implantable contraceptive capsules.
- Removal with reinsertion, implantable contraceptive capsules (e.g., Norplant) (once per five years) (females only).
- Destruction of vaginal lesion(s); simple, any method (females only).
- Biopsy of vaginal mucosa; simple (separate procedure) (females only).
- Biopsy of vaginal mucosa; extensive, requiring suture (including cysts) (females only).
- Colposcopy (vaginocopy); separate procedure (females only).^A
- Colposcopy (vaginocopy); with biopsy(s) of the cervix and/or endocervical curettage.^A
- Colposcopy (vaginocopy); with loop electrosurgical excision(s) of the cervix (LEEP) (females only).^B
- Intensive colposcopic examination with biopsy and or excision of lesion(s) (females only).^B
- Biopsy, single or multiple or local excision of lesion(s), with or without fulguration (separate procedure) (females only).
- Cauterization of cervix; electro or thermal (females only).
- Cauterization of cervix; cryocautery, initial or repeat (females only).
- Cauterization of cervix; laser ablation (females only).

- Endometrial and/or endocervical sampling (biopsy), without cervical dilation, any method (separate procedure) (females only).
- Alpha-fetoprotein; serum (females only).
- Nuclear molecular diagnostics; nucleic acid probe, each.
- Nuclear molecular diagnosis; nucleic acid probe, each.
- Nuclear molecular diagnostics; nucleic acid probe, with amplification; e.g., polymerase chain reaction (PCR), each.
- Fluorescent antibody; screen, each antibody.
- Immunoassay for infectious agent antibody; quantitative, not elsewhere specified.
- Antibody; HIV-1.
- Antibody; HIV-2.
- Treponema Pallidum, confirmatory test (e.g., FTA-abs).
- Culture, chlamydia.
- Cytopathology, any other source; preparation, screening and interpretation.
- Progestasert I.U.D. (females only).
- Depo-Provera injection (once per 60 days) (females only).
- ParaGuard I.U.D. (females only).
- Hemoglobin electrophoresis (e.g., A2, S, C).
- Microbial Identification, Nucleic Acid Probes, each probe used.
- Microbial Identification, Nucleic Acid Probes, each probe used; with amplification (PCR).

^A Medical record must show a Class II or higher pathology.

^B Medical record must show a documentation of a history of previous uterine cancer surgery or in-utero DES (diethylstilbestrol) exposure.

PROCEDURES WHICH MAY BE INCLUDED WITH A
FAMILY PLANNING CLINIC PROBLEM VISIT

- Gonadotropin, chorionic, (hCG); quantitative.
- Gonadotropin, chorionic, (hCG); qualitative.
- Syphilis test; qualitative (e.g., VDRL, RPR, ART).
- Culture, bacterial, definitive; any other source.
- Culture, bacterial, any source; anaerobic(isolation).
- Culture, bacterial, any source; definitive identification, each anaerobic organism, including gas chromatography.
- Culture, bacterial, urine; quantitative, colony county.
- Dark field examination, any source (e.g., penile, vaginal, oral, skin); without collection.
- Smear, primary source, with interpretation; routine stain for bacteria, fungi, or cell types.
- Smear, primary source, with interpretation; special stain for inclusion bodies or intracellular parasites (e.g., malaria, kala azar, herpes).
- Smear, primary source, with interpretation; wet mount with simple stain for bacteria, fungi, ova, and/or parasites.
- Smear, primary source, with interpretation; wet and dry mount, for ova and parasites.
- Cytopathology, smears, cervical or vaginal, the Bethesda System (TBS), up to three smears; screening by technician under physician supervision.
- Level IV - Surgical pathology, gross and microscopic examination.
- Antibiotics for Sexually Transmitted Diseases (course of treatment for 10 days) (two units may be dispensed per visit).
- Medication for Vaginal Infection (course of treatment for 10 days) (two units may be dispensed per visit).
- Breast cancer screen (females only).
- Mammography, bilateral (females only).
- Genetic Risk Assessment.

EXHIBIT G

PRIOR AUTHORIZATION GUIDELINES FOR PARTICIPATING MANAGED CARE ORGANIZATIONS IN THE CHC PROGRAM

A. GENERAL REQUIREMENT

The CHC-MCOs must submit to the Department all written policies and procedures for the Prior Authorization of services. These requirements do not apply to LTSS and cannot be made to apply to services for which Medicare is the primary payor except where a 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 Community HealthChoices RFP, Community HealthChoices Agreement, the CHC 1915(c) Waiver, the federal regulations, and applicable policy in Medical Assistance General Regulations, Title 55, PA. Code Chapter 1101 and DHS regulations;
- 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 (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.
- Specify that Person-Centered Service Plans serve as prior authorization for the services outlined therein.

Future changes in state and federal law, state and federal regulations, and court cases may require re-evaluation of any previously approved Prior Authorization proposal. Any deviation from the policies and procedures approved by the Department, including time frames for decisions, is considered to be a change and requires a new request for

approval. Failure of the 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 DHS Prior Authorization Review Panel 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 URCAP prior to implementation.
- 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 health care 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 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 health care 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 will outline what 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.
 - 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 following required maximum time frames:
 - Immediate: Inpatient Place of Service Review for emergency and urgent admissions.

- 24 hours: All drugs; and items or services which must be provided on an urgent basis.
 - 48 hours: (following receipt of required documentation): Home Health Services.
 - 21 days: All other services.
- b. The 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.

EXHIBIT J
MEDICAL ASSISTANCE TRANSPORTATION PROGRAM

The Medical Assistance Transportation Program (MATP) is responsible for the following:

- Non-emergency transportation to a medical service that is covered by the Medicare or the Medical Assistance Program. This includes transportation for urgent care appointments. Medical Assistance eligible recipients whose medical service is paid by Medicare can receive MATP service as long as the medical service is performed by a Medicaid service provider and all other eligibility requirements are met.
- Transportation to another county, as Medically Necessary, to get medical care as well as advice on locating a train, bus, and route information.
- Reimbursement for mileage, parking, and tolls with valid receipts, if the consumer used their own car or someone else's to get to the medical care Provider.

When requested, the CHC-MCO must arrange non-emergency medical transportation for urgent appointments for their Participants through the MATP. Some Participants may qualify for non-emergency medical transportation through programs such as Shared Ride. Because MATP is the payer of last resort, for Participants who require CHC-MCO assistance in coordinating non-emergency medical transportation the CHC-MCO must coordinate access to transportation through all available programs and not just the MATP program.

MATP agencies have been instructed to contact the CHC-MCO for verification that a Medical Assistance Participant's services request is for transportation to a Medical Assistance compensable service. The Department strongly encourages the CHC-MCO to jointly undertake activities with MATP agencies such as sharing Provider Network information, developing informational brochures, and establishing procedures which enhance transportation services for Participants.

EXHIBIT K(1)

QUALITY MANAGEMENT AND UTILIZATION MANAGEMENT PROGRAM REQUIREMENTS

The Department will monitor the Quality Management (QM) and Utilization Management (UM) programs of all CHC-MCOs and retains the right of advance written approval of all QM and UM activities. The CHC-MCO's QM and UM programs must incorporate all the requirements outlined in this Agreement and must be designed to assure and improve the accessibility, availability, and quality of care and services being provided to its Participants. The CHC-MCO's QM and UM programs must, at a minimum:

- A. Contain a written program description, work plan, evaluation and policies/procedures that meet requirements outlined in the agreement;
- B. Allow for the development and implementation of an annual work plan of activities that focuses on areas of importance as identified by the CHC-MCO in collaboration with the Department;
- C. Be based on statistically valid clinical and financial analysis of Encounter Data, Participant demographic information, HEDIS, CAHPS, Pennsylvania Performance Measures and other data that allows for the identification of prevalent medical conditions, barriers to care and services and racial/ethnic disparities to be targeted for quality improvement, case and disease management initiatives;
- D. Allow for the continuous evaluation of its activities and adjustments to the program based on these evaluations;
- E. Submit all reports on data elements and quality measures as required and in the manner to be required by the Department.
- F. Demonstrate sustained improvement for clinical performance over time; and
- G. Allow for the timely, complete, and accurate reporting of Encounter Data and other data required to demonstrate clinical and service performance, including HEDIS and CAHPS as outlined in Exhibit K(4), Healthcare Effectiveness Data and Information Set (HEDIS).
- H. Include processes for the investigation and resolution of individual performance or quality of care issues whether identified by the CHC-MCO or the Department that:
 - 1) Allow for the tracking and trending of issues on an aggregate basis pertaining to patterns of care and services;
 - 2) Allow for submission of improvement plans, as determined by and within time

frames established by the Department. Failure by the CHC-MCO to comply with the requirements and improvement actions requested by the Department may result in the application of penalties and/or sanctions as outlined in Section VIII.H, Sanctions, of the Agreement.

- I. Obtain accreditation by a nationally recognized organization, such as National Committee of Quality Assurance (NCQA) ; and
- J. Comply with National Quality Forum or other LTSS quality requirements as designated by the Department.

Standard I: The scope of the QM and UM programs must be comprehensive in nature; allow for improvement and be consistent with the Department's goals related to access, availability, and quality of care and services. At a minimum, the CHC-MCO's QM and UM programs, must:

- A. Adhere to current Medicaid CMS guidelines.
- B. Be developed and implemented by professionals with adequate and appropriate experience in QM/UM and techniques of peer review.
- C. Ensure that that all QM and UM activities and initiatives undertaken by the CHC-MCO are based upon clinical and financial analysis of Encounter Data, Participant demographic information, HEDIS, CAHPS, Pennsylvania Performance Measures and/or other identified areas.
- D. Contain policies and procedures which provide for the ongoing review of the entire scope of care and services provided by the CHC-MCO assuring that all demographic groups, races, ethnicities, disabilities, care and service settings and types and models of services are addressed.
- E. Contain a written program description that addresses all standards, requirements and objectives established by the Department and that describes the goals, objectives, and structure of the CHC-MCO's QM and UM programs. The written program description must, at a minimum:
 - 1) Include standards and mechanisms for ensuring the accessibility of primary care services, specialty care services, urgent care services, and Participant services in accordance with timeframes outlined in Exhibit BB, Provider Network Composition/Service Access of the Agreement.
 - 2) Distinct policies and procedures regarding how Service Coordinators will authorize LTSS and communicate those authorizations to providers.
 - 3) Include mechanisms for planned assessment and analysis of the quality of care and services provided and the utilization of services against formalized standards, including but not limited to:

- a) Primary, secondary, and tertiary care;
 - b) Preventive care and wellness programs;
 - c) Acute and/or chronic conditions;
 - d) Emergency Department utilization and ED diversion efforts;
 - e) Dental care;
 - f) LTSS;
 - g) Service Coordination; and
 - h) Continuity of care.
- 4) Allow for the timely, accurate, complete collection and clinical and financial analysis of Encounter Data and other data including, but not limited to, HEDIS, CAHPS, and Pennsylvania Performance Measures.
 - 5) Allow for systematic analysis and re-measurement of barriers to care and services, the quality of care and services provided to Participants, and utilization of services over time.
- F. Provide a comprehensive written evaluation, completed on at least an annual basis, that details all QM and UM program activities including, but not limited to:
- a) Studies and activities undertaken; including the rationale, methodology and results
 - b) Subsequent improvement actions; and
 - c) Aggregate clinical and financial analysis of Encounter, HEDIS, CAHPS, Pennsylvania Performance Measures, and other data on the quality of care rendered to Participants and utilization of services.
- G. Include a work plan and timetable for the coming year which clearly identifies target dates for implementation and completion of all phases of all QM activities, including, but not limited to:
- 1) Data collection and analysis;
 - 2) Evaluation and reporting of findings;
 - 3) Implementation of improvement actions where applicable; and
 - 4) Individual accountability for each activity.
- H. Provide for aggregate and individual analysis and feedback of Provider performance and CHC-MCO performance in improving access to Covered Services, the quality of care and services provided to Participants and utilization of Covered Services.
- I. Include mechanisms and processes which ensure related and relevant operational components, activities, and initiatives from the QM and UM programs are integrated into activities and initiatives undertaken by other departments within the CHC-MCO including, but not limited to, the following:

- 1) Provider Relations;
 - 2) Participant Services; and
 - 3) Management Information Systems
- J. Include procedures for informing both physician and non-physician Providers about the written QM and UM programs, and for securing cooperation with the QM and UM programs in all physician and non-physician Provider agreements.
- K. Include procedures for feedback and interpretation of findings from analysis of quality and utilization data to Providers, health professionals, CHC-MCO staff, and Medical Assistance Consumers/family members.
- L. Include mechanisms and processes which allow for the development and implementation of CHC-MCO wide and Provider specific improvement actions in response to identified barriers to care and services, quality of care and services concerns, and over- utilization, under-utilization and/or mis-utilization of services.
- M. The CHC-MCO shall provide for methods of assuring the appropriateness of inpatient care. Such methodologies shall be based on individualized determinations of medical necessity in accordance with UM policies and procedures.
- Pre-admission certification process for non-emergency admissions;
 - A concurrent review program to monitor and review continued inpatient hospitalization, length of stay, or diagnostic ancillary services regarding their appropriateness and medical necessity. In addition, the CHC-MCO shall have a process in place to determine for emergency admissions, based upon medical criteria, if and when a Participant can be transferred to a contract facility in the network, if presently in a non-contract facility;
 - Admission review for urgent and/or emergency admissions, on a retroactive basis when necessary, in order to determine if the admission is medically necessary and if the requested length of stay for the admission is reasonable based upon an individualized determination of medical necessity. Such reviews shall not result in delays in the provision of medically necessary urgent or emergency care;
 - Restrictions against requiring pre-admission certification for admissions for the normal delivery of children; and
 - Prospective review of same day surgery procedures.
- N. The CHC-MCO shall ensure that reimbursement of nursing facility care is provided for Participants who have been determined to be eligible for reimbursement of nursing facility care for the period specified. The CHC-MCO shall monitor the Participant's condition for ongoing care and potential discharge back to community living.

- O. The CHC-MCO shall utilize the following guidelines in identifying and managing care for Participants who are determined to have excessive and/or inappropriate ED utilization:
- Review ED utilization data, at a minimum, every six (6) months to identify Participants with utilization exceeding the threshold defined as six (6) or more visits in the defined six (6) month period (January through June and July through December);
 - For Participants whose utilization exceeds the threshold of ED visits defined above in the previous six (6) month period, the CHC-MCO shall conduct appropriate follow-up to identify the issues causing frequent ED utilization and determine appropriate next steps.
 - As appropriate, make contact with Participants whose utilization exceeded the threshold of ED visits in the previous six (6) month period and their primary care providers for the purpose of providing education on appropriate ED utilization.
 - Assess the most likely cause of high utilization and develop a PCSP based on results of the assessment for each Participant.
- P. The CHC-MCO shall comply with any applicable federal and state laws or rules related to length of hospital stay.
- Q. In addition to meeting the reporting requirement for oversight and monitoring of the program, the CHC-MCO must report all information required for early implementation evaluation, as outlined by the Department. The CHC-MCO must also comply with all implementation monitoring and oversight requirements. The CHC-MCO must comply with any program policy changes resulting from the Department's rapid cycle, implementation monitoring, or other evaluation of the CHC Program.

Standard II: The organizational structures of the CHC-MCO must ensure that:

- A. The Governing Body:
- 1) Has formally designated an accountable entity or entities, within the CHC-MCO to provide oversight of QM and UM program activities or has formally decided to provide such oversight as a committee, e.g. Quality Management Committee.
 - 2) Regularly receives written reports on the QM and UM program activities that describe actions taken, progress in meeting objectives and improvements made. The governing body formally reviews, on at least an annual basis, a written evaluation of the QM and UM program activities that includes studies undertaken, results of studies, and subsequent improvement actions taken. The written evaluation must include aggregate clinical and financial analysis of quality and utilization data, including HEDIS, CAHPS, and Pennsylvania Performance Measures.

- 3) Documents actions taken by the governing body in response to findings from QM and UM program activities.
- B. The Quality Management Committee (QMC):
- 1) Must contain policies and procedures which describe the role, structure and function of the QMC that:
 - a) Demonstrate that the QMC has oversight responsibility and input, including review and approval, on all QM and UM program activities;
 - b) Ensure membership on the QMC and active participation by individuals representative of the composition of the CHC-MCO's Providers; and
 - c) Provide for documentation of the QMC's activities, findings, recommendations, and actions.
 - 2) Meets at least monthly, and otherwise as needed.
- C. The Director of LTSS ensures the provision of LTSS in home and community-based settings is provided in accordance with the requirements outlined in this Agreement and the CHC 1915(c) Waiver.
- D. The Director of Quality Management serves as liaison and is accountable to the governing body and Quality Management Committee for all QM and UM activities and initiatives.
- E. The Senior Medical Director must be directly accountable to and act as liaison to the Chief Medical Officer for DHS.
- F. The Medical Director:
- 1) Is available to the CHC-MCO's medical staff for consultation on referrals, denials, Complaints and problems;
 - 2) Is directly involved in the CHC-MCO's recruiting and credentialing activities;
 - 3) Is familiar with local standards of medical practice and nationally accepted standards of practice, including those for LTSS and with "most integrated setting" requirements under the ADA;
 - 4) Has knowledge of due process procedures for resolving issues between Network Providers and the CHC-MCO administration, and between participants and the CHC-MCO, including those related to medical decision making and utilization review;

- 5) Is available to review, advise and take action on questionable hospital admissions, Medically Necessary days and all other medical care and medical cost issues;
- 6) Is directly involved in the CHC-MCO's process for prior authorizing or denying services and is available to interact with Providers on denied authorizations;
- 7) Has knowledge of current peer review standards and techniques;
- 8) Has knowledge of risk management standards;
- 9) Is directly accountable for all Quality Management and Utilization Management activities and
- 10) Oversees and is accountable for:
 - a) Referrals to the Department and appropriate agencies for cases involving quality of care and services that have adverse effects or outcomes; and
 - b) The processes for potential Fraud and Abuse investigation, review, sanctioning and referral to the appropriate oversight agencies.

G. The CHC-MCO must have sufficient material resources, and staff with the appropriate education, experience and training, to effectively implement the written QM and UM programs and related activities.

Standard III: The QM and UM programs must include methodologies that allow for the objective and systematic monitoring, measurement, and evaluation of the quality and appropriateness of care and services provided to Participants through quality of care studies and related activities with a focus on identifying and pursuing opportunities for continuous and sustained improvement.

A. The QM and UM programs must include professionally developed practice guidelines/standards of care and services that are:

- 1) Written in measurable and accepted professional formats,
- 2) Based on scientific evidence; and
- 3) Applicable to Providers for the delivery of certain types or aspects of health care or LTSS.

B. The QM and UM programs must include clinical/quality Indicators in the form of written, professionally developed, objective and measurable variables of a specified clinical or health services delivery area, which are reviewed over a period of time to screen delivered health care and/or monitor the process or outcome of care delivered in that clinical area.

- C. Practice guidelines and clinical indicators must address the full range of health care and LTSS needs of the populations served by the CHC-MCO. The areas addressed must include, but are not limited to:
- 1) Adult preventive care;
 - 2) LTSS;
 - 3) Service Coordination provision;
 - 4) Obstetrical care including a requirement that Participants be referred to obstetricians or certified nurse midwives at the first visit during which pregnancy is determined;
 - 5) Selected diagnoses and procedures relevant to the enrolled population;
 - 6) Selected diagnoses and procedures relevant to racial and ethnic subpopulations within the CHC-MCO's Participant; and Preventive dental care.
- D. The QM and UM programs must provide practice guidelines, clinical indicators and medical record keeping standards to all Providers and appropriate subcontractors. This information must also be provided to Participants upon request.
- E. The CHC-MCO must develop methodologies for assessing performance of PCPs/PCP sites, high risk/high volume specialists, dental Providers, LTSS Providers, and Providers of ancillary services not less than every two years (i.e. medical record audits). These methodologies must, at a minimum:
- 1) Demonstrate the degree to which PCPs, specialists, and dental Providers are complying with clinical and preventive care guidelines adopted by the CHC-MCO;
 - 2) Demonstrate the degree to which LTSS Providers are complying with requirements of the Department and the CHC-MCO;
 - 3) Allow for the tracking and trending of individual and CHC-MCO wide Provider performance over time;
 - 4) Include active mechanisms and processes that allow for the identification, investigation and resolution of quality of care and services concerns, including events such as Health Care-Associated Infections, medical errors, and adverse patient outcomes; and
 - 5) Include mechanisms for detecting instances of over-utilization, under-utilization, and mis-utilization;
- F. The QM and UM program must have policies and procedures for implementing and monitoring improvement plans. These policies and procedures must include the following:
- 1) Processes that allow for the identification, investigation and resolution of quality of care and services concerns including Health Care-Associated

- Infections, medical errors, and adverse patient outcomes;
- 2) Processes for tracking and trending patterns of care and services;
 - 3) Use of progressive sanctions as indicated;
 - 4) Person(s) or body responsible for making the final determinations regarding quality problems; and
 - 5) Types of actions to be taken, such as:
 - a) Education;
 - b) Follow-up monitoring and re-evaluation;
 - c) Changes in processes, structures, forms;
 - d) Informal counseling;
 - e) Procedures for terminating the affiliation with the physician or other health professional or Provider;
 - f) Assessment of the effectiveness of the actions taken; and
 - g) Recovery of inappropriate expenditures (e.g., related to Health Care-Associated Infections, medical errors, and other inappropriate expenditures).
- G. The QM and UM programs must include methodologies that allow for the identification, verification, and timely resolution of inpatient and outpatient quality of care and services concerns, Participant quality of care and services complaints, over-utilization, under- utilization, and/or mis-utilization, access/availability issues, and quality of care and services referrals from other sources;
- H. The QM and UM programs must contain procedures for Participant satisfaction surveys that are conducted on at least an annual basis including the collection of annual Participant satisfaction data through application of the CAHPS instrument as outlined in Exhibit K(4), Healthcare Effectiveness Data and Information Set (HEDIS). The Department will continue to monitor the development of evidence-based LTSS satisfaction surveys and reserves the right to implement a CAHPS, CAHPS-like, or other survey at a later date.
- I. The QM and UM programs must contain procedures for Provider satisfaction surveys to be conducted on at least an annual basis. Surveys are to include PCPs, specialists, LTSS Providers, Nursing Facilities, dental Providers, hospitals, and Providers of ancillary services.
- J. Each CHC-MCO will be required to comply with requirements for Performance Improvement Projects (PIPs) as outlined in Exhibit K(2) External Quality Review.
- K. The QM and UM programs must contain procedures for measuring Participant and Provider satisfaction with LTSS Service delivery.

Standard IV: The QM and UM programs must objectively and systematically monitor and evaluate the appropriateness and cost effectiveness of care and services provided to Participants through utilization review activities with a focus on identifying and correcting instances and patterns of over-utilization, under-utilization and mis-utilization.

- A. Semi-annually, or more frequently as appropriate, the QM and UM programs must provide for production and distribution to Providers, (in either hard copy or web-based electronic formats) profiles comparing the average medical care utilization rates of the Participants of each PCP to the average utilization rates of all CHC-MCO Participants. The CHC-MCO must develop statistically valid methodologies for data collection regarding Provider profiling. Profiles shall include, but not be limited to:
 - 1) Utilization information on Participant Encounters with PCPs;
 - 2) Specialty Claims;
 - 3) Prescriptions;
 - 4) Inpatient stays;
 - 5) Nursing Facility use;
 - 6) Community-based LTSS use;
 - 7) Emergency room use; and
 - 8) Clinical indicators for preventive care services (i.e., mammograms, immunizations, pap smear, etc.).
- B. The CHC-MCO must have mechanisms and processes for profiling all Providers using risk adjusted diagnostic data for profiles.
- C. The CHC-MCO must have mechanisms and processes for aggregate trending of changes to services, and reporting aggregate data to the Department
- D. The QM and UM programs must implement statistically valid methodologies for analysis and follow-up of semi-annual practitioner utilization profiles for patterns and instances of over-utilization, under-utilization, and mis-utilization across the continuum of care and services, as well as, trending of Provider utilization patterns over time. Follow up includes but is not limited to Provider education, Provider improvement plans, and Provider sanctions as necessary.
- E. The QM and UM programs must at least annually, provide for verification of Encounter reporting rates and accuracy and completeness of Encounter information submitted by PCPs.

Standard V: The CHC-MCO must develop mechanisms for integration of case/disease and health management programs that rely on wellness promotion, prevention of complications and treatment of chronic conditions for Participants identified. The CHC-MCO must have a Complex Case Management Program and a Disease Management Program that must:

- A. Include mechanisms and processes that ensure the active collaboration and coordination of care and services for identified Participants.
- B. Include mechanisms and processes that allow for the identification of conditions to be targeted for case/disease and health management programs and that allow for the assessment and evaluation of the effectiveness of these programs in improving outcomes for and meeting the needs of individuals with targeted conditions.
- C. Include care guidelines and/or protocols for appropriate and effective management of individuals with specified conditions. These guidelines must be written in measurable and accepted professional formats and be based on scientific evidence.
- D. Include performance indicators that allow for the objective measurement and analysis of individual and CHC-MCO wide performance in order to demonstrate progress made in improving access and quality of care and services.
- E. Include mechanisms and processes that lead to healthy lifestyles such as weight loss program memberships, gym memberships and asthma camps.

Standard VI: The QM and UM programs must have mechanisms to ensure that Participants receive seamless, continuous, and appropriate care and services throughout the continuum of care and services including transitions between care setting and coverage, by means of coordination of care and services, benefits, and quality improvement activities between:

- A. PCPs and specialty care practitioners and other Providers;
- B. Other CHC-MCOs;
- C. The CHC-MCO and Medicare D-SNPs whether aligned or not aligned;
- D. The CHC-MCO and Medicare FFS or Medicare Advantage;
- E. The CHC-MCO and HealthChoices BH-MCOs;
- F. The CHC-MCOs and Physical Health HealthChoices MCOs;
- G. The CHC-MCO and the Department's Fee For Service Program;
- H. The CHC-MCO and other third party insurers;
- I. The CHC-MCOs and LIFE providers;
- J. The CHC-MCOs and Lottery funded services;

- K. The CHC-MCOs and Hospitals or Nursing Facilities; and
- L. The CHC-MCO and any other agency providing services to the Participant.

Standard VII: The CHC-MCO must demonstrate that it retains accountability for all QM and UM program functions, including those that are delegated to other entities. The CHC-MCO must:

- A. Have a written description of the delegated activities, the delegate's accountability for these activities, and the frequency of reporting to the CHC-MCO.
- B. Have written procedures for monitoring and evaluating the implementation of the delegated functions and for verifying the actual quality of care and services being provided.
- C. Document evidence of continuous and ongoing evaluation of delegated activities, including approval of quality improvement plans and regular specified reports.
- D. Make available to the Department, and its authorized representatives, any and all records, documents, and data detailing its oversight of delegated QM and UM program functions.
- E. Must ensure that delegated entities make available to the Department, and its authorized representatives, any and all records, documents and data detailing the delegated QM and UM program functions undertaken by the entity of behalf of the CHC-MCO.
- F. Compensation and payments to individuals or entities that conduct Utilization Management activities may not be structured so as to provide incentives for the individual or entity to deny, limit, or discontinue Medically Necessary services to any Participant.

Standard VIII: The QM/UM program must have standards for credentialing/ recredentialing Providers to determine whether all Providers, who provide health services or LTSS in the Commonwealth and are under contract to the CHC-MCO, are qualified to perform their services.

- A. The CHC-MCO must establish and maintain minimum credentialing and recredentialing criteria for all Provider types that satisfies the Department's requirements outlined in this Agreement and through the credentialing framework to be provided to plans. Recredentialing activities must be conducted by the CHC-MCO at least every five (5) years. Criteria must include, but not be limited to, the following as applicable to the Provider type:

- 1) Appropriate license or certification as required by Pennsylvania state law;

- 2) Verification that Providers have not been suspended, terminated or entered into a settlement for voluntary withdrawal from the Medicaid or Medicare Programs;
 - 3) Verification that Providers and/or subcontractors have a current Provider Agreement and an active PROMISe™ Provider ID issued by the Department;
 - 4) Evidence of malpractice/liability insurance;
 - 5) A valid Drug Enforcement Agency (DEA) certification;
 - 6) Adherence to the Principles of Ethics of the American Medical Association, the American Osteopathic Association or any appropriate professional organization involved in a multidisciplinary approach;
 - 7) Consideration of quality issues such as Participant Complaint and/or Participant satisfaction information, sentinel events and quality of care concerns.
- B. For purposes of credentialing and recredentialing, the CHC-MCO must perform a check on all PCPs and other physicians by contacting the National Practitioner Data Bank (NPDB). If the CHC-MCO does not meet the statutory requirements for accessing the NPDB, then the CHC-MCO must obtain information from the Federation of State Medical Boards
- C. Appropriate PCP qualifications:
- 1) Seventy-five to 100% of the Network consists of PCPs who have completed an approved primary care residency in family medicine, osteopathic general medicine, internal medicine or geriatrics;
 - 2) No more than 25% of the Network consists of PCPs without appropriate residencies but who have, within the past seven years, five years of post-training clinical practice experience in family medicine, osteopathic general medicine, internal medicine or geriatrics. Post-training experience is defined as having practiced at least as a 0.5 full-time equivalent in the practice areas described; and
 - 3) No more than 10% of the Network consists of PCPs who were previously trained as specialist physicians and changed their areas of practice to primary care, and who have completed Department-approved primary care retraining programs.
 - 4) A PCP must have the ability to perform or directly supervise the ambulatory primary care services of Participants;
 - 5) Membership of the medical staff with admitting privileges of at least one

general hospital or an acceptable arrangement with a PCP with admitting privileges;

- 6) Demonstrate evidence of continuing professional medical education;
 - 7) Attend at least one CHC-MCO sponsored Provider education training session as outlined in Section V.BB.2, Provider Education, of the Agreement.
- D. Assurance that any CRNP, Certified Registered Midwife or physician's assistant, functioning as part of a PCP team, is performing under the scope of their respective licensure; and
 - E. As part of the Provider release form, the potential Provider must agree to release all Medical Assistance records pertaining to sanctions and/or settlement to the CHC-MCO and the Department.
 - F. The Department will recoup from the CHC-MCO any and all payments made to a Provider who does not meet the enrollment and credentialing criteria for participation or is used by the CHC-MCO in a manner that is not consistent with the Provider's licensure. In addition, the CHC-MCO must notify its PCPs and all subcontractors of the prohibitions and sanctions for the submission of false Claims and statements.
 - G. The CHC-MCO shall evaluate a Provider's professional qualifications through objective measures of competence and quality. Providers should be given the opportunity to have input on the CHC-MCO's credentialing practices.
 - H. Any economic profiles used by the CHC-MCOs to credential Providers should be adjusted to adequately account for factors that influence utilization independent of the Provider's clinical management, including Participant age, Participant sex, Provider case-mix and Participant severity. The CHC-MCO must report any utilization profile that it utilizes in its credentialing process and the methodology that it uses to adjust the profile to account for non-clinical management factors at the time and in the manner requested by the Department.
 - I. In the event that a CHC-MCO renders an adverse credentialing decision, the CHC-MCO must provide the affected Provider with a written notice of the decision. The notice should include a clear and complete explanation of the rationale and factual basis for the determination. The notice shall include any utilization profiles used as a basis for the decision and explain the methodology for adjusting profiles for non-clinical management factors. All credentialing decisions made by the CHC-MCO are final and may not be appealed to the Department.
 - J. The CHC-MCO must meet the following standards related to timeliness of processing new Provider applications for credentialing.

- 1) The CHC-MCO must begin its credentialing process upon receipt of a Provider's credentialing application if the application contains all required information.
- 2) The CHC-MCO may not delay processing the application if the Provider does not have an MAID number that is issued by the DHS. However, the CHC-MCO cannot complete its process until the Provider has received its MAID number from DHS.
- 3) Provider applications submitted to the CHC-MCO for credentialing must be completed within sixty (60) days of receipt of the application packet if the information is complete.

Standard IX: The CHC-MCO's written UM program must contain policies and procedures that describe the scope of the program, mechanisms, information sources used to make decisions on Covered Services and in conjunction with the requirements in Exhibit G Prior Authorization Guidelines for Participating Managed Care Organizations in the CHC Program.

- A. The UM program must contain policies and procedures for Prospective, Concurrent, and Retrospective review and coverage decisions on Covered Services.
- B. A Person Centered Service Plan shall be developed and implemented for all NFCE Participants and others who request or require Service Coordination. The CHC-MCO shall audit a Department-approved sample size sample of the PCSPs to demonstrate compliance with the requirements of the QM/UM program. The CHC-MCO must use a protocol to select the PCSPs that has been submitted to and reviewed by the Department. Audit results must be submitted to the Department as part of the Annual QAPI Program Evaluation.
- C. The UM program must allow for coverage decisions about Covered Services that are consistent with the CHC Program definition of Medically Necessary found in Section II, Definitions and the requirements of the CHC 1915(c) Waiver.

Coverage decisions for Covered Services whether made on a Prior Authorization, Concurrent Review or Retrospective Review basis, shall be documented in writing. The CHC-MCO shall base its determination on information provided by the Participant the Participant's family/care taker and the PCP, as well as any other Providers, programs and agencies that have evaluated the Participant. Medical necessity determinations must be made by qualified and trained Health Care Providers. A Health Care Provider who makes such determinations of Medical Necessity is not considered to be providing a health care service under this Agreement.

- D. If the CHC-MCO wishes to require Prior Authorization of any services, they must establish and maintain written policies and procedures for the Prior

Authorization review process as required under Section V.B., Prior Authorization of Services and Exhibit G of this Agreement.

- E. The CHC-MCO must provide all Licensed Proprietary Products that they will use in evaluating medical necessity for medical services. Licensed Proprietary Products may include, but are not limited to: Interqual and Milliman. All Utilization Review Criteria and/or policies and procedures that contain Utilization Review Criteria used to determine medical necessity must:
- 1) Require definitions of medical necessity that are consistent with the CHC definition of Medically Necessary;
 - 2) Make determinations of medical necessity that are consistent with the CHC Program definition of Medically Necessary;
 - 3) Assess the individual's current condition and response to treatment and/or co-morbidities, psychosocial, environmental and/or other needs that influences care and services;
 - 4) Provide direction to clinical reviewers on how to use clinical information gathered in making a determination to approve, deny, continue, reduce or terminate a service;
 - 5) Be developed using a scientific based process;
 - 6) Be reviewed at least annually and updated as necessary; and
 - 7) Provide for evaluation of the consistency with which reviewers implement the criteria on at least an annual basis.
- F. The CHC-MCO must ensure that Prior Authorization and Concurrent review decisions:
- 1) Are supervised by a physician or Health Care practitioner with appropriate clinical expertise in treating the Participant's condition or disease;
 - 2) That result in a denial may only be made by a licensed physician;
 - 3) Are made in accordance with established time-frames outlined in the agreement for routine, urgent, or emergency care; and
 - 4) Are made by clinical reviewers using the CHC definition of medical necessity.
- G. The CHC-MCO agrees to provide twenty-four (24) hour staff availability to authorize weekend services, including but not limited to: home health care, pharmacy, DME, LTSS, and medical supplies. The CHC-MCO must have written

policies and procedures that address how Participants and Providers can make contact with the CHC-MCO to receive instruction or Prior Authorization, as necessary

- H. Additional Prior Authorization requirements can be found in Exhibit G, Prior Authorization Guidelines for Participating Managed Care Organizations in the CHC Program.
- I. The CHC-MCO must ensure that utilization records document efforts made to obtain all pertinent clinical information and efforts to consult with the prescribing Provider before issuing a denial based upon medical necessity.
- J. The CHC-MCO must ensure that sources of utilization criteria are provided to Participants and Providers upon request.
- K. The UM program must contain procedures for providing written notification to Participants of denials of medical necessity and terminations, reductions and changes in level of care or placement, which clearly document and communicate the reasons for each denial. These procedures must:
 - 1) Meet requirements outlined in Exhibit T, Complaints, Grievances, and DHS Fair Hearing Process.
 - 2) Provide for written notification to Participants of denials, terminations, reductions and changes in medical services at least ten (10) days before the effective date.
 - 3) Include notification to Participants of their right to file a Complaint, Grievance or DHS Fair Hearing as outlined in Exhibit T, Complaints, Grievances, and DHS Fair Hearing Process.
- L. The CHC-MCO must agree to comply with the Department's quality monitoring and utilization review monitoring processes, including, but not limited to:
 - 1) Submission of a log of all denials issued using formats to be specified by the Department.
 - 2) Submission of denial notices for review as requested by the Department
 - 3) Submission of utilization review records and documentation as requested by the Department
 - 4) Ensure that all staff who have any level of responsibility for making determinations to approve or deny services, for any reason have completed a utilization review training program.
 - 5) Development of an internal quality assurance process designed to ensure that all denials issued by the plan and utilization review record documentation meet Department requirements. This process must be approved by the Department prior to implementation.

Standard X: The CHC-MCO must have a mechanism in place for Provider
Community HealthChoices Agreement Effective January 1, 2017

Appeals/Provider Disputes related to the following:

- A. Administrative denials including denials of Claims/payment issues, and payment of Claims at an alternate level of care than what was provided, i.e. acute versus skilled days. This includes the appeal by Health Care Providers of a CHC-MCO's decision to deny payment for services already rendered by the Provider to a Member.
- B. QM/UM sanctions
- C. Adverse credentialing/recredentialing decisions
- D. Provider Terminations

Standard XI: The CHC-MCO must ensure that findings, conclusions, recommendations and actions taken as a result of QM and UM program activities are documented and reported to appropriate individuals within the CHC-MCO for use in other management activities.

- A. The QM and UM program must have procedures which describe how findings, conclusions, recommendations, actions taken and results of actions taken are documented and reported to individuals within the CHC-MCO for use in conjunction with other related activities such as:
 - 1) CHC-MCO Provider Network changes;
 - 2) Benefit changes;
 - 3) Medical management systems (e.g., pre-certification);
 - 4) Practices feedback to Providers; and
 - 5) Service Coordination or Service Planning changes.

Standard XII: The CHC-MCO must have written policies and procedures for conducting prospective and retrospective DUR that meet requirements outlined in Exhibit CC, Outpatient Drug (Pharmacy) Services.

Standard XIII: The CHC-MCO must have written standards for maintaining Comprehensive Medical and Service Record (including PCSPs) record keeping. The CHC-MCO must ensure that the Comprehensive Medical and Service Records contain written documentation of the medical necessity of a rendered, ordered or prescribed service.

- A. The CHC-MCO must have written policies and procedures for the maintenance of Comprehensive Medical and Service Records so that those records are documented accurately and in a timely manner, are readily accessible and permit prompt and systematic retrieval of information. Written policies and procedures for the CHC-MCO and its Network Providers must contain standards for medical records that promote maintenance of medical records in a legible, current, detailed, organized and comprehensive manner that permits effective patient care and quality review.

- B. Medical record standards for the CHC-MCO and its Network Providers must meet or exceed medical record keeping requirements contained in 55 Pa. Code Section 1101.51(d)(e) of the Medical Assistance Manual and medical record keeping standards adopted by DOH.
- C. Comprehensive Medical and Service Records must, at a minimum, include the following information to the extent related to CHC-MCO Covered Services or related to other services coordinated by the CHC-MCO but covered by a Participant's Medicare or other source of coverage. The CHC-MCO record must include:
- 1) History and physical that is appropriate to the patient's current condition;
 - 2) Treatment plan, progress and changes in treatment plan;
 - 3) Diagnostic tests and results
 - 4) Therapies and other prescribed regimens;
 - 5) Disposition and follow-up;
 - 6) Referrals and results thereof;
 - 7) Hospitalizations;
 - 8) Reports of operative procedures and excised tissues;
 - 9) Medication record;\PCSP, where applicable;
 - 10) Services provided as per the PCSP for Participants who have one;
 - 11) Service Coordination contact notes; and
 - 12) All other aspects of patient care or Participant service delivery.
- D. The CHC-MCO must have written policies and procedures to assess the content of Comprehensive Medical and Service Records for legibility, organization, completion and conformance to its standards.
- E. The CHC-MCO must ensure access of the Participant to his/her Comprehensive Medical and Service Records at no charge and upon request.
- F. The Department and/or its authorized agents (i.e., any individual or corporation or entity employed, contracted or subcontracted with by the Department) shall be afforded prompt access to all Participants' Comprehensive Medical and Service Records whether electronic or paper. All Comprehensive Medical and Service Records copies are to be forwarded to the requesting entity within 15 calendar days of such request and at no expense to the requesting entity. The Department is not required to obtain written approval from a Participant before requesting the Participant's Comprehensive Medical and Service Records from the CHC-MCO, PCP or any other agency.
- H. Comprehensive Medical and Service Records must be preserved and maintained for a minimum of five years from expiration of the CHC-MCO's contract. Comprehensive Medical and Service Records must be made available in paper form upon request.

- I. When a Participant changes PCPs, the CHC-MCO must facilitate the transfer of his/her medical records or copies of medical records to the new PCP within five (5) business days from receipt of the request. In emergency situations, the CHC-MCO must facilitate the transfer of medical records as soon as possible from receipt of the request.
- J. When a Participant changes CHC-MCOs, the CHC-MCO must facilitate the transfer of his/her Comprehensive Medical and Service Records or copies of the Comprehensive Medical and Service Records to the new CHC-MCO within five (5) business days from the effective date of enrollment in the gaining CHC-MCO. In emergency situations, the CHC-MCO must facilitate the transfer of Comprehensive Medical and Service Records as soon as possible from receipt of the request.

Standard XIV: The QM and UM program must demonstrate a commitment to ensuring that Participants are treated in a manner that acknowledges their defined rights and responsibilities.

- A. The CHC-MCO must have a written policy that recognizes the rights of Participants outlined in this Agreement and Exhibit FF.
- B. The CHC-MCO must have a written policy that addresses Participant's responsibility for cooperating with those providing health care services. This written policy must address Participant's responsibility for:
 - 1) Providing, to the extent possible, information needed by professional staff in caring for the Member; and
 - 2) Following instructions and guidelines given by those providing health care services.
 - 3) Participants shall be asked to provide consent to managed care plans, Health Care Providers and their respective designees for the purpose of providing patient care management, outcomes improvement and research. For these purposes, Participants will remain anonymous to the greatest extent possible.
- C. The CHC-MCO's policies on Participant rights and responsibilities must be provided to all Network Providers.
- D. Upon enrollment, Participants must be provided with a written statement that includes information on the following:
 - 1) Rights and responsibilities of Participants as outlined in this Agreement and Exhibit FF;
 - 2) A Participant Handbook fulfilling the Participant Handbook requirements of this Agreement.
 - 3) All other items outlined in Section V.O. and requirements of that section for Community HealthChoices Agreement Effective January 1, 2017

distribution to Participants upon Enrollment.

- E. The CHC-MCO must have policies and procedures for resolving Participant Complaints and Grievances that meet all requirements outlined in Exhibit T, Complaints, Grievances, and DHS Fair Hearing Processes. These procedures must include mechanisms that allow for the review of all Complaints and Grievances to determine if quality of care and services issues exists and for appropriate referral of identified issues.
- F. Opportunity must be provided for Participants to offer suggestions for changes in policies and procedures.
- G. The CHC-MCO must take steps to promote accessibility of services offered to Participants. These steps must include identification of the points of access to primary care, specialty care, LTSS, and hospital services. At a minimum, Participants are given information about:
 - How to obtain services during regular hours of operation;
 - How to obtain after-hours, urgent and emergency care; and
 - How to obtain the names, qualifications, and titles of the Health Care or LTSS Provider providing and/or responsible for their care.
- H. Policies and procedures to ensure that Participant information (for example, Participant brochures, announcements, and handbooks) is provided in language that is readable and easily understood.

Standard XV: The CHC-MCO must maintain systems, which document implementation of the written QM and UM program descriptions.

- A. The CHC-MCO must document that it is monitoring the quality of care and services across all services, all treatment modalities, and all sub-populations according to its written QM and UM programs.
- B. The CHC-MCO must adhere to all systems requirements as outlined in Section V.X.5, Management Information Systems, and Section VIII.B, Systems Reporting, of the Agreement and in Management Information System and Systems Performance Review Standards provided by the Department on the Intranet supporting CHC.
- C. The CHC-MCO must adhere to all Encounter Data requirements as outlined in Section VIII.B.1, Encounter Data Reporting, of the Agreement.

Standard XVI: The QM and UM systems must ensure timely, complete, regular needs assessments for Participants who so require and must oversee development and implementation of PCSPs. They must also measure Participant satisfaction with quality of services, quality of life, experience of care, community integration, and quality of Service Coordination.

- A. The CHC-MCO must document that it is monitoring the comprehensive needs assessment process across all populations. Comprehensive needs assessments must comply with the content and timeline requirements outlined in this Agreement and must be provided to the populations outlined in Section V.E.
- B. The CHC-MCO must demonstrate that it is complying with its Department-approved service coordination staffing, communications, and Participant contact plan as required in this Agreement.
- C. The CHC-MCO must demonstrate that Participants who require it are provided person-centered service planning with input into who participates in their PCPTs and into the content of their PCSPs.
- D. The CHC-MCO must demonstrate how PCSPs are implemented and how they are monitored to ensure that services outlined are being provided or coordinated across coverages, systems, or agencies.
- E. The CHC-MCO must conduct annual Participant surveys using a survey tool approved by the Department to obtain feedback on quality of services, quality of life, experience of care, community integration, and quality of Service Coordination services provided.

EXHIBIT K(2)

EXTERNAL QUALITY REVIEW

External Quality Review (EQR) is a requirement under Title XIX of the Social Security Act, Section 1932(c)(2) for states to obtain an independent, external review body to perform an annual review of the quality of services furnished under state contracts with Managed Care Organizations, including the evaluation of quality outcomes, timeliness and access to services. The requirements for EQR were further outlined in 42 CFR Parts 433 and 438; External Quality Review of Medicaid Managed Care Organizations. EQR refers to the analysis and evaluation of aggregated information on timeliness, access, and quality of health care services furnished to Participants. "Quality", as it pertains to EQR, means the degree to which a CHC-MCO maintains or improves the health outcomes of its Participants through its structural and operational characteristics and through the provision of services. The results of the EQR are made available, upon request, to specified groups and to interested stakeholders. This is one of many tools that facilitate achieving continuous quality improvement in the delivery of care and services, health care outcomes, and timeliness of care and services, access to services, quality and utilization management systems, and program oversight. The Department will use the EQR process for its early implementation process. The CHC-MCO must comply with all information requests from the External Quality Review Organization (EQRO). The Department requires as part of the EQR process the CHC-MCOs:

- A. Actively participate in planning and developing the measures to be utilized with the Department and the EQRO. The Medical Assistance Advisory Committee will be given an opportunity to provide input into the measures to be utilized.
- B. Accurately, completely and within the required timeframe identify eligible Participants to the EQRO.
- C. Correctly identify and report the numerator and denominator for each measure.
- D. Actively encourage and require Providers, including subcontractors, to provide complete and accurate Provider medical records within the timeframe specified by the EQRO.
- E. Demonstrate how the results of the EQR are incorporated into the Plan's overall Quality Improvement Plan and demonstrate progressive improvements during the term of the contract.
- F. Improve Encounter Data in an effort to decrease the need for extensive Provider medical record reviews.
- G. Provide information to the EQRO as requested to fulfill the requirements of the mandatory and optional activities required in 42 CFR Parts 433 and 438.
- H. Ensure that data, clinical records and workspace located at the CHC-MCO's work site are available to the independent review team and to the Department, upon request.

- I. Participate in Performance Improvement Projects whose target areas are dictated by the Department to address key quality areas of focus for improvements. The CHC-MCO will comply with the PIP timelines as prescribed by the EQRO.
 1. The CHC-MCO shall perform at least two PIPs, one (1) clinical and one (1) non-clinical PIPs. Clinical PIPs include projects focusing on prevention and care of acute and chronic conditions, high-volume services, high-risk services, and continuity and coordination of care and services; non-clinical PIPs include projects focusing on availability, accessibility, and cultural competency of services, interpersonal aspects of care and services, and appeals, grievances, and other complaints.
 2. The CHC-MCO shall ensure that CMS protocols for PIPs are followed and that all steps outlined in the CMS protocols for performance improvement projects are documented.
 3. The CHC-MCO shall identify benchmarks and set achievable performance goals for each of its PIPs. The CHC-MCO shall identify and implement intervention and improvement strategies for achieving the performance goal set for each PIP and promoting sustained improvements.
 4. The CHC-MCO shall report on PIPs as required in the Reporting Requirements. For Performance Improvement Project topics that are conducted in the assigned Zone of the State. The CHC-MCO shall submit one Performance Improvement Project Summary Report that includes Zone-specific data and information, including *improvement strategies* as required by CMS.
 5. After three (3) years, the CHC-MCO shall, using evaluation criteria established by the Department, determine if one or all of the PIPs should be continued.

Exhibit K(3)

Critical Incident Reporting and Management and Provider Preventable Conditions/Preventable Serious Adverse Events Reporting

CHC-MCOs must and must ensure that Network Providers comply with the reporting requirements established in the Older Adult Protective Services Act and the Adult Protective Services Act. In addition, CHC-MCOs must and must ensure that Network Providers comply with the following critical incident and adverse event reporting requirements outlined in this Exhibit.

Critical Incident Reporting to the Department

CHC-MCOs and their Network Providers and Subcontractors must report critical events or incidents via the Department's Enterprise Incident Management System. . Using the Department's Enterprise Incident Management System, the CHC-MCOs must investigate critical events or incidents reported by Network Providers and Subcontractors and report the outcomes of these investigations.

The following are critical incidents:

- Death (other than by natural causes);
- Serious injury that results in emergency room visits, hospitalizations, or death;
- Hospitalization except in certain cases, such as hospital stays that were planned in advance;
- Provider or staff misconduct, including deliberate, willful, unlawful, or dishonest activities;
- Abuse, which includes the infliction of injury, unreasonable confinement, intimidation, punishment, mental anguish, or sexual abuse of a participant. Types of abuse include, but not necessarily limited to:
 - Physical abuse, defined as a physical act by an individual that may cause physical injury to a participant;
 - Psychological abuse, defined as an act, other than verbal, that may inflict emotional harm, invoke fear, or humiliate, intimidate, degrade or demean a participant;
 - Sexual abuse, defined as an act or attempted act, such as rape, incest, sexual molestation, sexual exploitation, or sexual harassment and/or inappropriate or unwanted touching of a participant; and
 - Verbal abuse, defined as using words to threaten, coerce, intimidate, degrade, demean, harass, or humiliate a participant;
- Neglect, which includes the failure to provide a participant the reasonable care that he or she requires, including, but not limited to food, clothing, shelter, medical care, personal hygiene, and protection from harm. Seclusion, which is the involuntary confinement of an individual alone in a room or an area from which the individual is physically prevented from having contact with others or leaving, is a form of neglect;
- Exploitation, which includes the act of depriving, defrauding, or otherwise obtaining the personal property from a participant in an unjust, or cruel manner, against one's will, or without one's consent, or knowledge for the benefit of self or others;

- Restraint, which includes any physical, chemical or mechanical intervention that is used to control acute, episodic behavior that restricts the movement or function of the individual or a portion of the individual's body. Use of restraints and seclusion are both restrictive interventions, which are actions or procedures that limit an individual's movement, a person's access to other individuals, locations or activities, or restricts participant rights;
- Service interruption, which includes any event that results in the participant's inability to receive services that places his or her health and or safety at risk. This includes involuntary termination by the provider agency, and failure of the participant's back-up plan. If these events occur, the provider agency must have a plan for temporary stabilization; and
- Medication errors that result in hospitalization, an emergency room visit or other medical intervention.

Critical Incident Reporting Requirements for Providers

Providers must report in accordance with applicable requirements.

The CHC-MCO must require providers to cooperate with the Department investigation of critical incidents.

Provider Preventable Conditions/Preventable Serious Adverse Events (PSAE)

The CHC-MCO must require all Network Providers to identify provider preventable conditions as defined in 42 CFR § 447.26 and may not pay for services related to provider preventable conditions unless the condition existed prior to the initiation of treatment for the patient. The CHC-MCO must submit all identified Provider Preventable Conditions in a form or frequency as required by the Department.

Please refer to the Department's website for additional information regarding PSAE
http://www.dpw.state.pa.us/cs/groups/webcontent/documents/document/c_101648.pdf

EXHIBIT K(4)

HEALTHCARE EFFECTIVENESS DATA AND INFORMATION SET (HEDIS®)

Annually, the CHC-MCO must complete all HEDIS measures designated by NCQA as relevant to Medicaid. The only exclusions from the complete Medicaid HEDIS data set must be childhood related and pregnancy related measures. The HEDIS measure results must be reported separately for each Zone in which the CHC-MCO operates. The CHC-MCO must contract with an NCQA certified HEDIS auditor to validate the processes of the CHC-MCO in accordance with NCQA requirements. Audited HEDIS results must be submitted to the Department, NCQA and the Department's EQRO annually by June 15 of each calendar.

The CHC-MCO must utilize the Hybrid methodology (i.e., gathered from administrative and medical record data) as the data collection method for any Medicaid HEDIS measure containing Hybrid Specifications as identified by NCQA. If, in the event the CHC-MCO fails to pass the medical record review for any given standard and NCQA *mandates* administrative data must be submitted instead of hybrid, the administrative data may be used.

The CHC-MCO must submit to the Department by June 15 of each calendar year a detailed explanation for any Medicaid HEDIS measure marked as "Not Reported"

HEDIS is a set of standardized performance measures designed to reliably compare health plan performance. HEDIS performance measures are divided into five domains of care:

- Effectiveness of care,
 - Access/availability of care,
 - Experience of care (Adult CAHPS),
 - Utilization and Relative resource use, and
- Health plan descriptive information, The Department requires that the CHC-

MCOs:

- A. Must produce rates for all Medicaid reporting measures, with the exclusion of the behavioral health measures, unless otherwise specified by the Department.
- B. Must follow NCQA specifications as outlined in the HEDIS Technical Specifications clearly identifying the numerator and denominator for each measure.
- C. Must have all HEDIS results validated by an NCQA-licensed vendor. The Department currently contracts with an NCQA-licensed entity to validate the MCOs' HEDIS results used in public reporting. The MCO may utilize these validation results for other purposes such as pursuit of accreditation. The Department may at some future date relinquish the direct contracting of

NCQA validation activities.

- D. Must assist with the HEDIS validation process by the Department's NCQA licensed contractor.
- E. Must demonstrate how HEDIS results are incorporated into the CHC-MCO's overall Quality Improvement Plan.
- F. Must submit validated HEDIS results annually on June 15th unless otherwise specified by the Department.

The CHC-MCO must conduct a CAHPS survey. The CHC-MCO must enter into an agreement with a vendor that is certified by NCQA to perform CAHPS surveys. The CHC-MCO's vendor must perform the CAHPS adult and HCBS survey using the most current CAHPS version specified by NCQA. The CHC-MCO must also conduct any other CAHPS survey required by the Department. Survey results must be reported to the Department. The survey results must be reported separately for each Zone in which the CHC-MCO operates. Survey results must be submitted to the Department, NCQA and the Department's EQRO annually by June 15 of each calendar year beginning in 2017.

The CHC-MCO must submit annually the Relative Resource Use (RRU) data to the Department within ten (10) business days of receipt from NCQA. The CHC-MCO must submit both the Regional and National RRU results.

CAHPS are a set of standardized surveys that assess patient satisfaction with the experience of care. CAHPS surveys (Adult and HCBS) are subsets of HEDIS reporting required by the Department. For HEDIS, MCOs must contract with an NCQA-certified vendor to administer the survey according to the HEDIS survey protocol that is designed to produce standardized results. The survey is based on a randomly selected sample of Participants from the CHC-MCO and summarizes satisfaction with the experience of care through ratings and composites.

The HEDIS protocol for administering CAHPS surveys consists of a mail protocol followed by telephone administration to those not responding by mail. CHC-MCOs must contract with a certified vendor to administer both the Adult and HCBS CAHPS surveys. The CHC-MCO must generate a sample frame for each survey sample, and arrange for an NCQA-certified auditor to verify the integrity of the sample frame before the certified vendor draws the sample and administers the survey. The CHC-MCOs are also required to have the certified vendor submit Participant level data files to NCQA for calculation of HEDIS CAHPS survey results. The Department requires that the CHC-MCOs:

- A. Must conduct both an Adult and HCBS CAHPS survey using the current version of CAHPS.
- B. Must include all Medicaid core questions in both surveys.
- C. Must add the following supplemental dental care questions, one through three, from the Supplemental Items for Adult/HCBS Questionnaires to both the Adult

and HCBS CAHPS surveys and questions four, five, and six to the HCBS CAHPS survey:

- D1. In the last six months, did you get care from a dentist's office or dental clinic?
- D2. In the last six months, how many times did you go to a dentist's office or dental clinic for care for yourself?
- D3. We want to know your rating of your dental care from all dentists and other dental Providers in the last six months. How would you rate your dental care (on a scale of 1 to 10)?
- D4. What are the major difficulties you have in seeing a dentist as often as you need?
- I have trouble getting transportation to my dentist
 - I forget to go
 - I do not like dentists
 - It is difficult to schedule an appointment
 - My dentist does not have convenient office hours
 - I have to wait too long in the waiting room
 - I am afraid or nervous to go
 - I don't have time
 - I don't have someone to watch my children
 - I can't take time off from work
 - I don't know how to find a dentist
 - I cannot find an office with physically accessible equipment
 - I cannot find an office whose site is physically accessible
 - I have trouble finding a dentist who speaks my language
 - I have trouble getting orthodontic (braces) care
 - The dentists I call do not accept my insurance
 - Medicaid does not cover dentists
 - None of the above. I haven't had any difficulty in seeing a dentist
 - Other (write in)
- D5. Which of the following would help you see the dentist more often?
- Help with transportation to the dentist
 - Reminders to visit the dentist
 - More dentists to choose from
 - More convenient office hours
 - Dentists that speak my language
 - Help in finding a dentist
 - If I could find an office with physically accessible equipment
 - If I could find an office whose site is physically accessible
 - Better communication about benefits from my healthplan
 - Education about good dental care
 - None of the above. I see the dentist as often as I like.
 - Other (write in)
- D6. What are the major difficulties for providing dental services in LTSS settings and for the LTSS population?
- Willingness of dentists to see participants in the home
 - Willingness of dentists to see participants in a Nursing facilities
 - Willingness of dentists to accommodate individuals with disabilities
 - Other

- D. Must add the following supplemental question from the Supplemental Items for the Adult Questionnaires to the Adult CAHPS survey:
 - H16. Have you had a flu shot since September 1, 20xx (zone specific date)?
- E. Must forward CAHPS data to the Department both electronically and hardcopy in an Excel file in the format determined by the Department.
- F. Must submit validated CAHPS results annually on June 15th unless otherwise specified by the Department.

The Department annually releases an Ops Memo that contains detailed information regarding the submission of HEDIS and CAHPS.

EXHIBIT L

NOTICE OF DENIAL

A written notice of denial including reasons for denial must be issued to the Participant for the following:

- a. The denial or limited authorization of a requested service, including the type or level of service.
- b. The reduction, suspension or termination of a previously authorized service.
- c. The denial of a requested service because it is not a covered service for the Participant.
- d. The denial of a requested service but approval of an alternative service.

Please refer to Templates L(1) through L(6) for denial notices and L(7), Request for Additional Information Letter template on the Intranet supporting CHC.

EXHIBIT M

COORDINATION WITH BH-MCOS

The CHC-MCOs and the BH-MCOs are required to develop and implement written agreements regarding the interaction and coordination of services provided to Participants enrolled in the Program. These agreements must reflect the requirements for how the CHC-MCO and BH-MCO will coordinate services for all CHC Participants, including those in Nursing Facilities and those receiving LTSS at home. These agreements must be submitted and approved by the Department. The CHC-MCOs and BH-MCOs in the Zone are encouraged to develop uniform coordination agreements to promote consistency in the delivery and administration of services. A sample coordination agreement (which does not include all required procedures) is available on the Intranet supporting CHC. Complete agreements, including operational procedures, must be available for review by the Department upon request. The agreements must be submitted for final review and approval to the Department at least 30 days prior to the implementation of the CHC Program. The written agreements must include, but not be limited to:

- Procedures which govern referral, collaboration and coordination of diagnostic assessment and treatment, prescribing practices, the provision of emergency room services and other treatment issues necessary for optimal health and prevention of disease. The CHC-MCO and the BH-MCO must collaborate in relation to the provision of emergency room services. Emergency services provided in general hospital emergency rooms are the responsibility of the Participant's CHC-MCO, regardless of the diagnosis or services provided. The only exception is for emergency room evaluations for voluntary or involuntary commitment pursuant to the 1976 Mental Health Procedures Act which is the responsibility of the BH-MCO. Responsibility for inpatient admission will be based upon the Participant's primary diagnosis. Procedures must define and explain how payment will be shared when the Participant's primary diagnosis changes during a continuous hospital stay;
- Procedures, including Prior Authorization, which govern reimbursement by the BH-MCO to the CHC-MCO for behavioral health service provided by the CHC-MCO or vice versa and the resolution of any payment disputes for services rendered. Procedures must include provisions for differential diagnosis of persons with co-existing physical and behavioral health disorders, as well as provisions for cost-sharing when both Physical and Behavioral Health Services are provided to a Participant by a service Provider;
- Procedures for the exchange of relevant enrollment and health-related information among the BH-MCO, the CHC-MCO, and PCP and Behavioral and CHC Covered Services Providers in accordance with federal and state confidentiality laws and regulations; (e.g., periodic treatment updates with identified primary and relevant specialty Providers);
- Policy and procedures for obtaining releases to share clinical information and providing health records to each, other as requested, consistent with state and federal confidentiality requirements;

- Procedures for training and consultation to each other to facilitate continuity of care and cost-effective use of resources;
- A mechanism for timely resolution of any clinical and fiscal payment disputes, including procedures for entering into binding arbitration to obtain final resolution;
- Procedures for serving on interagency teams, as necessary;
- Procedures for the development of adequate Provider Networks to serve Special Needs populations and coordination of specialized service plans between the BH-MCO service managers, Behavioral Health Service Provider(s) and the CHC-MCO PCP for Participants with special health needs (e.g., older adults with coexisting physical and behavioral health disorders);
- The BH-MCO is required to provide behavioral health crisis intervention and other necessary State Plan Services to Participants with behavioral health Emergency Conditions. The CHC-MCO and BH-MCO must establish clear procedures for coordinating the transport and treatment of persons with behavioral health emergencies who initially present themselves at general hospital emergency rooms to appropriate behavioral health facilities;
- Procedures for the coordination and payment of emergency and non-emergency medically necessary ambulance transportation of Participants. All emergency and non-emergency medically necessary ambulance transportation for both physical and behavioral health Covered Services is the responsibility of the Participant's CHC-MCO even for a behavioral health diagnosis.
- Procedures for the coordination of laboratory services;
- Mechanisms and procedures to ensure coordination between the BH-MCO service managers, Participant services staff and BH-MCO network Providers with the CHC-MCO's Service Coordination Unit. The effectiveness of these mechanisms shall be included as an area for review by the BH-MCO's Quality Assurance Program and the CHC-MCO's Quality Management Program;
- Procedures for the CHC-MCO to provide physical examinations required for the delivery of Behavioral Health Services, within designated time frames for each service;
- Procedures for the interaction and coordination of pharmacy.

To insure that there is support for the coordination of care between the PCP and the behavioral health Provider, appropriate county contacts can be found at the following Internet addresses:

County MH/MR Administrators: <https://www.hcsis.state.pa.us/hcsis-ssd/pgm/asp/PRCNT.ASP>

Single County Authorities

Community HealthChoices Agreement Effective January 1, 2017

(SCA's): <https://apps.ddap.pa.gov/gethelpnow/CountyServices.aspx>

EXHIBIT N

WRITTEN COORDINATION AGREEMENTS BETWEEN CHC-MCO AND NETWORK PROVIDERS

Any written coordination agreements entered into between the CHC-MCO and Network Providers must contain, at a minimum:

- Provisions for ongoing communications; exchange of relevant enrollment and individual health related information; service needs among the CHC-MCO, PCP and the Provider, including a process to monitor such activity; and the Quality Management and Utilization Management program responsibilities of each entity.
- Provisions which govern referral, collaboration and coordination of diagnostic assessment and treatment, prescribing practices and other treatment issues necessary for optimal health and disease prevention, including coordination of specialized service plans for Participants with special health needs.
- Provisions for requiring interaction by the PCP for prompt treatment, coordination of care or referral of Participants for other identified services that are not the responsibility of the Provider.
- Provisions for jointly identifying the services to be delivered and monitoring by the CHC-MCO to determine the quality of the service delivered.
- Provisions for the CHC-MCO and the Provider to work cooperatively to establish programmatic responsibility for each Community HealthChoices Participant.
- Provisions for serving on interagency teams, when requested.
- Provisions for assisting, when appropriate, in the coordination of services with the BH-MCO, including Pharmacy Coordination, to the extent permitted by law.
- Provisions for mutual intensive outreach efforts to Participants identified as needing service (processes to conduct outreach and the measurement of the outreach efforts must be documented in the procedures governing the execution of the written agreement).
- Provisions for a timely resolution of any disputes.
- Provisions for training and consultations between both parties to facilitate continuity of care and the cost-effective use of resources.
- Provisions for assisting, when appropriate, in the development of an adequate Provider Network to serve Special Needs populations.

- Provisions for obtaining the appropriate releases necessary to share clinical information and provide health records to each other as requested consistent with state and federal laws.
- Provisions for the designation of a CHC-MCO representative who will function as the liaison between the CHC-MCO and the Provider, if appropriate.
- Provisions for the development and implementation of corrective action plans in the event the provisions of the agreement are not being met.
- Provisions for the adherence to the Americans with Disabilities Act (ADA) (42 U.S.C. Section 12101 et seq) and the Rehabilitation Act of 1973 (29 U.S.C. Section 701 et seq).
- Provisions for the maintenance and confidentiality of medical records and other information considered confidential, including provisions for resolving confidentiality problems.
- Provisions for the collection of information on the service(s) delivered to be shared with the Department, upon request.
- Provisions for collaboration on identifying and reducing the frequency of Fraud, Abuse, overuse, under use, inappropriate or unnecessary medical care.
- Provisions for the reporting of health related information to the appropriate regulatory agency, if necessary.

EXHIBIT O

GUIDELINES FOR CHC-MCO ADVERTISING, SPONSORSHIPS, AND OUTREACH

I. Overview

The CHC-MCO must submit a plan for advertising, sponsorship, and outreach procedures to the Department for advance written approval in accordance with the guidelines outlined in this exhibit. This plan must address how the CHC-MCO will market its D-SNP product to CHC-MCO Participants.

II. Community HealthChoices Outreach Procedures

CHC-MCOs must adhere to the following guidelines and all the requirements specified in Section V.O.2, CHC-MCO Outreach Materials, and V.O.3, CHC-MCO Outreach Activities, of the agreement when submitting outreach materials, policies and procedures to the Department.

A. Submission of CHC-MCO Outreach Materials

Purpose: To obtain Department approval of new or revised outreach materials, plans or procedures.

Objectives:

1. To assure that CHC-MCO outreach materials are accurate.
2. To prevent the CHC-MCO from distributing outreach materials that mislead, confuse or defraud either the Participant or the Department.

Process:

1. The CHC-MCO submits outreach materials to the Department for prior approval using the CHC Educational Materials Approval Form (form attached).
2. The Department's contract monitoring Core Team will review and forward to the CHC-MCO a preliminary response within thirty (30) calendar days from date of receipt of the request form.

Exception: Should the materials require comments or approval from offices outside the Department contract monitoring Core Team, the turnaround time would be as soon as possible.

3. The CHC-MCO will submit a final copy of the outreach materials to the Department contract monitoring Core Team for a final written approval prior to circulating the materials.
4. The Department review agency will forward a final written approval to

the CHC-MCO within ten (10) business days.

5. Outreach material usage:
 - a. Direct outreach materials will be used only by the IEE personnel after final written approval is received by the CHC-MCO from the Department.
 - b. Indirect outreach materials (i.e., advertisements) may be utilized immediately after final written approval is received by the CHC-MCO from the Department.

B. Criteria for Review of CHC-MCO Outreach Materials

Purpose: To assure that printed materials, advertising, promotional activities and new Participant orientations coordinated through the IEE are designed to enable Participants to make an informed choice.

Objectives:

1. To assure that the information complies with all federal and state requirements.
2. To determine if the information is grammatically correct and appropriate for Pennsylvania's Medical Assistance population.
3. To ensure that outreach materials are accurate and do not mislead, confuse, or defraud the Participant or the Department with the assertion or statement that the Participant must enroll in the CHC-MCO in order to obtain Medical Assistance benefits, or in order to not lose Medical Assistance benefits.
4. To ensure that the outreach materials do not contain assertions or statements that a Participant must enroll in the aligned D-SNP of the CHC-MCO.
5. To ensure that there are no assertions or statements that the CHC-MCO is endorsed by CMS, the federal or state government, or similar entity.

Process:

1. Receive a written overall outreach plan annually if the CHC-MCO anticipates participation in outreach activities. Requests for specific indirect advertising must be submitted thirty (30) calendar days in advance for written Department approval.
2. Determine if approval is necessary from other offices.

3. Review the information with the following criteria:
 - a. Is the CHC-MCO identified?
 - b. Does the information comply with all federal and state regulations?
 - c. Is the information presented in grammatically correct, precise, appropriate and unambiguous language, easily understood by the target audience (i.e., age and language) and does it avoid the use of industry jargon?
 - d. Is the information fair, relevant, accurate and not misleading or disparaging to competitors?
 - e. Can the information be easily understood by a person with a sixth grade education?
 - f. Does the information include symbols or pictures that are discriminating because of race, color, age, religion, sex, national origin, physical handicap or otherwise?
 - g. Does the information create a negative image of the traditional FFS system?
4. The Department will forward a final written response to the CHC-MCO within ten (10) business days.

c. CHC-MCO Participating In or Hosting an Event

The CHC-MCO may submit requests to sponsor or participate in health fairs or community events; the request should demonstrate that the CHC-MCO will participate in such fairs or events through activities, including approved outreach activities that are primarily health-care related. The CHC-MCO must receive advance written approval from the Department prior to the event date. All requests must be submitted to the Department at least thirty (30) calendar days in advance of the event, on the forms which are included as part of this attachment.

Purpose: To clarify for CHC-MCOs that Pennsylvania laws and regulations prohibit certain kinds of offers or payments to Participants as inducements or incentives for Participants to use the CHC-MCO's services.

Objectives:

1. To provide amenities that create an environment that is comfortable and convenient for Participants but is not offered as an artificial outreach inducement or incentive.
2. To eliminate fraudulent, abusive and deceptive practices that may occur as incentives or inducements to obtain specific Covered Services from the CHC-MCO.

Process:

1. The CHC-MCO must submit a request, using the applicable Community HealthChoices CHC-MCO Outreach Approval Form or the Community HealthChoices Educational Materials Approval Form, to the appropriate Department review agency thirty (30) calendar days in advance of the event (see attached). Should the event require approval from other offices, the approval process may extend beyond thirty (30) calendar days.
2. The Department review agency considers the request as confidential.

D. Community HealthChoices CHC-MCO Outreach Approval Form

E. Community HealthChoices Educational Materials Approval Form

COMMUNITY HEALTHCHOICES EDUCATIONAL MATERIALS APPROVAL FORM

CHC-MCO Name: _____ Tracking #: _____

Contact Person: _____ Date: _____

Request Received By DHS: _____

Subject: _____

_____ W

ho: _____

_____ W

hat: _____

_____ W

hen: _____

_____ W

here: _____

_____ An

y Fees: _____

Confirmation Letter Attached: Yes No

Discussion:

DHS USE ONLY:

Approved: Denied:

Reviewer: _____

Final Approval Date: _____

**COMMUNITY HEALTHCHOICES CHC-MCO OUTREACH
APPROVAL FORM**

CHC-MCO Name: _____ Tracking #: _____

Contact Person: _____ Date: _____

Request Received By DHS: _____

Subject: _____

_____ W

ho: _____

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here: _____

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y Fees: _____

Confirmation Letter Attached. Yes _____ No _____

Discussion:

DHS USE ONLY:

Approved: _____ Denied: _____

Reviewer: _____

Final Approval Date: _____

EXHIBIT P

CHC-MCO PARTICIPANT COVERAGE DOCUMENT

This Participant Coverage Document (PCD) includes descriptions of policies supported by the Department data systems and processes. In cases in which policies expressed in this document conflict with another provision of the CHC-MCO Agreement, the Agreement will take precedence.

CHC-MCO coverage as detailed in this document does not imply coverage under a BH-MCO. Refer to the BH-MCO Recipient Coverage Document for behavioral health coverage guidelines.

The Department will provide sufficient information to the CHC-MCO in order for it to reconcile CHC-MCO Participant data and amounts paid to and recovered from the CHC-MCO. The Department will only pay capitation to one plan per Participant per month.

Coverage Rules

A CHC-MCO is responsible for a Participant if coverage is determined by applying the general rules found in any of paragraphs A, B, or C below, subject to exceptions and clarifications found in paragraphs D, E, F, and G.

Refer to the Intranet supporting CHC for additional information on Participant coverage, clarifications, examples, and Participant Enrollment/disenrollment procedures.

- A. Responsibility to Provide Medical Assistance Benefits.** - Unless otherwise specified, the CHC-MCO is responsible to provide Medical Assistance benefits to Participants in accordance with eligibility information included on the Monthly Participant File and/or the Daily Participant File, which is provided by the Department to each CHC-MCO.

- B. Participant Files/Coverage Dates/Eligibility.** - Daily and Monthly Participant Files containing information and changes that apply to their Participants are provided to each CHC-MCO. The CHC-MCO is responsible to provide services for each non-LTSS CHC-MCO Participant identified on the Daily or Monthly Participant File from the first day of the calendar month or the CHC-MCO coverage begin date, whichever is later, through the last day of the calendar month, or the CHC-MCO end-date, if any. The Department will pay the CHC-MCO from the first day of coverage in a month through the last day of the calendar month. CHC-MCO coverage dates beyond the last day of the month in which the Daily or Monthly Participant File is created are preliminary information that is subject to change.

For LTSS participants, the CHC-MCO is responsible to provide services the day

after eligibility determination. The Department will provide information to the CHC-MCOs about these identified individuals through a transaction file.

Participants who become ineligible for Medical Assistance will retain their CHC-MCO selection for six months. These Participants will become the responsibility of the same CHC-MCO if they regain Medical Assistance eligibility during that six-month period, as long as their category of assistance and geographic location are valid for that CHC-MCO. Upon regaining eligibility, their CHC-MCO effective date will be their eligibility begin date or the date Client Information System (CIS) is updated with their coverage, whichever is later.

C. Exceptions and Clarifications. - The Department will recover Capitation payments made for Participants for whom it has been determined that the CHC-MCO was not responsible to provide services.

The CHC-MCO will not be responsible and will not be paid when the Department notifies the CHC-MCO of Participants for whom they are not responsible.

1. Errors in CHC-MCO coverage identified from any source must be reported to the Department within forty-five (45) days of receipt of the Daily Participant File in order for changes to be considered.

If a Participant is enrolled in a CHC-MCO in error, that CHC-MCO is responsible to cover the Participant until the Department is notified and the correction is applied to the CIS eligibility record.

If at the time of notification to the Department, the Participant was disenrolled in error from a CHC-MCO and the Participant is enrolled in a different CHC-MCO, the Participant will be reenrolled in the previous CHC-MCO effective the first of the next month. However, if at the time of notification the Participant is covered by FFS, the Participant will be reenrolled into the same CHC-MCO effective the day following notification to the Department.

2. If CIS shows an exemption code or a facility/placement code that precludes CHC-MCO coverage, the Participant will not be enrolled in a CHC-MCO.
3. If CIS shows Fee-For-Service (FFS) coverage that coincides with CHC-MCO coverage, the Participant may use either coverage and there will be no monetary adjustment between the Department and the CHC-MCO. (This is subordinate to #7 below.)
4. If a CHC-MCO has actual knowledge that a Participant is deceased, and if such Participant shows on either the Monthly Participant or the Daily Participant file as active, the CHC-MCO is required to notify the County Assistance Office (CAO) and the Department. The Department will

recover Capitation payments made for up to eighteen (18) months after the service month in which the date of death occurred.

5. The Department will recover Capitation payments for Participants who were later determined to be ineligible for CHC-MCO coverage or who were placed in settings that result in the termination of CHC-MCO coverage by the Department. The Department will recoup payments back to the month following the month in which the termination of coverage occurred, for up to twelve (12) months afterwards (i.e. today's date is 9/18/17 and central office staff end date managed care coverage 9/30/16 – payments are recouped for 10/17 through 9/18. See Section F for examples of placements that result in termination of coverage).
6. Movement out of a CHC-MCO's service area does not necessarily eliminate the CHC-MCO's responsibility to provide Medical Assistance benefits. It is the CHC-MCO's responsibility to inform the CAO of the address change upon receipt of information that a Participant is residing outside the CHC-MCO service area.
7. Pursuant to the rules outlined in the PCD, a lack of Medical Assistance eligibility indicated on CIS for a certain date does not necessarily eliminate the CHC-MCO's responsibility to provide Medical Assistance benefits. (Refer to Section E, Coverage during Inpatient Hospital Stays, for rules regarding the CHC-MCO's responsibility for hospital stays when a Participant loses Medical Assistance eligibility during the stay.)
8. The Department reserves the right to intercede in requests for expedited enrollments when Medically Necessary. The Department's determination for the expedited enrollment will be final. The Capitation rate will be retroactively adjusted for each CHC-MCO based on the effective date of the expedited enrollment.
9. The CHC-MCO must provide Out-of-Area Covered Services such that a Participant who is attending a college or university in a state other than Pennsylvania or a zone other than their zone of residence or who is travelling outside of the zone remains the responsibility of the CHC-MCO for so long as the Participant remains a resident of the Commonwealth and the zone.

D. Change in CHC-MCO Coverage during Inpatient Hospital Stays. - When a Medical Assistance Participant has CHC coverage during part of a hospital stay, payment responsibility is as documented in Section E, Coverage during Inpatient Hospital Stays.

Note: One or more of the rules documented in the following sections may apply during a hospital stay.

RULE: E-1.	
Condition	A Participant who is covered by FFS when admitted to a hospital assumes CHC-MCO coverage while still in the hospital.
CHC-MCO Coverage Responsibility	As of the begin date of CHC-MCO coverage, the CHC-MCO is responsible for physician, DME and all other Covered Services not included in the hospital bill.
MA FFS Coverage Responsibility	The FFS program is responsible for the hospital bill through the date of discharge. Note: If the Participant is discharged from the initial hospital to another hospital (acute or rehabilitation) after the CHC-MCO begin date, FFS is only responsible for the stay in the initial hospital through the date of discharge. The CHC-MCO is responsible for the stay in the subsequent hospital upon admission.

RULE: E-2.	
Condition	A Participant who is covered by a CHC-MCO when admitted to a hospital loses CHC-MCO coverage and assumes FFS coverage while still in the hospital.
CHC-MCO Coverage Responsibility	The CHC-MCO is responsible for the hospital stay with the following exceptions. EXCEPTION #1: If the Participant is still in the hospital on the FFS coverage begin date, and the Participant's FFS coverage begin date is the first day of the month, the CHC-MCO is financially responsible for the stay through the last day of that month. Example: If a Participant covered by the CHC-MCO is admitted to a hospital on June 21 and the FFS coverage begin date is July 1, the FFS program assumes payment responsibility for the stay on August 1. The CHC-MCO remains financially responsible for the stay through July 31. EXCEPTION #2: If the Participant is still in the hospital on the FFS coverage begin date, and the Participant's FFS coverage begin date is any day other than the first day of the month, the CHC-MCO is financially responsible for the stay through the last day of the following month. Example: If a Participant covered by a CHC-MCO is admitted to a hospital on June 21 and the FFS program coverage begin date is July 15, the FFS program assumes payment responsibility for the stay on September 1. The CHC-MCO program remains financially responsible for the stay through August 31.
MA FFS Coverage Responsibility	Starting with the FFS begin date, FFS is responsible for physician, DME and other bills not included in the hospital bill. EXCEPTION #1: The FFS program is financially responsible for the stay beginning on the first day of the next month. EXCEPTION #2: The FFS program is financially responsible for the stay beginning on the first day of the month following the next month.

RULE: E-3.	
Condition	A Participant covered by a CHC-MCO when admitted to a hospital transfers to another CHC-MCO while still in the hospital.
CHC-MCO Coverage Responsibility	<p>The losing CHC-MCO is responsible for the hospital stay with the following exceptions. Starting with the gaining CHC-MCO's begin date, the gaining CHC-MCO is responsible for the physician, DME and all other Covered Services not included in the hospital bill.</p> <p>EXCEPTION #1: If the Participant is still in the hospital on the gaining CHC-MCO coverage begin date, and the Participant's gaining CHC-MCO coverage begin date is the first day of the month, the losing CHC-MCO is financially responsible for the stay through the last day of the month. The gaining CHC-MCO is financially responsible for the stay beginning on the first day of the next month.</p> <p>Example:</p> <p>If a Participant is admitted to a hospital on June 21 and the gaining CHC-MCO coverage begin date is July 1, the gaining CHC-MCO assumes payment responsibility for the stay on August 1. The losing CHC-MCO remains financially responsible for the stay through July 31.</p> <p>EXCEPTION #2: If the Participant is still in the hospital on the gaining CHC-MCO coverage begin date, and the Participant's gaining CHC-MCO coverage begin date is any day other than the first day of the month, the losing CHC-MCO is financially responsible for the stay through the last day of the following month. The gaining CHC-MCO is financially responsible for the stay beginning on the first day of the month following the next month.</p> <p>Example:</p> <p>If a Participant is admitted to a hospital on June 21 and the gaining CHC-MCO coverage begin date is July 15, the gaining CHC-MCO assumes payment responsibility for the stay on September 1. The losing CHC-MCO remains financially responsible for the stay through August 31.</p>
MA FFS Coverage Responsibility	There is no FFS coverage in this example.

RULE: E-4a.	
Condition	A Participant covered by a CHC-MCO when admitted to a hospital loses and <u>regains Medical Assistance eligibility while in the hospital (Participant is not discharged)</u>, resulting in a break in CHC-MCO coverage. The Department's Division of Managed Care Systems Support (DMCSS) becomes aware of the break in CHC-MCO coverage by the end of the month following the month in which it is lost.

CHC-MCO Coverage Responsibility	<p>DMCSS will reopen the Participant's CHC-MCO coverage retroactive to the day it was end-dated on CIS and adjust the Capitation payment accordingly. The CHC-MCO continues to be financially responsible for the stay including the physician, DME, and all other Covered Services.</p> <p>Example:</p> <ul style="list-style-type: none"> • A Participant who is admitted to the hospital on March 10 loses Medical Assistance eligibility effective March 22 and regains it on April 9 retroactive to March 22. The CHC-MCO coverage on CIS shows the Participant was end-dated March 31 and reopened in the CHC-MCO with a new CHC-MCO begin date of April 9. On April 25, DMCSS becomes aware of the situation. • Because DMCSS is aware of the loss of Medical Assistance eligibility within the month following the month in which it was lost, DMCSS reopens the CHC-MCO coverage retroactive to April 1, the day after the CHC-MCO end-date is posted on CIS (March 31). The CHC-MCO continues to be financially responsible for the stay including the physician, DME, and all other Covered Services.
MA FFS Coverage Responsibility	There would be no FFS coverage in this example.

RULE: E-4b.	
Condition	A Participant covered by a CHC-MCO when admitted to a hospital <u>loses and regains Medical Assistance eligibility while in the hospital (Participant is not discharged)</u>, resulting in a break in CHC-MCO coverage. DMCSS does <u>not</u> become aware of the break in CHC-MCO coverage by the end of the month following the month in which it is lost.
CHC-MCO Coverage Responsibility	<p>Example:</p> <p>Same as in RULE: E-4a except, because DMCSS is not aware of the break in CHC-MCO coverage by the end of the month following the month in which it was lost, the CHC-MCO coverage is not reopened retroactive to the day it was end-dated on CIS (March 31). The CHC-MCO is only responsible to cover the Participant through the end of March.</p>
MA FFS Coverage Responsibility	FFS is responsible effective April 1.

RULE: E-4c.	
Condition	A Participant covered by a CHC-MCO when admitted to a hospital <u>loses Medical Assistance eligibility while in the hospital (Participant is not discharged)</u>. The Participant regains Medical Assistance eligibility retroactively after the month following the month in which the Medical Assistance eligibility was ended, regardless of when DMCSS became aware of the action.

CHC-MCO Coverage Responsibility	<p>Example:</p> <ul style="list-style-type: none"> • A Participant who is admitted to the hospital on March 10 loses Medical Assistance eligibility effective March 22. The Participant regains Medical Assistance eligibility on May 15 retroactive to March 22. The CHC-MCO coverage on CIS shows the Participant was end-dated March 31 and reopened in the CHC-MCO with a new begin date of May 15. • Because the Medical Assistance eligibility was not reopened within the month following the month in which it was lost, the CHC-MCO coverage is not reopened retroactive to the day it was end-dated on CIS (March 31). The CHC-MCO is only responsible to cover the Participant through the end of March.
MA FFS Coverage Responsibility	FFS is responsible effective April 1.

RULE: E-4d.	
Condition	A Participant covered by a CHC-MCO when admitted to a hospital loses Medical Assistance eligibility while in the hospital. The Participant <u>is discharged</u> from the hospital after the month in which the Medical Assistance eligibility was lost but <u>before</u> the Medical Assistance eligibility is regained by the Participant and reopened retroactively, regardless of when DMCSS became aware of the situation.
CHC-MCO Coverage Responsibility	<p>Example:</p> <ul style="list-style-type: none"> • A Participant who is admitted to the hospital on March 10 loses Medical Assistance eligibility effective March 22. The Participant is discharged from the hospital April 3. The Participant regains Medical Assistance eligibility on April 22 retroactive to March 22. The CHC-MCO coverage on CIS shows the Participant was end-dated March 31 and reopened in the CHC-MCO with a new begin date of April 22. • Because the Participant <u>was discharged</u> from the hospital before the Medical Assistance eligibility was reopened, which resulted in a 3-day period of FFS coverage on CIS, DMCSS does not reopen the CHC-MCO coverage retroactive to April 1. The CHC-MCO is only responsible for the stay through the end of March.
MA FFS Coverage Responsibility	FFS is responsible effective April 1.

RULE: E-4e.	
Condition	A hospitalized Participant never regains Medical Assistance eligibility.

CHC-MCO Coverage Responsibility	If the Participant is never determined retroactively eligible for MA, the CHC-MCO is only responsible to cover the Participant through the end of the month in which Medical Assistance eligibility ended.
MA FFS Coverage Responsibility	FFS is not responsible for coverage since the Participant has not regained Medical Assistance eligibility .

E. Other Causes for Coverage Termination and Involuntary Disenrollment. - If a condition described in the following sections occurs, the CHC-MCO must notify the Department. In accordance with Department's disenrollment guidelines, DMCSS will take action to disenroll the Participant. The Department will recoup payments back to the month following the month in which the termination of coverage occurred, for up to twelve (12) months afterwards (i.e. today's date is 9/18/17 and central office staff end date managed care coverage 9/30/17 – payments are recouped for 10/17 through 9/18).

If a Participant is placed in a setting listed in these sections, and is under FFS prior to the CHC-MCO's begin date, CHC-MCO coverage will be voided and adjustments will be processed for any Capitation payments made.

<p>The CHC-MCO must notify the Department within sixty (60) days following the satisfaction of the Department's disenrollment guidelines in order for the Division of Managed Care System Supports (DMCSS) to end-date the Participant's enrollment. Failure on the part of the CHC-MCO to notify DMCSS within the sixty (60) days will result in the end-date being delayed, thereby extending the CHC-MCO's responsibility for covering the Participant. The CHC-MCO should not hold and then later submit the notifications.</p> <p>RULE: F-1.</p>	
Condition	<p>A. A Participant who is covered by a CHC-MCO when admitted to a Nursing Facility transfers to another CHC-MCO or to FFS during the thirty (30) day period.</p> <p>B. A Participant is admitted to an out of state Nursing Facility (regardless of who places the Participant in the facility).</p> <p>C. A Participant is admitted to a Veteran's Home (MA Provider type/specialty 03/042).</p>

CHC-MCO Coverage Responsibility	<p>B. The CHC-MCO is not responsible for Participants who are placed in a Nursing Facility outside of Pennsylvania. A Participant who is placed in an out of state Nursing Facility is disenrolled from the CHC-MCO the day before the admission date.</p> <p>C. The CHC-MCO is not responsible for Participants who are admitted to a Veteran's Home. A Participant who is admitted to a Veteran's Home is disenrolled from the CHC-MCO the day before the admission date.</p>
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RULE: F-3.	
Condition	A Participant is admitted to a State Facility (MA Provider Type/Specialty Codes 01/23 - Public Psychiatric Hospital and 03/37 - State LTC Unit located at State Mental Hospitals).
CHC-MCO Coverage Responsibility	The CHC-MCO is not responsible for Participants in a state facility. A Participant admitted to a state facility is disenrolled from the CHC-MCO the day before the admission date.
MA FFS Coverage Responsibility	FFS coverage is effective on the admission date.

RULE: F-4.	
Condition	A Participant is incarcerated in a Penal Facility, Correctional Institution (including work release), or Youth Development Center.
CHC-MCO Coverage Responsibility	The CHC-MCO is not responsible for coverage since the Participant is no longer eligible for Medical Assistance upon placement in a correctional facility. The Participant is disenrolled from the CHC-MCO effective the day before incarceration in the facility or institution.
MA FFS Coverage Responsibility	FFS is not responsible for coverage since the Participant is no longer eligible for Medical Assistance upon placement in a correctional facility, except for inpatient hospital services.
NOTE:	This rule is based upon section 392.2 of the Medical Assistance Eligibility Handbook which states,
	"For purposes of MA eligibility, other than eligibility for inpatient hospital services, the needs of an inmate in a correctional institution are the responsibility of the governmental authority exercising administrative control over the facility."

RULE: F-7.	
Condition	<p>A Participant is enrolled in the Living Independence for the Elderly Program (LIFE) (MA Provider Type/Specialty Code 07/70 – LIFE)</p> <p>LIFE is Pennsylvania’s managed care demonstration for Nursing Facility eligibles. It provides for long term care needs of frail elderly Participant who wish to remain independent in their community but require intensive, integrated primary and psychosocial care to do so.</p>
CHC-MCO Coverage Responsibility	A Participant enrolled in LIFE is disenrolled from the CHC-MCO effective the day before the begin date of LIFE.
MA FFS Coverage Responsibility	LIFE Coverage begins the day after the disenrollment date.

- E. **Other Facility Placement Coverage.** - Refer to the following sections for rules concerning CHC-MCO coverage of Participants placed in other facilities.

RULE: G-4.	
Condition	<p>A Participant is admitted to an Extended Acute Psychiatric Care Hospital (MA Provider Type/Specialty Code 01/18 – Extended Acute Psych Inpatient Unit)..</p>
CHC-MCO Coverage Responsibility	<p>A Participant admitted to an extended acute psychiatric hospital remains covered by the selected CHC-MCO for all Covered Services.</p> <ul style="list-style-type: none"> • If the Participant is placed in the facility by the BH-MCO, then the BH-MCO is responsible for the residential/treatment costs.
MA FFS Coverage Responsibility	FFS is responsible for the residential/treatment costs.

RULE: G-5.	
Condition	<p>A Participant is admitted to an Inpatient Private Psychiatric Facility (MA Provider Type/Specialty Code 01/11 – Private Psychiatric Hospital and 01/22 – Private Psychiatric Unit).</p>
CHC-MCO Coverage Responsibility	<p>A Participant admitted to a private psychiatric hospital remains covered by the selected CHC-MCO for all Covered Services.</p> <ul style="list-style-type: none"> • The BH-MCO is responsible for the residential/treatment costs.
MA FFS Coverage Responsibility	FFS is responsible for the residential/treatment costs.

EXHIBIT Q

DATA SUPPORT FOR CHC-MCOs

Each CHC-MCO will be required to connect to the Department's Network for the purpose of on-line inquiries, intranet access and file transfers. Specifications and limited technical assistance will be made available. No information made available to the CHC-MCO is to be used for any purpose other than supporting their program under CHC. Access to the Department's Network will continue for the functions not included under PROMISe™.

The CHC-MCOs will be required to adhere to Department requirements and HIPAA transactions. Each CHC-MCO will need to be certified through PROMISe™ prior to implementing any data exchange. The Department will provide training on the use and interpretation of information found on the system.

DHS INQUIRY ACCESS:

1. Client Information System (CIS)

The Department will make available to each CHC-MCO access to the Department's CIS database. This database provides eligibility history, demographic information, and TPL information to support the CHC-MCO in meeting their obligations.

2. Intranet

The Department will make available to each CHC-MCO access to the Department's intranet supporting CHC.

3. DHS Internet

Each CHC-MCO will have access to the Department's internet at www.dhs.pa.gov.

PROMISe™ INQUIRY ACCESS:

1. Eligibility Verification System (EVS)

All CHC-MCOs will be provided access to EVS. EVS can be used to verify eligibility, MCO coverage and TPL information. Access will be via the following methods:

- Toll-free via an Automated Voice Response System (AVRS).
- Web access to a Bulletin Board System (BBS).
- Toll free via Provider Electronic Solutions software or point of service (POS) device.
- Internet.
- Provider Portal.
- Direct line/VAN.

2. On-Line Inquiry

Access to the following on-line screens will be made available to the CHC-MCOs:

- Provider.
- Reference.
- Participant Eligibility Verification.
- Claims.
- Prior Authorization.

DATA FILES:

Following are the descriptions of the data files that will be provided to the CHC-MCO by the IEE, or by the Department; the data files that the CHC-MCO will be required to submit to the IEE or the Department; and the files that the IEE will be required to provide to the Department. Additional files may be made available upon request. File layouts and schedules can be found on the Intranet supporting CHC.

FILES AND REPORTS PROVIDED TO THE CHC-MCO:

NAME	PURPOSE	FREQUENCY
834 Daily Participant File	HIPAA compliant file of any change affecting a Participant's demographic, eligibility and enrollment data and TPL information for that day.	Daily
834 Monthly Participant File	HIPAA compliant file containing one record for each Participant who is both Medical Assistance and CHC eligible at some point in the following month as of the date that the file is generated.	Monthly
Weekly Enrollment/Alert Reconciliation File	File of the disposition of each record submitted on the Weekly Enrollment/Alert Reconciliation File of enrollments and alerts.	Weekly
Pending Enrollment File	File from the IEE that provides the CHC-MCOs with pre-enrollment data.	Weekly
Response to the Automated Provider Directory	A response file (from the IEE) to the Automated Provider Directory that is posted each time a file has been processed.	Weekly
ARM 568 Report File	Report file of CIS eligibility statistics by county/district.	Monthly - Optional

DHS Casualty and Estate Encounter Data File Request	TPL file of Participants for every CHC-MCO where TPL needs adjudicated encounter claims information.	Daily - Urgent
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NAME	PURPOSE	FREQUENCY
CHC-MCO Electronic Resource Error File	TPL file of records returned by DHS due to errors.	Weekly
CMS Drug Product Data File	Listing of CMS approved drugs covered by Medicaid.	Quarterly
Response to PCP File	Report of records returned by PROMISE due to error.	Weekly
Procedure Code Extract	The Procedure Code File contains five files within the zip file: Modifier Max Fee, Procedure Code, Provider Type, Restricted, and Related.	Monthly
Diagnosis Code File	Diagnosis Code File to assist in the coding of Claims and Encounter Data.	Monthly
820 Capitation Payment File	HIPAA compliant file reflecting Capitation payments and adjustments processed for eligible Participants.	Monthly
835 Remittance Advice File	HIPAA compliant file of all gross adjustments that processed.	Weekly
MCO Payment Summary File	Summary file of capitation payments by county group, rate cell and date of service up to 36 months.	Monthly
List of Active and Closed Providers (PRV-415)	File of enrolled Medical Assistance Providers in Pennsylvania and the surrounding states and Providers closed within the last 90 days.	Monthly
List of Active and Closed Providers (PRV-414)	File of enrolled Medical Assistance Providers in Pennsylvania and the surrounding states and Providers closed within the last 90 days.	Weekly
NPI Crosswalk File (PRV-430)	File of Providers that registered their NPI number with the Department.	Weekly
Special Indicator File (PRV-435)	File of Provider/service locations and special indicators to identify those Providers eligible for the enhanced payments.	Weekly
CHC-MCO Provider Error Report	Report of CHC-MCO Provider records returned by DHS due to error.	Monthly
The Annual Refresh File	The file contains TPL data for anyone who has been in managed care any time in the last two years.	Annual

TPL Service Class and Matrix	This file contains HCPCS procedure service class and coverage codes. It is used to determine coverage, cost avoidance, and benefit recovery for a particular service on a claim.	Monthly
Daily EDI Claims Submission Statistics	Summary report providing EDI encounter totals sent to the PROMISe™ claims engine by submission type, listing counts of accepted, rejected, and suspended encounters submitted during the day.	Daily
Weekly EDI Claims Submission Statistics	Summary report providing EDI encounter totals sent to the PROMISe™ claims engine by submission type, listing counts of accepted, rejected, and suspended encounters submitted during the week.	Weekly
Monthly EDI Claims Submission Statistics	Summary report providing EDI encounter totals sent to the PROMISe™ claims engine by submission type, listing counts of accepted, rejected, and suspended encounters submitted during the month.	Monthly
Record Accept/Reject Report	Report sent from the translator in response to incoming HIPAA transaction files from the CHC-MCOs.	Daily/After Each Submission
U277	HIPAA transaction generated from PROMISe™ at the end of each processing day, providing a limited data set of all accepted, suspended, and rejected encounters during that Business Day's processing.	Daily
NCPDP Response	HIPAA transaction generated from PROMISe™ providing a limited data set of all accepted and rejected drug encounters per file submission.	Daily
Record Accept/Reject File	Flat file sent from the translator in response to incoming HIPAA transaction files from the CHC-MCOs.	Daily
Monthly Rejected Encounter Activity Report	Report sent to the CHC-MCOs providing a summary/counts of all encounters remaining uncorrected in the suspense database at a given month's end.	Monthly
997 BES Report	Provided by the BES Translator. Sent to the Submitter when the entire file is rejected for invalid HIPAA formats.	Daily
FFS Pharmacy Files	Pharmacy data from FFS to the CHC, PH, and BH plans.	Weekly

Reapplication File	File of Participants who have Medical Assistance reapplication and SAR (Semi Annual Reporting) due dates that are 90 days in advance of the run date.	Monthly
Quarterly Network Provider File	File of Network Providers returned to the MCO.	Quarterly
TPL Monthly File	This file provides the MCOs with TPL information from DHS's TPL database specific to their Participants.	Monthly
Service History Data Files	Files containing service history data (FFS and encounters) for enrolled Participants from the DHS data warehouse.	Weekly

FILES PROVIDED BY THE CHC-MCO:

NAME	PURPOSE	FREQUENCY
CHC-MCO Network Provider File (PRV640)	File provided listing all Providers within the Network to serve Participants.	Monthly
PCP File	File provides the PCP assignments for all Participants.	Weekly
CHC-MCO Casualty /Estate Claims File	TPL file of adjudicated claims for Participants on DHS for use in casualty/estate recoveries.	Weekly, sometimes daily
CHC-MCO Recovery Flagging File	TPL file provides DHS with a list of encounters on which the CHC-MCO intends to pursue recovery.	Monthly/Weekly
CHC-MCO Reconciliation File	TPL file provides DHS with a list of encounters on which the CHC-MCO has realized a recovery, been denied by the third party, or has abandoned recovery activity.	Monthly/Weekly

CHC-MCO Electronic Resource File	TPL file provides the CHC-MCOs with a process to send both new and updated resource referrals electronically in batch format to DHS for update to the TPL file.	Weekly
NAME	PURPOSE	FREQUENCY
837P, 837I, 837D, NCPDP	HIPAA compliant file submitted by the CHC-MCO providing the Department with Encounter Data for all CHC-MCO Participants.	As Scheduled
NCPDP Supplemental File	A file containing supplemental data for NCPDP transactions used for the purpose of drug rebate dispute resolution.	Monthly
Weekly Enrollment/ Alert File	File provided to notify the Department of return mail, newborns not in CIS, a Participant's pregnancy not reflected in CIS, or a deceased Participant with no Date of Death reflected in CIS.	Weekly
Automated Provider Directory File	File contains information on all Providers in the Network for the CHC-MCO. The information will be used by the IEE for their Electronic (On-line) Provider Directory.	Weekly
CHC/PH/BH Pharmacy File	Pharmacy data from the physical health plans to the behavioral health plans.	Submission based on schedule developed by the CHC-MCO (at least twice per month).
Insure Kids Now—Dental Provider Data File	A quarterly file provided by the MCOs to DHS containing select information about their Dental Providers.	Quarterly

EXHIBIT R

CHC-MCO PARTICIPANT HANDBOOK

The CHC-MCOs must adhere to the following guidelines and all the requirements, in section V.0.4, Limited English Proficiency (LEP) requirements, V.O.5, Alternate Format Requirements, and V.O.16, Participant Handbook, of the agreement. The CHC-MCO must provide a Participant handbook in the appropriate prevalent language, or alternate format, to all Participants within five (5) business days of being notified of a Participant's Enrollment, but no sooner than five (5) business days before the Participant's effective date of Enrollment. The CHC-MCO may provide the Participant handbook in formats other than hard copy. If this option is exercised, the CHC-MCO must inform Participants what formats are available and how to access each. Upon request, the CHC-MCO must provide a hard copy version of the Participant handbook to the Participant.

At a minimum, the Participant handbook shall include:

1. Information about the CHC-MCO, its Covered Services, excluded services, the practitioners providing care, and the Participant's rights and responsibilities as outlined in this Agreement and Exhibit FF.
2. Role of the PCP in directing and managing care and as a Participant advocate.
3. Information on the role of the IEE and how to access services, including but not limited to, what services they provide to the Participant and contact information.
4. Description of services which should include assistance with changing CHC-MCOs, PCPs, and the right to request an updated Provider directory.
5. How to access after-hour, non-emergency care.
6. Description of the CHC-MCO ID card and the ACCESS card and their uses.
7. Statement that no balanced billing is allowed, Participants are not to be balanced billed by Providers, and are to be held harmless for any bills the CHC-MCO declines to pay, and a statement of what steps to take in the event the Participant is billed or balance billed.
8. Information about the right to file a grievance or appeal, about the right to contact the Long-Term Care ombudsman, and about how to contact Protective Services (to assist those at risk for abuse, neglect, financial exploitation and abandonment).
9. Information about co-payments, Prior Authorization, service limits, and the Covered Services exception process.

10. An explanation of the Participant's financial responsibilities for payment of services provided by a Non-participating Provider, when an item or service that requires Prior Authorization is provided by a Provider without Prior Authorization being obtained, or when an item or service is provided that is not covered by the CHC-MCO.
 - An explanation that prescriptions for medications that are written by Non-participating Providers (whether or not they are presented at a participating or non-participating pharmacy) will be the Participant's responsibility with the following exceptions:
 - o The Non-participating/non-network Provider arrangements were approved in advance by the CHC-MCO and any prior authorization requirements (if applicable) were met;
 - o The Non-participating/non-network prescriber and the pharmacy are the Participant's Medicare Providers; or
 - o The Participant is covered by a third party carrier and the Non-participating/non-network prescriber and the pharmacy are the Participant's third party Providers.
11. Information that the Participant is not liable for payment of Covered Services provided when a Pennsylvania Medical Assistance participating healthcare Provider does not receive payment from the CHC-MCO.
12. Rights of the Participant regarding confidentiality of their medical records.
13. Rights of the Participant to request and receive a copy of his or her medical records and to request that they be corrected or amended as specified in 45 CFR Parts 164.524 and 164.526.
14. Rights of Participants to receive information regarding the patient payment responsibilities related to Nursing Facility services.
15. Information on the availability of and how to access or receive assistance in accessing, at no cost to the Participant, oral interpretation services for all services provided by the CHC-MCO for all non-English languages. The CHC-MCO must make vital documents disseminated to English-speaking Participants available in alternative languages, upon request of the Participant. Documents may be deemed vital if related to the access of LEP persons to programs and services.
16. Availability of and information on how to access or receive assistance in accessing, at no cost to the Participant, communication methods including TTY and relay services and materials in an alternate format such as Braille, audio tape, large print, compact disc (CD), DVD, computer diskette, and/or electronic communication including how the CHC-MCO will arrange for providing these alternate format Participant materials.
17. Table of contents.

18. Information about choosing and changing PCPs.
19. Information about choosing a primary dentist, if applicable.
20. Information on how to request a specialist as a PCP or a standing referral to a specialist.
21. Information on availability of specialists.
22. Information about dual eligibles' right to access Medicare providers for Medicare services regardless of whether the Medicare providers are in the CHC-MCO network and without having to obtain prior approval from the CHC-MCO for Medicare covered services.
23. Information about what to do when family size, address or phone number changes.
24. Information regarding appointment standards.
25. Information regarding Medical Assistance Participants' rights and CHC-MCOs' responsibilities per Section 1867 of the Social Security Act.
26. A description of all available covered services, including how to access those services, which services require Prior Authorization, and an explanation of any service limitations or exclusions from coverage, including an explanation that limitations and most exclusions do not apply to Participants under the age of 21, specific instructions on how transportation is provided, and a notice stating that the CHC-MCO will be liable only for those services that are the responsibility of the CHC-MCO.
27. A description of the services not covered if the CHC-MCO elects not to provide, reimburse for, or provide coverage of, a counseling or referral service because of an objection on moral or religious grounds.
28. Information on how to request guidelines, including utilization review and clinical practice guidelines.
29. An explanation of the procedures for obtaining benefits, including self-referred services, services requiring Prior Authorization, services requiring a Covered Service Limit Exception request, if applicable, and services requiring a referral.
30. How to contact Participant Services, the Nurse Hotline, the Service Coordinator unit and a description of their functions.
31. Information regarding the Complaint, Grievance and DHS Fair Hearing processes, as set forth in the CHC Participant handbook Template for Complaints, Grievances and Fair Hearings, and the right to interim relief within the relevant time frames of the process (55 PA Code

Section 275.4(d).

32. An explanation of how to obtain a list of all available PCPs, specialists, pharmacies, and Providers of ancillary services, upon request, in the appropriate alternate format or language.
33. What to do in case of an Emergency Medical Condition and instructions for receiving advice on care in case of an emergency. The Participant handbook should instruct Participants to use the emergency medical services (EMS) available and/or activate EMS by dialing 9-1-1 in a life-threatening situation.
34. How to obtain non-medical transportation, emergency transportation and Medically Necessary transportation. Provide the names and telephone numbers for county MATP Providers.
35. How and where to access Behavioral Health, Family Planning and vision services.
36. Information on how to obtain prescription drugs, including information on the CHC-MCO's formulary and how to request a copy and how to obtain assistance with and benefit of enrolling in a Medicare Part D plan with a zero copay.
37. Information on what to do regarding out of county/out of state moves.
38. Wellness behaviors and activities the Participant can engage in to improve his/her own health such as diet, exercise, and age-appropriate vaccinations and screenings.
39. Information regarding pregnancies which conveys the importance of prenatal care and continuity of care to promote optimum care for mother and infant. The concept of remaining with the same CHC-MCO for the entire pregnancy will be advocated.
40. Notification that the selection of certain PCP sites may result in medical residents, nurse practitioners and physicians assistants providing care to Participants.
41. Information regarding the availability of second opinions and when and how to access them.
42. Information regarding the right to receive services from an Out-of-Network Provider when the CHC-MCO cannot offer a choice of two qualified specialists, and an explanation of how to request authorization for out-of-network services and how to appeal an Adverse Action such as a denial of Covered Services.
43. Information on the availability and process for accessing Medical Assistance Out-of-Plan Services which are not the responsibility of the CHC-MCO, but

are available to Participants.

44. Information regarding the Women's, Infants' and Children (WIC) Program and how to access the program.
45. Information regarding HIV/AIDS Programs and how to access them.
46. Information on Tobacco Cessation Programs and how to access them.
47. Information about Estate Recovery.
48. Information about LTSS.
49. Information about Assessment, Reassessment, and PSCP processes.
50. Information about Service Coordination.
51. Information on advance directives (durable healthcare power of attorney and living wills) for adult Participants including:
 - a. The description of State law, if applicable.
 - b. The process for notifying the Participant of any changes in applicable state law as soon as possible, but no later than ninety (90) days after the effective date of the change.
 - c. Any limitation the CHC-MCO has regarding implementation of advanced directives as a matter of conscience.
 - d. The process for Participants to file a Complaint concerning noncompliance with the advanced directive requirements with the CHC-MCO and the State survey and certification agency.
 - e. How to request written information on advance directive policies.
52. A statement that all Participants will be treated with respect and due consideration for their dignity and privacy.
53. A statement that Participants may receive, from a Provider, information on available treatment options and alternatives, presented in a manner appropriate to the Participant's condition and ability to understand.
54. A statement that Participants have the right to participate in decisions regarding their healthcare, including the right to refuse treatment.
55. A statement that Participants are guaranteed the right to be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience, or retaliation.
56. A statement that each Participant is free to exercise his or her rights and that the exercise of those rights does not adversely affect the way the CHC-MCO and its Providers or the state agency treat the Participant.
57. Explanation of CHC-MCO's and Participant Restriction Program including Community HealthChoices Agreement Effective January 1, 2017

how to request a DHS Fair Hearing regarding a restriction action and how to request a change of pharmacy or Provider.

58. The Department's Medical Assistance Provider Compliance Hotline number and explanatory statement.
59. A statement outlining the expanded or value-added services the CHC-MCO has been approved by DHS to provide and the guaranteed period in which those services must be available to participants.
60. How Participants can become involved in CHC-MCO advisory committees.
61. Procedures for disenrolling from the CHC-MCO;
62. Procedures for recommending changes in policies and services.

EXHIBIT S PROVIDER DRECTORY

A) Provider Directory

The CHC-MCO shall be required to provide its Participants with a Provider directory upon request. The CHC-MCO must adhere to the following guidelines, and all the requirements, in Section V.O.17, Provider Directory of the Agreement. The Directory must include at a minimum, the following information about PCPs:

- The names, addresses, and telephone numbers of participating PCPs.
- The hospital affiliations of the PCP.
- Identification of whether the PCP is a Doctor of Medicine or Osteopathy.
- Identification of whether PCPs are board-certified and, if so, in what area(s).
- Identification of PCP Teams which include physicians, Certified Registered Nurse Practitioners (CRNPs), Certified Nurse Midwives and physicians' assistants.
- Indication of whether dentist is DDS or DMD, and whether dentist is a periodontist.
- Identification of whether dentist possess anesthesia certificates.
- Identification of whether the dentist is able to serve adults with developmental disabilities.
- Identification of languages spoken and communication competencies by healthcare Providers at the primary care and dental sites.
- Identification of sites which are wheelchair accessible.
- Identification of the days of operation and the hours when the PCP or dentist office is available to Participants.

The CHC-MCO, at the request of the PCP or dentist, may include the PCP's or dentist's experience or expertise in serving individuals with particular conditions.

The directory shall include specialists and Providers of ancillary services in the directory, which shall, at a minimum, the following information:

- The names, addresses and telephone numbers of specialists and their hospital affiliations.
- Identification of the specialty area of each specialist's practice.
- Identification of whether the specialist is board-certified and, if so, in what area(s).
- Experience or expertise in serving individuals with particular conditions.
- Identification of special services, languages spoken and communication competencies, etc.

The directory shall include LTSS Providers in the directory, which shall, at a minimum, the following information:

- The names, addresses and telephone numbers of LTSS Providers.
- Identification of the services provided by each LTSS Provider listed.
- Identification of special services, languages spoken and communication competencies, etc.
- Experience or expertise in serving individuals with particular conditions.

EXHIBIT T

COMPLAINT, GRIEVANCE AND DHS FAIR HEARING PROCESSES

A. General Requirements

1. The CHC-MCO must obtain the Department's prior written approval of all Complaint, Grievance and DHS Fair Hearing policies and procedures.
2. The CHC-MCO may not charge Participants a fee for filing a Complaint or Grievance at any level of the process.
3. The CHC-MCO must have written policies and procedures for registering, responding to and resolving Complaints and Grievances (at all levels) as they relate to the Medical Assistance population and must make these policies and procedures available upon request.
4. The CHC-MCO must maintain written documentation of each Complaint and Grievance and the actions taken by the CHC-MCO.
5. The CHC-MCO must provide Participants with access to all relevant documentation pertaining to the subject of the Complaint or Grievance.
6. The CHC-MCO must have a data system to process, track and trend all Complaints and Grievances, and submit data to the Department.
7. The CHC-MCO must have a link between the Complaint and Grievance processes and the Quality Management and Utilization Management Programs.
8. The CHC-MCO must designate and train sufficient staff to be responsible for receiving, processing, and responding to Participant Complaints and Grievances in accordance with the requirements in this Exhibit.
9. CHC-MCO 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.
10. The CHC-MCO may not use the timeframes or procedures of the Complaint and Grievance process to avoid the decision process or to discourage or prevent the Participant from receiving Covered Services in a timely manner.
11. The CHC-MCO must accept Complaints and Grievances from individuals with disabilities which are in alternative formats including: TTY/TDD for telephone inquiries and Complaints and Grievances from Participants who are hearing impaired; Braille; tape; or computer disk; and other commonly accepted alternative forms of communication. The CHC-MCO must make its employees who receive telephone Complaints and Grievances aware of the speech limitation of Participants with disabilities so they can treat these individuals with

patience, understanding, and respect.

12. The CHC-MCO must provide Participants assistance in presenting their case at Complaint or Grievance reviews at no cost to the Participant. This includes:
 - Providing qualified sign language interpreters for Participants who are severely hearing impaired.
 - Providing information submitted on behalf of the CHC-MCO at the Complaint or Grievance review in an alternative format accessible to the Participant filing the Complaint or Grievance. The alternative format version should be supplied to the Participant at or before the review, so the Participant can discuss and/or refute the content during the review. Providing personal assistance to Participants with other physical limitations in copying and presenting documents and other evidence.
13. The CHC-MCO must provide language interpreter services when requested by a Participant, at no cost to the Participant.
14. The CHC-MCO must offer Participants the assistance of a CHC-MCO staff member throughout the Complaint and Grievance processes at no cost to the Participant.
15. The CHC-MCO must require 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.
16. The CHC-MCO must notify the Participant when the CHC-MCO fails to decide a first level Complaint or first level Grievance within the time frames specified in this Exhibit, using the required template. The CHC-MCO must mail this notice one day following the date the decision was to be made.
17. The CHC-MCO must notify the Participant when it denies payment after a service has been delivered because the service or item was provided without authorization by a Provider not enrolled in the Pennsylvania Medical Assistance Program using the required template (template U(11)). Templates located on the CHC Intranet site. The CHC-MCO must mail this notice to the Participant on the day the decision was made to deny payment.
18. The CHC-MCO must notify the Participant when it denies payment after a service has been delivered because the service or item provided is not a Covered Service for the Participant, using the required template (template U(12)). The CHC- MCO must mail this notice to the Participant on the day the decision is made to deny payment.
19. The CHC-MCO must notify the Participant when it denies payment after a service has been delivered because the CHC-MCO determined that the service was not Medically Necessary, using the required template. The CHC-MCO must mail this notice to the Participant on the day the decision is made to deny payment.

20. The CHC-MCO must, at a minimum, hold in-person reviews of Complaints and Grievances (at all levels) at one location within each of its zones of operation. If a Participant requests an in-person review, the CHC-MCO must notify the Participant of the location of the review and who will be present at the review using the required template (template U(14)).
21. The CHC-MCO must ensure that any location where it will hold in-person reviews is physically accessible for persons with disabilities.
22. The CHC-MCO must use the templates (template U(1) through U(14) which are available on the intranet supporting CHC).

B. Complaint Requirements

1. First Level Complaint Process

- a. A CHC-MCO must permit a Participant or Participant's representative, which may include the Participant's Provider, with proof of the Participant's written authorization for the representative to be involved and/or act on the Participant's behalf, to file a Complaint either in writing or orally. The CHC-MCO must commit oral requests to writing if not confirmed in writing by the Participant. The CHC-MCO must provide the written confirmation to the Participant or the Participant's representative 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. If the Complaint disputes the failure of the CHC-MCO to decide a Complaint or Grievance within the specified time frames; challenges the failure to meet the required time frames for providing a service/item; disputes a denial made for the reason that a service/item is not a covered benefit; disputes a denial of payment after the service(s) has been delivered because the service/item was provided without authorization by a Provider not enrolled in the Pennsylvania Medical Assistance Program; or disputes a denial of payment after a service(s) has been delivered because the service/item provided is not a covered benefit for the Participant, the Participant must file a Complaint within forty-five (45) days from the date of the incident complained of or the date the Participant receives written notice of the decision. For all other Complaints, there is no time limit for filing a Complaint.
- b. The CHC-MCO must provide Participants with a toll free number to file a Complaint, request information about the Complaint process, and ask any questions the Participant may have about the status of a Complaint.
- c. If a Participant files a Complaint to dispute a decision to discontinue, reduce, or change a service/item that the Participant has been receiving on the basis that the service/item is not a covered benefit, the Participant must continue to receive the disputed service/item at the previously authorized level pending resolution of the Complaint, if the Complaint is hand delivered or post-marked within ten (10) days from the mail date on the written notice of decision.

- d. Upon receipt of the Complaint, the CHC-MCO shall send the Participant and Participant's representative, if any, an acknowledgment letter using the template (templates U(2a) and U(2b)).
- e. The first level Complaint review for Complaints **not involving** a clinical issue shall be performed by a first level Complaint review committee, which shall include one or more employees of the CHC-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 shall be performed by a first level Complaint review committee, which shall include one or more employees of the CHC-MCO who were not involved in any previous level of review or decision making on the issue that is the subject of the Complaint. The Complaint review committee must include a licensed physician in the same or similar specialty that typically manages or consults on the service/item in question. Other appropriate Providers may participate in the review, but the licensed physician must decide the Complaint.
- g. The Participant must be afforded a reasonable opportunity to present evidence, and allegations of fact or law, in person as well as in writing. The CHC-MCO shall be flexible when scheduling the review to facilitate the Participant's attendance. The Participant shall be given at least seven (7) days advance written notice of the review date. If the Participant cannot appear in person at the review, the CHC-MCO must provide an opportunity to communicate with the first level Complaint review committee by telephone or video conference. The Participant may elect not to attend the first level Complaint meeting but the meeting must be conducted with the same protocols as if the Participant was present.
- h. If a Participant requests an in-person first level Complaint review, at a minimum, a member of the first level Complaint review committee must be physically present at the location where the first level Complaint review will be held and the other members of the first level Complaint review committee must participate in the review through the use of video conferencing.
- i. The first level Complaint review committee shall complete its review of the Complaint as expeditiously as the Participant's health condition requires, but no more than thirty (30) days from receipt of the Complaint, which may be extended by fourteen (14) days at the request of the Participant.
- j. 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.
- k. The CHC-MCO must send a written notice of the first level Complaint decision, using the required template, to the Participant, Participant's representative, if any, service Provider and prescribing PCP, if applicable, within five (5) business days from the first level Complaint review committee's decision.

- i. The Participant or the Participant's representative, with proof of the Participant's written authorization for the representative to be involved and/or act on the Participant's behalf, may file a request for a second level Complaint review ("second level Complaint") within forty-five (45) days from the date the Participant receives written notice of the CHC-MCO's first level Complaint decision.
- m. If the Complaint disputes the failure of the CHC-MCO to provide a service/item or to decide a Complaint or Grievance within specified time frames or disputes a denial made for the reason that a service/item is not a covered benefit, or disputes a denial of payment after a service(s) has been delivered because the service/item was provided without authorization by a Provider not enrolled in the Pennsylvania MA Program; or disputes a denial of payment after a service(s) has been delivered because the service/item provided is not a covered benefit for the Participant, the Participant may file a request for a DHS Fair Hearing within thirty (30) days from the mail date on the written notice of the CHC-MCO's first level Complaint decision.

2. **Second Level Complaint Process**

- a. Upon receipt of the second level Complaint, the CHC-MCO shall send the Participant and Participant's representative, if any, an acknowledgment letter using the required template (template U(4)).
- b. If a Participant files a second level Complaint to dispute a decision to discontinue, reduce, or change a service/item that the Participant has been receiving on the basis that the service/item is not a covered benefit, the Participant must continue to receive the disputed service/item 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 (10) days from the mail date on the written notice of the CHC-MCO's first level Complaint decision.
- c. The second level Complaint review shall be performed by a second level Complaint review committee made up of three (3) or more individuals who were not involved in any previous level of review or decision-making on the matter under review.
- d. At least one-third of the second level Complaint review committee may not be employees of the CHC-MCO or a related subsidiary or Affiliate.
- e. A committee member who does not personally attend the second level Complaint review may not be part of the decision-making process unless that member actively participates in the review by telephone or video conference and has the opportunity to review all information introduced during the review.
- f. The Participant must be provided the opportunity to appear before the second level Complaint review committee. The CHC-MCO shall be flexible when scheduling the second level Complaint review to facilitate the

Participant's attendance. The Participant shall be given at least fifteen (15) days advance written notice of the review date. If the Participant cannot appear in person at the second level Complaint review, the CHC-MCO must provide the opportunity to communicate with the second level Complaint review committee by telephone or video conference. The Participant may elect not to attend the second level Complaint meeting but the meeting must be conducted with the same protocols as if the Participant was present.

- g. If a Participant requests an in-person second level Complaint review, at a minimum, a member of the second level Complaint review committee must be physically present at the location where the second level Complaint review will be held and the other members of the second level Complaint review committee must participate in the review through the use of video conferencing.
- h. The decision of the second level Complaint review committee must be based solely on the information presented at the review.
- i. The second level Complaint review committee shall complete the second level Complaint review within forty-five (45) days from the CHC-MCO's receipt of the Participant's second level Complaint.
- j. Testimony taken by the second level Complaint review committee (including the Participant'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.
- k. The CHC-MCO must send a written notice of the second level Complaint decision, using the required template (template GG(5)) to the Participant, Participant's representative, if any, service Provider and prescribing Provider, if applicable within five (5) business days from the second level Complaint review committee's decision.
- l. The Participant or the Participant's representative, with proof of the Participant's written authorization for the representative to be involved and/or act on the Participant's behalf, may file a request for an external review of the second level Complaint decision with either the DOH or the PID within fifteen (15) days from the date the Participant receives the written notice of the CHC-MCO's second level Complaint decision.
- m. If the second level Complaint disputes the failure of the CHC-MCO to provide a service/item or to decide a Complaint or Grievance within specified timeframes or disputes a denial made for the reason that a service/item is not a covered benefit, or disputes a denial of payment after a service(s) has been delivered because the service/item was provided without authorization by a Provider not enrolled in the Pennsylvania Medical Assistance Program; or disputes a denial of payment after a service(s) has been delivered because the service/item provided is not a covered benefit for the Participant, the Participant may file a request for a DHS Fair Hearing within thirty (30) days from the mail date on

the written notice of the CHC-MCO's second level Complaint decision.

3. External Review of Second Level Complaint Review Decision

- a. If a Participant files a request for an external review of a second level Complaint decision to dispute a decision to discontinue, reduce, or change a service/item that the Participant has been receiving on the basis that the service/item is not a covered benefit, the Participant must continue to receive the disputed service/item at the previously authorized level pending resolution of the external review, if the request for external review is hand-delivered or post-marked within ten (10) days from the mail date on the written notice on the CHC-MCO's second level Complaint decision.
- b. Upon the request of either the DOH or PID, the CHC-MCO must transmit all records from the first level review and second level review to the requesting department within thirty (30) days from the request in the manner prescribed by that department. The Participant, the Healthcare Provider or the CHC-MCO may submit additional materials related to the Complaint.
- c. The DOH and PID will determine the appropriate agency for the review.

4. Expedited Complaint Process

- a. The CHC-MCO must conduct expedited review of a Complaint at any point prior to the second level Complaint decision, if a Participant or Participant's representative, with proof of the Participant's written authorization for the representative to be involved and/or act on the Participant's behalf, provides the CHC-MCO with a certification from the Participant's Provider that the Participant'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 Participant's request for the expedited review 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, by fax or orally. Oral requests must be committed to writing by the CHC-MCO. The Participant's signature is not required.
- c. Upon receipt of an oral or written request for expedited review, the CHC-MCO must inform the Participant 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.

If the Provider certification is not included with the request for an expedited review, the CHC-MCO, must inform the Participant that the Provider must submit a certification as to the reasons why the expedited review is needed. The CHC-MCO must make a reasonable effort to obtain the certification from the Provider. If the Provider certification is not received within three (3)

business days of the Participant's request for expedited review, the CHC-MCO shall decide the Complaint within the standard time frames as set forth in this Exhibit. The CHC-MCO must make a reasonable effort to give the Participant prompt oral notice that the Complaint is to be decided within the standard time frame and send a written notice within two (2) days of the decision to deny expedited review, using the required template (template U(6b)).

- d. If a Participant files a request for expedited review of a Complaint to dispute a decision to discontinue, reduce, or change a service/item that the Participant has been receiving on the basis that the service/item is not a covered benefit, the Participant must continue to receive the disputed service/item at the previously authorized level pending resolution of the Complaint, if the request for expedited review is hand delivered or post-marked within ten (10) days from the mail date on the written notice of decision.
- e. Complaints requiring expedited review must be reviewed by a licensed physician in the same or similar specialty that typically manages or consults on the service/item in question. Other appropriate Providers may participate in the review. The members of the Complaint review committee may not have been involved in any previous level of review or decision-making on the issue under review. The licensed physician must decide the Complaint.
- f. The CHC-MCO must issue the decision resulting from the expedited review in person or by phone to the Participant, the Participant's representative, if the Participant has designated one, and the Participant's Healthcare Provider within either forty-eight (48) hours of receiving the Provider certification or three (3) business days of receiving the Participant's request for an expedited review, whichever is shorter. In addition, the CHC-MCO must mail written notice of the decision to the Participant, the Participant's representative, if the Participant has designated one, and the Participant's Healthcare Provider within two (2) days of the decision using the required template (template U(6a)).
- g. The CHC-MCO must prepare a summary of the issues presented and decisions made, which must be maintained as part of the expedited Complaint record.
- h. The Participant, or the Participant's representative, with proof of the Participant's written authorization for the representative to be involved and/or act on the Participant's behalf, may file a request for an expedited external Complaint review with the CHC-MCO within two (2) business days from the date the Participant receives the CHC-MCO's expedited Complaint decision.
- i. The CHC-MCO shall follow DOH guidelines relating to submission of requests for expedited external reviews.
- j. The CHC-MCO may not take punitive action against a Provider who either requests expedited resolution of a Complaint or supports a Participant's request for expedited review of a Complaint.

- k. The Participant may file a request for a DHS Fair Hearing within thirty (30) days from the mail date on the written notice of the CHC-MCO's expedited Complaint decision.

C. Grievance Requirements

1. First Level Grievance Process

- a. A CHC-MCO shall permit a Participant or the Participant representative, which may include the Participant's Provider, with proof of the Participant's written authorization for the representative to be involved and/or act on the Participant's behalf, to file a Grievance either in writing or orally. The CHC-MCO must commit oral requests to writing if not confirmed in writing by the Participant and must provide the written confirmation to the Participant for signature. The Participant's signature may be obtained at any point in the process, and failure to obtain a signed Grievance may not delay the Grievance process. Participants will be given forty-five (45) days from the date the Participant receives the written notice to file a Grievance.
- b. The CHC-MCO must provide Participants with a toll free number to file a Grievance, request information about the Grievance process, and ask questions the Participant may have about the status of a Grievance.
- c. A Participant who files a Grievance to dispute a decision to discontinue, reduce or change a service/item that the Participant has been receiving must continue to receive the disputed service/item at the previously authorized level pending resolution of the Grievance, if the Grievance is hand delivered or post-marked within ten (10) days from the mail date on the written notice of decision.
- d. Upon receipt of the Grievance, the CHC-MCO shall send the Participant and Participant's representative, if the Participant has designated one, an acknowledgment letter using the required template (template U(7)).
- e. A Participant who consents to the filing of a Grievance by a Healthcare Provider may not file a separate Grievance. The Participant may rescind consent throughout the Grievance process upon written notice to the CHC-MCO and the Provider.
- f. In order for the Provider to represent the Participant in the conduct of a Grievance, the Provider must obtain the written consent of the Participant. A Provider may obtain the Participant's written permission at the time of treatment. A Provider may not require a Participant to sign a document authorizing the Provider to file a Grievance as a condition of treatment. The written consent must include:
 - i. The name and address of the Participant, the Participant's date of birth and identification number.
 - ii. If the Participant is a minor, or is legally incompetent, the name,

- address and relationship to the Participant of the person who signed the consent.
- iii. The name, address and CHC-MCO identification number of the Provider to whom the Participant is providing consent.
 - iv. The name and address of the CHC-MCO to which the Grievance will be submitted.
 - v. An explanation of the specific service/item for which coverage was provided or denied to the Participant to which the consent will apply.
 - vi. The following statement: "The Participant or the Participant's representative may not submit a Grievance concerning the services/items listed in this consent form unless the Participant or the Participant's representative rescinds consent in writing. The Participant or the Participant's representative has the right to rescind consent at any time during the Grievance process."
 - vii. The following statement: "The consent of the Participant or the Participant's representative shall be automatically rescinded if the Provider fails to file a Grievance or fails to continue to prosecute the Grievance through the second level review process."
 - viii. The following statement: "The Participant or the Participant's representative, if the Participant is a minor or is legally incompetent, has read, or has been read this consent form, and has had it explained to his/her satisfaction. The Participant or the Participant's representative understands the information in the Participant's consent form."
 - ix. The dated signature of the Participant, or the Participant's representative, and the dated signature of a witness.
- g. The first level Grievance review shall be performed by the first level Grievance review committee, which shall include one or more employees of the CHC-MCO who was not involved in any previous level of review or decision making on the subject of the Grievance.
 - h. The first level Grievance review committee shall include a licensed physician in the same or similar specialty that typically manages or consults on the service/item in question. Other appropriate Providers may participate in the review, but the licensed physician must decide the Grievance.
 - i. The Participant must be afforded a reasonable opportunity to present evidence, and allegations of fact or law, in person as well as in writing. The CHC-MCO shall be flexible when scheduling the review to facilitate the Participant's attendance. The Participant shall be given at least seven (7) days advance written notice of the review date. If the Participant cannot appear in person at the review, the CHC-MCO must provide an opportunity to communicate with the first level Grievance review committee by telephone or

video conference. The Participant may elect not to attend the first level Grievance meeting but the meeting must be conducted with the same protocols as if the Participant was present.

- j. If a Participant requests an in-person first level Grievance review, at a minimum, a member of the first level Grievance review committee must be physically present at the location where the first level Grievance review will be held and the other members of the first level Grievance review committee must participate in the review through the use of video conferencing.
- k. The first level Grievance review committee shall complete its review of the Grievance as expeditiously as the Participant's health condition requires, but no more than thirty (30) days from receipt of the Grievance, which may be extended by fourteen (14) days at the request of the Participant.
- l. 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.
- m. The CHC-MCO must send a written notice of the first level Grievance decision, using the required template (template U(3b)), to the Participant, Participant's representative, if the Participant has designated one, service Provider and prescribing PCP, if applicable, within five (5) business days from the first level Grievance review committee's decision.
- n. The Participant or the Participant's representative, with proof of the Participant's written authorization for the representative to be involved and/or act on the Participant's behalf, may file a request for a second level Grievance review ("second level Grievance") within forty-five (45) days from the date the Participant receives the written notice of the CHC-MCO's first level Grievance decision.
- o. The Participant may file a request for a DHS Fair Hearing within thirty (30) days from the mail date on the written notice of the CHC-MCO's first level Grievance decision.

2. **Second Level Grievance Process**

- a. Upon receipt of the second level Grievance, the CHC-MCO shall send the Participant and the Participant's representative, if the Participant has designated one, an acknowledgment letter using the required template (template U(8)).
- b. A Participant who files a second level Grievance to dispute a decision to discontinue, reduce, or change a service/item that the Participant has been receiving must continue to receive the disputed service/item 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 (10) days from the mail date on the written notice of the CHC-MCO's first level Grievance decision.

- c. The second level Grievance review shall be performed by a second level Grievance review committee made up of three (3) 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/item. At least one-third of the second level Grievance review committee may not be employees of the CHC-MCO or a related subsidiary or affiliate.
- d. The second level Grievance review committee shall include a licensed physician in the same or similar specialty that typically manages or consults on the service/item in question. Other appropriate Providers may participate in the review.
- e. The Participant must be provided the opportunity to appear before the second level Grievance review committee. The CHC-MCO shall be flexible when scheduling the second level review to facilitate the Participant's attendance. The Participant shall be given at least fifteen (15) days advance written notice of the review date. If the Participant cannot appear in person at the second level review, the CHC-MCO must provide an opportunity to communicate with the second level Grievance review committee by telephone or video conference. The Participant may elect not to attend the second level Grievance meeting but the meeting must be conducted with the same protocols as if the Participant was present.
- f. If a Participant requests an in-person second level Grievance review, at a minimum, a member of the second level Grievance review committee must be physically present at the location where the second level Grievance review will be held and the other members of the second level Grievance review committee must participate in the review through the use of video conferencing.
- g. The decision of the second level Grievance review committee must be based solely on the information presented at the review.
- h. The second level Grievance review committee shall complete the second level Grievance review within forty-five (45) days from receipt of the Participant's second level Grievance.
- i. Testimony taken by the second level Grievance review committee (including the Participant'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.
- j. The CHC-MCO must send a written notice of the second level Grievance decision, using the required template (template GG(9)), to the Participant, Participant's representative, if the Participant has designated one, service Provider and prescribing Provider, if applicable, within five (5) business days of the second level Grievance review committee's decision.
- k. The Participant or Participant representative, which may include the

Participant's Provider, with proof of the Participant's written authorization for a representative to be involved and/or act on the Participant's behalf, may file a request with the CHC-MCO for an external review ("external Grievance review") of the second level Grievance decision by a certified review entity appointed by the DOH. The request must be filed within fifteen (15) days from the date the Participant receives the written notice of the CHC-MCO's second level Grievance decision.

- l. The Participant may file a request for a DHS Fair Hearing within thirty (30) days from the mail date on the written notice of the CHC-MCO's second level Grievance decision.

3. **External Review of Second Level Grievance Decision:**

- a. The CHC-MCO must process all requests for external Grievance review. The CHC-MCO must follow the protocols established by the DOH in meeting all timeframes and requirements necessary in coordinating the request and notification of the decision to the Participant, Participant's representative, if the Participant has designated one, service Provider and prescribing Provider.
- b. A Participant who files a request for an external Grievance review to dispute a decision to discontinue, reduce or change a service/item that the Participant has been receiving must continue to receive the disputed service/item 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 (10) days of the mail date on the written notice of the CHC-MCO's second level Grievance decision.
- c. Within five (5) business days of receipt of the request for an external Grievance review, the CHC-MCO shall notify the Participant, the Participant's representative, if the Participant has designated one, or the Healthcare Provider, and the DOH that the request for external Grievance review has been filed.
- d. The external Grievance review shall be conducted by a certified review entity (CRE) not directly affiliated with the CHC-MCO.
- e. Within two (2) business days from receipt of the request for an external Grievance review, the DOH randomly assigns a CRE to conduct the review. The CHC-MCO and assigned CRE entity will be notified of this decision.
- f. If the DOH fails to select a CRE within two (2) business days from receipt of a request for an external Grievance review, the CHC-MCO may designate a CRE to conduct a review from the list of CREs approved by the DOH. The CHC-MCO may not select a CRE that has a current contract or is negotiating a contract with the CHC-MCO or its Affiliates or is otherwise affiliated with the CHC-MCO or its Affiliates.
- g. The CHC-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. The CHC-MCO must transmit this information within fifteen (15) days from receipt of the Participant's request for an external Grievance review.

- h. Within fifteen (15) days from receipt of the request for an external Grievance review by the CHC-MCO, the Participant or the Participant's representative, which may include the Participant's Provider, with proof of the Participant's written authorization for the representative to be involved and/or act on the Participant's behalf, may supply additional information to the CRE conducting the external Grievance review for consideration. Copies must also be provided at the same time to the CHC-MCO so that the CHC-MCO has an opportunity to consider the additional information.
- i. Within sixty (60) days from the filing of the request for the external Grievance review, the CRE conducting the external Grievance review shall issue a written decision to the CHC-MCO, the Participant, the Participant's representative and the Provider (if the Provider filed the Grievance with the Participant's consent), that includes the basis and clinical rationale for the decision. The standard of review shall be whether the service/item was Medically Necessary and appropriate under the terms of the CHC-MCO's contract.
- j. The external Grievance decision may be appealed by the Participant, the Participant's representative, or the Healthcare Provider to a court of competent jurisdiction within sixty (60) days from the date the Participant receives notice of the external Grievance decision.

4. Expedited Grievance Process

- a. The CHC-MCO must conduct expedited review of a Grievance at any point prior to the second level Grievance decision, if a Participant or Participant representative, with proof of the Participant's written authorization for a representative to be involved and/or act on the Participant's behalf, provides the CHC-MCO with a certification from his or her Provider that the Participant'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 Participant's request for the expedited review 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, by fax or orally. Oral requests must be committed to writing by the CHC-MCO. The Participant's signature is not required.
- c. The expedited review process is bound by the same rules and procedures as the second level Grievance review process with the exception of timeframes, which are modified as specified in this section.

- d. Upon receipt of an oral or written request for expedited review, the CHC-MCO must inform the Participant 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.
- e. If the Provider certification is not included with the request for an expedited review, the CHC-MCO, must inform the Participant that the Provider must submit a certification as to the reasons why the expedited review is needed. The CHC-MCO must make a reasonable effort to obtain the certification from the Provider. If the Provider certification is not received within three (3) business days of the Participant's request for expedited review, the CHC-MCO shall decide the Grievance within the standard time frames as set forth in this Exhibit. The CHC-MCO must make a reasonable effort to give the Participant prompt oral notice that the Grievance is to be decided within the standard time frame and send a written notice within two (2) days of the decision to deny expedited review, using the required template (template U(6b)).
- f. A Participant who files a request for expedited review of a Grievance to dispute a decision to discontinue, reduce or change a service/item that the Participant has been receiving must continue to receive the disputed service/item 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 (10) days from the mail date on the written notice of decision.
- g. Review of Grievances must be performed by a Grievance review committee that includes a licensed physician in the same or similar specialty that typically manages or consults on the service/item in question. Other appropriate Providers may participate in the review. The members of the Grievance review committee may not have been involved in any previous level of review or decision-making on the subject of the Grievance. The licensed physician must decide the Grievance.
- h. The CHC-MCO must issue the decision resulting from the expedited review in person or by phone to the Participant, the Participant's representative, if the Participant has designated one, and the Participant's Provider within either forty-eight (48) hours of receiving the Provider certification, or three (3) business days of receiving the Participant's request for an expedited review, whichever is shorter. In addition, the CHC-MCO must mail written notice of the decision to the Participant, the Participant's representative, if the Participant has designated one, and the Participant's Healthcare Provider within two (2) days of the decision using the required template (template U (10)).
- i. The Participant, or the Participant's representative, with proof of the Participant's written authorization for the representative to be involved and/or act on the Participant's behalf, may file a request for an expedited external Grievance review with the CHC-MCO; within two (2) business days from the date the Participant receives the CHC-MCO's expedited Grievance decision.

- j) The CHC-MCO shall follow DOH guidelines relating to submission of requests for expedited external reviews.
- k) The CHC-MCO may not take punitive action against a Provider who either requests expedited resolution of a Grievance or supports a Participant's request for expedited review of a Grievance.
- l) The Participant may file a request for a DHS Fair Hearing within thirty (30) days from the mail date on the written notice of the CHC-MCO's expedited Grievance decision.

D. Department's Fair Hearing Requirements

1. Department's Fair Hearing Process

- a) Participants do not have to exhaust the Complaint or Grievance process prior to filing a request for a DHS Fair Hearing.
- b) The Participant or the Participant's representative may request a DHS Fair Hearing within thirty (30) days from the mail date on the initial written notice of decision and within thirty (30) days from the mail date on the written notice of the CHC-MCO's first or second level Complaint or Grievance notice of decision for any of the following:
 - i) The denial, in whole or part, of payment for a requested service/item if based on lack of Medical Necessity.
 - ii) The denial of a requested service/item on the basis that the service/item is not a Covered Service.
 - iii) The denial or issuance of a limited authorization of a requested service/item, including the type or level of service/item.
 - iv) The reduction, suspension, or termination of a previously authorized service/item.
 - v) The denial of a requested service/item but approval of an alternative service/item.
 - vi) The failure of the CHC-MCO to provide services/items in a timely manner, as defined by the Department.
 - vii) The failure of the CHC-MCO to decide a Complaint or Grievance within the time frames specified in this Exhibit.
 - viii) the denial of payment after a service(s) has been delivered because the service/item was provided without authorization by a Provider not enrolled in the Pennsylvania Medical Assistance Program.

- ix) The denial of payment after a service(s) has been delivered because the service/item provided is not a covered benefit for the Participant.
- c. The request for a DHS Fair Hearing must include a copy of the written notice of decision that is the subject of the request. Requests must be sent to:

Pennsylvania Department of
Human Services
Bureau of Hearings and Appeals
2330 Vartan Way, Second Floor
Harrisburg, PA 17110-9721
Telephone: (717) 783-3950
Fax: (717) 772-2769 or (717) 346-1959

- d. A Participant who files a request for a DHS Fair Hearing to dispute a decision to discontinue, reduce or change a service/item that the Participant has been receiving must continue to receive the disputed service/item at the previously authorized level pending resolution of the DHS Fair Hearing, if the request for a DHS Fair Hearing is hand delivered or post-marked within ten (10) days from the mail date on the written notice of decision.
- e. Upon receipt of the request for a DHS Fair Hearing, the Department's BHA or a designee will schedule a hearing. The Participant and the CHC-MCO will receive notification of the hearing date by letter at least ten (10) days in advance, or a shorter time if requested by the Participant. The letter will outline the type of hearing, the location of the hearing (if applicable), and the date and time of the hearing.
- f. The CHC-MCO is a party to the hearing and must be present. The CHC-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 failure of the CHC-MCO to participate in the hearing will not be reason to postpone the hearing.
- g. The CHC-MCO must provide Participants, at no cost, with records, reports, and documents, relevant to the subject of the DHS Fair Hearing.
- h. If BHA has not issued a final administrative action within ninety (90) days of the receipt of the request for a DHS Fair Hearing, the CHC-MCO shall follow the requirements at 55 PA Code § 275.4 regarding the provision of interim assistance upon the request for such by the Participant. When the Participant 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 Participant.
- i. BHA adjudication is binding on the CHC-MCO unless reversed by the Secretary of DHS. Either party may request reconsideration from the

Secretary within fifteen (15) days from the date of the adjudication. Only the Participant may appeal to Commonwealth Court within thirty (30) days from the date of final administrative action or from the Secretary's final order, if reconsideration was granted. The decisions of the Secretary and the Court are binding on the CHC-MCO.

2. Expedited Fair Hearing Process

- a. A request for an expedited DHS Fair Hearing may be filed by the Participant or the Participant's representative, with proof of the Participant's written authorization for the representative to be involved and/or act on the Participant's behalf, with the Department either in writing or orally.
- b. Participants do not have to exhaust the Complaint or Grievance process prior to filing a request for an expedited DHS Fair Hearing.
- c. An expedited DHS Fair Hearing will be conducted if a Participant or a Participant's representative provides the Department with written certification from the Participant's Provider that the Participant's life, health or ability to attain, maintain or regain maximum function would be placed in jeopardy by following the regular DHS Fair Hearing process. This certification is necessary even when the Participant's request for the expedited Fair Hearing is made orally. The certification must include the Provider's signature. The Provider may also testify at the DHS Fair Hearing to explain why using the usual time frames would place the Participant's health in jeopardy.
- d. A Participant who files a request for an expedited Fair Hearing to dispute a decision to discontinue, reduce or change a service/item that the Participant has been receiving must continue to receive the disputed service/item at the previously authorized level pending resolution of the DHS Fair Hearing, if the request for an expedited Fair Hearing is hand delivered or post-marked within ten (10) days from the mail date on the written notice of decision.
- e. Upon the receipt of the request for an expedited Fair Hearing, the Department's BHA or a designee will schedule a hearing.
- f. The CHC-MCO is a party to the hearing and must participate in the hearing. The CHC-MCO, which may be represented by an attorney, must be prepared to explain and defend the issue on appeal. The failure of the CHC-MCO to participate in the hearing will not be reason to postpone the hearing.
- g. The CHC-MCO must provide the Participant, at no cost, with records, reports, and documents, relevant to the subject of the DHS Fair Hearing.
- h. BHA has three (3) business days from the receipt of the Participant's oral or written request for an expedited review to process final administrative action.
- i. BHA adjudication is binding on the CHC-MCO unless reversed by the Secretary of DHS. Either party may request reconsideration from the

Secretary within fifteen (15) days from the date of the adjudication. Only the Participant may appeal to Commonwealth Court within thirty (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 CHC-MCO.

E. Provision of and Payment for Services/Items following Decision

1. If the CHC-MCO or BHA reverses a decision to deny, limit, or delay services/items that were not furnished during the Complaint, Grievance or DHS Fair Hearing process, the CHC-MCO must authorize or provide the disputed services/items promptly and as expeditiously as the Participant's health condition requires. If the CHC-MCO requests reconsideration, the CHC-MCO must authorize or provide the disputed services/items pending reconsideration unless the CHC-MCO requests a stay of the BHA decision and the stay is granted.
2. If the CHC-MCO or BHA reverses a decision to deny authorization of services/items, and the Participant received the disputed services/items during the Complaint, Grievance or DHS Fair Hearing process, the CHC-MCO must pay for those services/items.

EXHIBIT V

REQUIRED CONTRACT TERMS FOR ADMINISTRATIVE SUBCONTRACTORS

All subcontracts must be in writing and must include, at a minimum, the following provisions:

- The specific activities and report responsibilities delegated to the subcontractor.
- A provision for revoking delegation or imposing other sanctions if the subcontractor's performance is inadequate.
- All subcontractors shall comply with all applicable requirements of the agreement between the CHC-MCO and the Department concerning the Community HealthChoices Program.
- Meet the applicable requirements of 42 CFR Subsection 434.6.
- Include nondiscrimination provisions.
- Include the provisions of the Americans with Disabilities Act (42 U.S.C. Section 12101 et seq.).
- Contain a provision in all subcontracts with any individual firm, corporation or any other entity which provides medical services and receives reimbursement from the CHC-MCO either directly or indirectly through capitation, that data for all services provided will be reported timely to the CHC-MCO. Penalties and sanctions will be imposed for failure to comply. The data is to be included in the utilization and encounter data provided to the Department in the format required.
- Contain a provision in all subcontracts with any individual, firm, corporation or any other entity which provides medical services to CHC Participants, that the subcontractor will report all new third party resources to the CHC-MCO identified through the provision of medical services, which previously did not appear on the Department's Participant information files provided to the CHC-MCO.
- Contain a hold harmless clause that stipulates that the CHC-MCO subcontractor agrees to hold harmless the Commonwealth, all Commonwealth officers and employees and all CHC-MCO Participants in the event of nonpayment by the CHC-MCO to the subcontractor. The subcontractor shall further indemnify and hold harmless the Commonwealth and their agents, officers and employees against all injuries, death, losses, damages, claims, suits, liabilities, judgments, costs and expenses which may in any manner accrue against the Commonwealth or their agents, officers or employees, through the intentional conduct, negligence or omission of the subcontractor, its agents, officers, employees or the CHC-MCO.
- Contain a provision in all subcontracts of compliance with all applicable federal and state laws.

- Contain provisions in all subcontracts with any individual firm, corporation or any other entity which provides medical services to Community HealthChoices Participants, that prohibits gag clauses which limit the subcontractor from disclosure of medical necessary or appropriate healthcare information or alternate therapies to Participants, other healthcare professionals or the Department.
- Contain provisions in all employee contracts prohibiting gag clauses which limit said employees from the disclosure of information pertaining to the Community HealthChoices Program.
- Contain provisions in all subcontracts with any individual, firm, corporation or any other entity which provides medical services to Community HealthChoices Participants, that limits incentives to those permissible under the applicable federal regulation.

The CHC-MCO shall require as a written provision in all subcontracts that the Department has ready access to any and all documents and records of transactions pertaining to the provision of services to Participants.

The CHC-MCO and its subcontractor(s) must agree to maintain books and records relating CHC services and expenditures, including reports to the Department and source information used in preparation of these reports. These records include but are not limited to financial statements, records relating to quality of care, medical records and prescription files.

The CHC-MCO and its subcontractor(s) also must agree to comply with all standards for practice and medical records keeping specified by the Commonwealth.

The CHC-MCO and its subcontractor(s) 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 CHC-MCO's chosen location, subject to approval of the Commonwealth. The CHC-MCO must fully cooperate with any and all reviews and/or audits by state or federal agencies or their agents, such as the Independent Assessment Contractor, by assuring that appropriate employees and involved parties are available for interviews relating to reviews or audits. All records to be sent by mail shall be sent to the requesting entity in the form of accurate, legible paper copies, unless otherwise indicated, within 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 CHC-MCO and its subcontractor(s) shall maintain books, records, documents and other evidence pertaining to all revenues, expenditures and other financial activity pursuant to this contract as well as to all required programmatic activity and data pursuant to this contract. Records other than medical records may be kept in an original paper state or preserved on micro media or electronic format. Medical records shall be maintained in a format acceptable by the Department. These books, records, documents and other evidence shall be available for review, audit or evaluation by authorized Commonwealth personnel or their representatives during the contract period and five years thereafter, except if an audit is in progress or audit findings are yet unresolved, in which case, records shall be kept until all tasks are completed.

The CHC-MCO and its subcontractor(s) must agree to retain the source records for its data reports for a minimum of seven years and must have written policies and procedures for storing this information.

The CHC-MCO shall require, as a written provision in all subcontracts that the subcontractor recognize that payments made to the subcontractor are derived from federal and state funds. Additionally, the CHC-MCO shall require, as a written provision in all contracts for services rendered to the Participant, that the subcontractor shall be held civilly and/or criminally liable to both the CHC-MCO and the Department, in the event of nonperformance, misrepresentation, fraud, or abuse. The CHC-MCO shall notify its PCPs and all subcontractors of the prohibition and sanctions for the submission of false claims and statements.

The CHC-MCO shall require, as a written provision in all subcontracts that the subcontractor cooperate with Quality Management/Utilization Management Program requirements.

The CHC-MCO shall require Providers to comply with all Service Coordination program requirements, including, where applicable, cooperation with the PCPT approach for PCSP and Service Coordination.

The CHC-MCO shall monitor the subcontractor's performance on an on-going basis and subject it to formal review according to a periodic schedule established by the Department, consistent with industry standards or state laws and regulations. If the CHC-MCO identifies deficiencies or areas needing improvement, the CHC-MCO and the subcontractor must take corrective action.

EXHIBIT U

REPORTING SUSPECTED FRAUD AND ABUSE TO THE DEPARTMENT

The following requirements are adapted from 55 PA Code Chapter 1101, General Regulations for the Medical Assistance Program, specifically 55 PA Code § 1101.75(a) and (b), Provider Prohibited Acts, which are directly adapted from the 62 P.S. § 1407, (also referred to as Act 105 of 1980, Fraud and Abuse Control Act). The basis for Recipient referrals is 55 PA Code § 1101.91 and § 1101.92, Recipient Mis-utilization and Abuse and Recipient Prohibited Acts. For information on these regulations, go to <http://www.pacode.com>.

Reporting Requirements:

CHC-MCOs must report to the Department any act by Providers, Participants, caregivers and employees that may affect the integrity of the CHC Program under the Medical Assistance Program. Specifically, if the CHC-MCO suspects that Fraud, Abuse or Waste, as discussed in the Fraud and Abuse section of the agreement, may have occurred, the CHC-MCO must report the issue to the OLTL. The CHC-MCO must have a process to notify OLTL of any adverse actions and/or Provider disclosures received during the credentialing/re-credentialing process. Depending on the nature or extent of the problem, it may also be advisable to place the individual Provider on prepayment review or suspend payments to avoid unnecessary expenditures during the review process.

CHC-MCOs are required to report quality issues to the Department for further investigation. Quality issues are those which, on an individual basis, affect the Participant's health (e.g., poor quality services, inappropriate treatment, aberrant and/or abusive prescribing patterns, and withholding of Medically Necessary services from the Participant).

The CHC-MCO must make all Fraud, Abuse, Waste, or quality referrals within thirty (30) days of the identification of the problem/issue. The CHC-MCO must send to OLTL all relevant documentation collected to support the referral. Such information includes, but is not limited to, the materials listed on the "Checklist of Supporting Documentation for Referrals" located at the end of this exhibit. The Fraud and Abuse Coordinator, or the responsible party completing the referral, should check the appropriate boxes on the "Checklist of Supporting Documentation for Referrals" form 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. Any egregious situation or act (e.g., those that are causing or imminently threaten to cause harm to a Participant or significant financial loss to the Department) must be referred immediately to the Department's OLTL for further investigation.

The CHC-MCO must train or educate its Network Providers on the reporting requirements of incidents of abuse and of the Older Adult Protective Services Act

and the Adult Protective Services Act. To the extent a Participant is an alleged victim of abuse, neglect, exploitation or abandonment the CHC-MCO shall fully cooperate in the investigation of the case and the coordination of any services provided by the CHC-MCO. As part of its quality management plan, the CHC-MCO shall have a means to identify Participants who may be at risk of abuse or neglect and take steps to minimize those risks while balancing the right of the Participant to live in their community or place of choice.

The CHC-MCO must follow the processes unless prior approval is received from OLTL. Reports must be submitted online using the CHC-MCO Referral Form. The instructions and form templates are located at [\(Will add link at a later time\)](#).

Once completed, the CHC-MCO must electronically submit the form to BPI and must submit the following information by fax or mail to OLTL:

- Checklist of Supporting Documentation for Referrals, accessible on the CHC-MCO Referral Form.
- A copy of the confirmation page which will appear after “Submit” button is clicked, submitting the CHC-MCO Referral Form.
- All supporting documentation.

OLTL BPI FAX Number 717-772-4638, Attn: BPI
DPPC

DHS Bureau of Program Integrity
Managed Care Unit
P.O. Box 2675
Harrisburg, PA 17105-2675

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 [*The below list is provided as examples of materials that could be relevant to an investigation of the referral. The list is not all inclusive.*]-

- confirmation page from online referral
- encounter forms (lacking signatures or forged signatures)
- timesheets
- attendance records of Participant
- 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
- résumé and supporting résumé documentation (college transcripts, copy of degree)
- credentialing file (DEA license, CME, medical license, board certification)
- copies of complaints filed by Participants
- 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 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(s)
- encounter forms (lacking signatures or forged signatures)
- plan of care summaries
- documentation of treatment team or Interagency Service Planning Team meetings
- progress notes
- other: _____

Example of materials for DME referrals –

- orders, prescriptions, and/or certificates of medical necessity (CMN for the equipment)
 - delivery slips and/or proof of delivery of equipment
 - copies of checks or proof of copay payment by recipient
 - diagnostic testing in the records
 - copy of company's current licensure
 - copy of the policy and procedure manual applicable to DME items
 - other: _____
-

EXHIBIT X

GUIDELINES FOR SANCTIONS REGARDING FRAUD, WASTE AND ABUSE

The Department recognizes its responsibility to administer the Community HealthChoices Program and ensure that the public funds which pay for this program are properly spent.

To maintain the integrity of the Community HealthChoices Program and to ensure that CHC-MCOs comply with pertinent provisions and related state and federal policies, rules and regulations involving Fraud, Waste and Abuse issues, the Department will impose sanctions on the CHC-MCOs as deemed appropriate where there is evidence of violations involving Fraud, Waste and Abuse issues in the Community HealthChoices Program. To that end, program compliance and improvement assessments, including financial assessments payable to BPI, will be applied by BPI for the CHC-MCO's identified program integrity compliance deficiencies. The Department may impose sanctions available to it under applicable law and regulations.

FRAUD, WASTE AND ABUSE ISSUES WHICH MAY RESULT IN SANCTIONS

The Department may impose sanctions, for non-compliance with Fraud, Waste and Abuse requirements which include, but are not limited to, the following:

- A. Failure to implement, develop, monitor, continue and/or maintain the required compliance plan and policies and procedures directly related to the detection, prevention, investigation, referral or sanction of Fraud, Waste and Abuse.
- B. Failure to cooperate with reviews by oversight agencies or their representative, including the Department, Office of Attorney General, Office of Inspector General of the U.S. DHHS, and other state or federal agencies and auditors.
- C. Failure to adhere to applicable state and federal laws and regulations.
- D. Failure to adhere to the terms of the Community HealthChoices agreement, and the relevant exhibits which relate to Fraud, Waste and Abuse issues.

RANGE OF SANCTIONS

The Department may impose any of the sanctions indicated in Section VIII.H. of the agreement including, but not limited to, the following:

- A. Preclusion or exclusion of the CHC-MCO, its officers, managing employees or other individuals with direct or indirect ownership or control interest in accordance with 42 U.S.C. §1320a-7, 42 C.F.R. Parts 1001 and 1002; 62 P.S. §1407 and 55 PA Code §§ 1101.75 and 1101.77.

These sanctions may, but need not be, progressive. The Department intends to maintain an effective, reasonable and consistent sanctioning process as deemed necessary to protect the integrity of the Community HealthChoices Program.

EXHIBIT W

PROVIDER MANUALS

The CHC-MCO shall work with the Department to develop, distribute prior to implementation, and maintain a Provider manual. In addition, the CHC-MCO and/or CHC-MCO Subcontractors will be expected to distribute copies of all manuals and subsequent policy clarifications and procedural changes to Network Providers following advance written approval of the documents by the Department. Provider manuals must be updated to reflect any program or policy change(s) made by the Department via Medical Assistance bulletin within six (6) months of the effective date of the change(s), or within six (6) months of the issuance of the Medical Assistance bulletin, whichever is later, when such change(s) affect(s) information that the CHC-MCO is required to include in its Provider manual, as set forth in this exhibit. The Provider manual must include, at a minimum, the following information:

- A. A description of the needs screening, comprehensive needs assessment and reassessment, and service planning system and protocols and a description of the Provider's role in Service Planning and Service Coordination.
- B. A description of Service Coordination and how the Provider will fit into the Person-Centered Planning Team approach.
- C. A description of the population being served through CHC.
- D. A description of the accessibility requirements with which Providers are required to comply.
- E. A description of the role of a PCP as described in Section II, Definitions, and Section V.Z.4, Primary Care Practitioner (PCP) responsibilities, of the agreement.
- F. Information on how Participants may access specialists, including standing referrals and specialists as PCPs.
- G. A summary of the guidelines and requirements of Title VI of the Civil Rights Act of 1964 and its guidelines, and how Providers can obtain qualified interpreters familiar with medical terminology.
- H. Contact information to access the CHC-MCO, DHS, advocates, other related organizations, etc.
- I. A copy of the CHC-MCO's Formulary, Prior Authorization, and program exception process.
- J. Contact follow-up responsibilities for missed appointments.
- K. Description of role of the Service Coordinator and how to contact them.
- L. Description of drug and alcohol treatment available and how to make referrals.

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- M. Complaint, Grievance and DHS Fair Hearing information.
- N. Information on Provider Disputes.
- O. CHC-MCO policies, procedures, available services, sample forms, and fee schedule applicable to the Provider type.
- P. A full description of Covered Services, listing all Covered Services outlined in Exhibit EE(1) and EE(2).
- Q. Billing instructions.
- R. Information regarding applicable portions of 55 PA Code, Chapter 1101, General Provisions.
- S. Information on self-referred services and services which are not the responsibility of the CHC-MCO but are available to Participants on a Fee-for-Service basis.
- T. Provider performance expectations, including disclosure of Quality Management and Utilization Management criteria and processes.
- U. Information on procedures for sterilizations, hysterectomies and abortions (if applicable).
- V. A description of certain Providers' obligations, under law, to follow applicable procedures in dealing with Participants on "Advanced Directives" (durable healthcare power of attorney and living wills). This includes notification and record keeping requirements.
- W. Information on ADA and Section 504 of the Rehabilitation Act of 1973, other applicable laws, and available resources related to the same.
- X. A definition of "Medically Necessary" consistent with the language in the agreement.
- Y. Information on Participant confidentiality requirements.
- Z. Information regarding school-based/school-linked services in this CHC zone;
- AA. The Department's Medical Assistance Provider Compliance Hotline (formerly the Fraud and Abuse Hotline) number and explanatory statement.
- BB. Explanation of CHC-MCO's and DHS's Recipient Restriction Program.
- CC. Information regarding written translation and oral interpretation services for Participants with LEP and alternate methods of communication for those requesting communication in alternate formats.
- DD. List and scope of services for referral and Prior Authorization.

EE. Information about Recipient Restriction and how it works.

The CHC-MCO is required to provide documented training to its Providers and their staffs and to Subcontractors, regarding the contents and requirements of the Provider manuals.

EXHIBIT Y

CHC AUDIT CLAUSE AUDITS

Annual Contract Audits

The CHC-MCO 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 digitally submitted to OLTL, OMAP, BMCO, Division of Financial Analysis via the E-FRM system no later than June 30 after the contract year is ended.

If circumstances arise in which the Commonwealth or the CHC-MCO 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 CHC-MCO is responsible to provide Medical Assistance benefits to Community HealthChoices recipients shall be submitted to the Commonwealth within 180 days after the contract termination date or the last date the CHC-MCO is responsible to provide Medical Assistance benefits.

The CHC-MCO shall ensure that audit working papers and audit reports are retained by the CHC-MCO's auditor for a minimum of five (5) years from the date of final payment under the contract, unless the CHC-MCO's auditor is notified in writing by the Commonwealth to extend the retention period. Audit working papers shall be made available, upon request, to authorized representatives of the Commonwealth or federal agencies. Copies of working papers deemed necessary shall be provided by the CHC-MCO's auditor.

Annual Entity-Wide Financial Audits

The CHC-MCO shall provide to the Commonwealth a copy of its annual entity-wide financial audit, performed by an independent, licensed Certified Public Accountant. Such audit shall be made in accordance with generally accepted auditing standards. Such audit shall be submitted to the OLTL, OMAP, BMCO via E-FRM within t h i r t y (30) days from the date it is made available to the CHC-MCO.

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 CHC-MCO, its subcontractors or Providers. Any such additional audit work will rely on work already performed by the CHC-MCO's auditor to the extent possible. The costs incurred by the federal or state agencies for such additional work will be borne by those agencies.

Audits of the CHC-MCO, its subcontractors or Providers may be performed by the Commonwealth or its designated representatives and include, but are not limited to: Community HealthChoices Agreement effective January 1, 2017

1. Financial and compliance audits of operations and activities for the purpose of determining the compliance with financial and programmatic record keeping and reporting requirements of this contract.
2. Audits of automated data processing operations to verify that systems are in place to ensure that financial and programmatic data being submitted to the Commonwealth is properly safeguarded, accurate, timely, complete, reliable, and in accordance with contract terms and conditions.
3. 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 CHC-MCO or its subcontractor's operations will generally be performed on an annual basis. However, the Commonwealth reserves the right to audit more frequently, to vary the audit period, and to determine the type and duration of these audits. Audits of subcontractors or Providers will be performed at the Commonwealth's discretion.

The following provisions apply to the CHC-MCO, its subcontractors, and Providers:

1. Except in cases where advance notice is not possible or advance notice may render the audit less useful, the Commonwealth will give the entity at least three (3) weeks advance written notice of the start date, expected staffing, and estimated duration of the audit. In the event of a claims processing audit, the Commonwealth will strive to provide advance written notice of a minimum of thirty (30) calendar days. While the audit team is on-site, the entity shall provide the team with adequate workspace; access to a telephone, photocopier and facsimile machine; electrical outlets; and privacy for conferences. The CHC-MCO shall also provide, at its own expense, necessary systems and staff support to timely extract and/or download information stored in electronic format, gather requested documents or information, complete forms or questionnaires, and respond to auditor inquiries. The entity shall cooperate fully with the audit team in furnishing, either in advance or during the course of the audit, any policies, procedures, job descriptions, contracts or other documents or information requested by the audit team.
2. Upon issuance of the final report to the entity, the entity shall prepare and submit, within thirty (30) calendar days after issuance of the report, a Corrective action plan for each observation or finding contained therein. The corrective action plan shall include a brief description of the finding, the specific steps to be taken to correct the situation or specific reasons why corrective action is not necessary, a timetable for performance of the corrective action steps, and a description of the monitoring to be performed to ensure that the steps are taken.

Record Availability, Retention and Access

The CHC-MCO shall, at its own expense, make all records available for audit, review or evaluation by the Commonwealth, its designated representatives or federal agencies. Access shall be provided either on-site, during normal business hours, or through the mail. During the contract and record retention period, these records shall be available at the CHC-MCO's chosen location, subject to approval of the Commonwealth. All records to be sent by mail shall be sent to the requesting entity within fifteen (15) calendar days of such request and at no expense to the requesting entity. Such requests made by the Commonwealth shall not be unreasonable.

The CHC-MCO shall maintain books, records, documents, and other evidence pertaining to all revenues, expenditures and other financial activity pursuant to this agreement as well as to all required programmatic activity and data pursuant to this agreement. Records other than medical records may be kept in an original paper state or preserved on micro media or electronic format. Medical records shall be maintained in a format acceptable by the Department. These books, records, documents and other evidence shall be available for review, audit or evaluation by authorized Commonwealth personnel or their representatives during the 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 CHC-MCO shall include in all risk sharing CHC-MCO 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 CHC-MCO shall include in all contract agreements with other subcontractors or Providers, clauses which reflect the above provisions relative to "Other Financial and Performance Audits" and "Record Availability, Retention, and Access."

EXHIBIT Z
ENCOUNTER DATA SUBMISSION REQUIREMENTS
And PENALTY
APPLICATIONS

The submission of timely and accurate Encounter Data is critical to the Commonwealth's ability to establish and maintain cost effective and Quality Managed care programs. Consequently, the requirements for submission and metrics for measuring the value of the data for achieving these goals are crucial.

- **CERTIFICATION REQUIREMENT**

- All MCOs must be certified through PROMISE prior to the submission of live Encounter Data. The certification process is detailed at: (Will add link at a later time)

- **SUBMISSION REQUIREMENTS**

- Timeliness:

- With the exception of pharmacy Encounters, all CHC-MCO approved Encounters and those specified CHC-MCO denied Encounters must be approved in PROMISE by the last day of the third month following the month of initial CHC- MCO adjudication.

- Pharmacy Encounters must be submitted and approved in PROMISE within thirty (30) days following the CHC-MCO adjudication.

- Metric: During the sixth month following the month of the initial PROMISE adjudication, the Encounters will be analyzed for timely submission of Encounters.

- Failure to achieve PROMISE approved/paid status for ninety-eight percent (98%) of all CHC-MCO paid/approved and specified CHC-MCO denied Encounters by the last day of the third month following initial CHC-MCO adjudication may result in a penalty.
 - Any Encounter corrected or initially submitted after the last day of the third month following initial CHC-MCO adjudication may be subject to a penalty.

- Accuracy and Completeness:

- Accuracy and completeness are based on the consistency between Encounter information submitted to the Commonwealth and information for the same service maintained by the CHC-MCO in their claims/service history data base.

- Metric: Accuracy and completeness will be determined through a series of analyses applied to CHC-MCO claims history data and Encounters received and processed through PROMISE. This analysis will be done at least yearly but no more than twice a year and consist of making a comparison between an Encounter sample and what is found in CHC-MCO claims history. A sample may also be drawn from the CHC-MCO service history and compared against Encounters processed through PROMISE.

expenditures for each transaction type submitted during the review period. Each annual or semi-annual analysis will be based on a statistically valid sample of no less than two hundred (200) records.

- PENALTY
PROVISION Timelines

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- Failure to comply with timeliness requirements will result in a sanction of up to \$10,000 for each program month.

Completeness and Accuracy

- Errors in accuracy or completeness that are identified by the Department in an annual or semi-annual analysis will result in sanctions as follows. An error in accuracy or completeness or both, in one sample record, counts as one error.

Percentage of the sample that includes an error	Sanction
Less than 1.0 percent	None
1.0 – 1.4 percent	\$4,000
1.5 – 2.0 percent	\$10,000
2.1 - 3.0 percent	\$16,000
3.1 – 4.0 percent	\$22,000
4.1 – 5.0 percent	\$28,000
5.1 – 6.0 percent	\$34,000
6.1 – 7.0 percent	\$40,000
7.1 – 8.0 percent	\$46,000
8.1 – 9.0 percent	\$52,000
9.1 – 10.0 percent	\$58,000
10.1 percent and higher	\$100,000

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EXHIBIT AA AUTOMATIC ASSIGNMENT

Any Participant who does not select a CHC-MCO will be subject to the auto-assignment process as described below. The auto-assignment process does not negate the Participant's option to change his/her CHC-MCO.

Individuals will be assigned to plans that align with the way in which they are currently receiving their services.

- First, if a Participant is residing in a nursing facility at the time of enrollment, they will be assigned to a plan in which their nursing facility is a Network Provider.
- Second, a Participant enrolled in a D-SNP will be assigned to a CHC-MCO aligned with their D-SNP.
- Third, if the Participant is transferring from Health Choices, and the HC-MCO is also contracted as CHC-MCO, and the Participant has not made a CHC-MCO selection, the Participant will be enrolled in the affiliated CHC-MCO.
- Last, if a Participant is receiving HCBS and their HCBS provider is contracted with a CHC plan, the Participant will be enrolled in that plan. Plan assignment will follow automatic assignment logic after these conditions are exhausted.

If none of the above conditions apply, an eligible Participant who has not made a CHC-MCO selection and who has a case record that also includes another active Participant in the case with an active CHC-MCO record will be assigned to that same CHC-MCO. These Participants will not count toward the percentages designated for auto-assignment. Participants in a family unit will be assigned together to a CHC-MCO. All remaining eligible Participants, who have not voluntarily selected a CHC-MCO, will be considered in the pool of Participants who will be equally auto- assigned to CHC-MCOs. The formula will direct an equal distribution of the auto- assignment pool in all Zones monthly based on the number of CHC-MCOs in the Zone. For example, if there are five CHC-MCOs in the Zone, each CHC-MCO would receive 20%.

A. Participant Re-Assignment Following Resumption of Eligibility:

Participants who lose eligibility and regain it within six (6) months will automatically be re-enrolled in their previously selected CHC-MCO, as long as the Participant's eligibility status or geographical residence is still valid for participation in that same CHC-MCO.

If the Participant loses eligibility and regains it after six (6) months, s/he may be enrolled in the same CHC-MCO as the payment name, the case payment name or any other Participant in the case that has an active CHC-MCO record. If there is no active CHC-MCO record in the case, s/he will automatically become enrolled in a CHC-MCO through the automatic assignment process.

Prior to the future begin date for the auto-assigned CHC-MCO, the Participant
Community HealthChoices Agreement effective January 1, 2017

may select a different CHC-MCO and override the auto-assigned CHC-MCO by contacting the IEE. When the Participant contacts the IEE to make this change, it will be the IEE's responsibility to enroll the Participant in the CHC-MCO of his/her choice. The IEE will process the enrollment into the new CHC-MCO through the weekly enrollment process.

B. Continuing Enrollment When Moving Between Zones:

Eligible Participants who move from one CHC Zone to another will remain in the CHC-MCO in which they were enrolled prior to their move, if the CHC-MCO is also operational in the Zone to which they move.

The Department reserves the right to reassess the distribution process and to modify it in accordance with sound programmatic management principles. The Department shall institute such modifications at any time following appropriate written notification to the CHC-MCOs.

EXHIBIT BB

PROVIDER NETWORK COMPOSITION/SERVICE ACCESS

1. Network Composition

The CHC-MCO must consider the following in establishing and maintaining its Provider Network:

- The anticipated Medical Assistance Enrollment.
- The expected utilization of services, taking into consideration the characteristics and needs of specific Medical Assistance populations represented in the CHC-MCO.
- The number and types, in terms of training, experience, and specialization, of Providers required to furnish the contracted Medical Assistance services.
- All Providers operating within the Provider Network who provide services to Recipients must be enrolled in the Commonwealth's Medical Assistance program and possess an active PROMISE™ Provider ID.
- The number of Network Providers who are not accepting new Medical Assistance Participants.
- The geographic location of Providers and Participants, considering distance, travel time, the means of transportation ordinarily used by Participants, and whether the location provides physical access for Participants with disabilities.

The CHC-MCO must ensure that its Provider Network is adequate to provide its Participants in this CHC zone with access to quality Participant care through participating professionals, in a timely manner, and without the need to travel excessive distances. Upon request from the Department, the CHC-MCO must supply geographic access maps using Participant level data detailing the number, location, and specialties of their Provider Network to the Department in order to verify accessibility of Providers within their Network in relation to the location of its Participants. The Department may require additional numbers of specialists, ancillary, and LTSS Providers should it be determined that geographic access is not adequate. The CHC-MCO must also have a process in place which ensures that the CHC-MCO knows the capacity of their Network PCP panels at all times and have the ability to report on this capacity.

The CHC-MCO must make all reasonable efforts to honor a Participant's choice of Providers who are credentialed in the Network. If the CHC-MCO is unable to ensure a Participant's access to Provider or specialty Provider services within the Provider Network, within the travel times set forth in this exhibit, the CHC-MCO must make all reasonable efforts to ensure the Participant's access to these services within the travel times herein through Out-of-Network providers. In locations where the CHC-MCO can provide evidence that it has conducted all reasonable efforts to contract with Providers and specialists and can provide verification that no Providers or specialists exist to ensure a Participant's access to these

services within the travel times set forth in this exhibit, the CHC-MCO must work with Participants to offer reasonable Provider alternatives. Additionally, the CHC-MCO must ensure and demonstrate that the following Provider Network and access requirements are established and maintained for the entire CHC zone in which the CHC-MCO operates if Providers exist.

a. PCPs

Make available to every Participant a choice of at least two (2) appropriate PCPs with open panels whose offices are located within a travel time no greater than thirty (30) minutes (Urban) and sixty (60) minutes (Rural). This travel time is measured via public transportation, where available.

Participants may, at their discretion, select PCPs located further from their homes.

b. Specialists

For all specialty Provider types, the CHC-MCO must ensure a choice of two (2) Providers who are accepting new patients within the travel time limits (thirty (30) minutes Urban, sixty (60) minutes Rural). This travel time is measured via public transportation, where available.

c. Hospitals

Ensure at least one (1) hospital within the travel time limits (thirty (30) minutes Urban, sixty (60) minutes Rural) and a second choice within the CHC zone. This travel time is measured via public transportation, where available.

d. LTSS Providers

Ensure at least two (2) Providers for each LTSS Covered Service within the travel time limits (thirty (30) minutes Urban, sixty (60) minutes Rural).

e. Out-of-Network Access

Ensure the provision of Covered Services to all Participants such that if the CHC-MCO does not have at least two (2) specialists or sub-specialists qualified to meet the particular needs of the individuals who are accepting new patients and within the travel time requirements, then the CHC-MCO must allow Participants to pick an Out-of-Network Provider if not satisfied with the Network Provider. The CHC-MCO must develop a system to determine Prior Authorization for Out-of-Network Services through the Person-Centered Planning Team and UM, depending on the service for which the Out-of-Network Provider is being authorized, including provisions for informing the Participant of how to request this authorization

for Out-of- Plan Services.

If the CHC-MCO is unable to ensure a Participant's access to Provider or specialty Provider services within the Provider Network, within the travel times set forth in this exhibit, the CHC-MCO must make all reasonable efforts to ensure the Participant's access to these services within the travel times herein through Out-of-Network Providers. In locations where the CHC-MCO can provide evidence that it has conducted all reasonable efforts to contract with Providers and specialists and can provide verification that no Providers or specialists exist to ensure a Participant's access to these services within the travel times set forth in this exhibit, the CHC-MCO must work with Participants to offer reasonable Provider alternatives.

f. Medicare Network Compliance

If the Medicare Network standards would require more Providers for any Provider type or Service Area, the CHC-MCO must meet the Medicare standards in its CHC-MCO.

g. Anesthesia for Dental Care

For Participants needing anesthesia for dental care, the CHC-MCO must ensure a choice of at least two (2) dentists within the Provider Network with privileges or certificates to perform specialized dental procedures under general anesthesia or pay Out-of-Network.

h. Rehabilitation Facilities

Ensure a choice of at least two (2) rehabilitation facilities within the Provider Network, at least one (1) of which must be located within this CHC zone.

i. CNMs / CRNPs, Other Healthcare Providers

Ensure access to Certified Nurse Midwives (CNMs) and Certified Registered Nurse Practitioners (CRNPs) and other Healthcare Providers. The CHC-MCO must demonstrate its attempts to contract in good faith with a sufficient number of CNMs and CRNPs and other Healthcare Providers and maintain payment policies that reimburse CNMs and CRNPs and other Healthcare Providers for all services provided within the scope of their practice and allow them to practice to the fullest extent of their education, training and licensing.

j. Qualified Providers

The CHC-MCO must limit its PCP Network to appropriately Qualified Providers. The CHC-MCO's PCP Network must meet the following:

- Seventy-five to one hundred percent (75-100%) of the Network consists

of PCPs who have completed an approved Primary Care residency in family medicine, osteopathic general medicine, or internal medicine.

- No more than twenty-five percent (25%) of the Network consists of PCPs without appropriate residencies but who have, within the past seven (7) years, five (5) years of post-training clinical practice experience in family medicine, osteopathic general medicine, internal medicine. Post-training experience is defined as having practiced at least as a 0.5 full-time equivalent in the practice areas described.

k. Participants Freedom of Choice

The CHC-MCO must demonstrate its ability to offer its Participants freedom of choice in selecting a PCP. At a minimum, the CHC-MCO must have or provide one (1) full-time equivalent (FTE) PCP who serves no more than one thousand (1,000) Participants. For the purposes of this section, a full-time equivalent PCP must be a physician involved in clinical care. The minimum weekly work hours for 1.0 FTE is the number of hours that the practice considers to be a normal work week, which may be 37.5, 40, or 50 hours. A physician cannot be counted as more than 1.0 FTE regardless of the number of hours worked. If the PCP/PCP Site employs Certified Registered Nurse Practitioners (CRNPs)/Physician Assistants (PAs), then the Provider/Provider Site will be permitted to add an additional one thousand (1,000) Participants to the panel. The number of Participants assigned to a PCP may be decreased by the CHC-MCO if necessary to maintain the appointment availability standards.

l. PCP Composition and Location

The CHC-MCO and the Department will work together to avoid the PCP having a caseload or medical practice composed predominantly of Participants. In addition, the CHC-MCO must organize its PCP Sites so as to ensure continuity of care to Participants and must identify a specific PCP within the PCP site for each Participant. The CHC-MCO may apply to the Department for a waiver of these requirements on a PCP Site-specific basis. The Department may waive these requirements for good cause demonstrated by the CHC-MCO.

m. FQHCs / RHCs

The CHC-MCO must contract with a sufficient number of Federally Qualified Health Centers (FQHCs) and Rural Health Clinics (RHCs) to ensure access to FQHC and RHC services, provided FQHC and RHC services are available, within a travel time of thirty (30) minutes (Urban) and sixty (60) minutes (Rural). If the CHC-MCO's Primary care Network includes FQHCs and RHCs, these sites may be designated as PCP Sites. If a CHC-MCO cannot contract with a sufficient number of FQHCs and RHCs, the CHC-MCO must demonstrate in writing it has attempted to reasonably contract

in good faith.

n. Medically Necessary Emergency Service

The CHC-MCO must comply with the provisions of Act 112 of 1996 (H.B. 1415, P.N. 3853, signed July 11, 1996), the Balanced Budget Reconciliation Act of 1997 and Act 68 of 1998, the Quality Healthcare Accountability and Protection Provisions, 40 P.S. 991.2101 et seq. pertaining to coverage and payment of Medically Necessary Emergency Services. The definition of such services is set forth herein at Section II of this agreement, Definitions.

o. ADA Accessibility Guidelines

The CHC-MCO must inspect the office of any Provider who provides services on site at the Provider's location and who seeks to participate in the Provider Network to determine whether the office is architecturally accessible to persons with mobility impairments. Architectural accessibility means compliance with ADA accessibility guidelines with reference to parking (if any), path of travel to an entrance, and the entrance to both the building and the office of the Provider, if different from the building entrance.

The CHC-MCO must submit quarterly reports to the Department, in a format to be specified by the Department, on the results of the inspections.

If the office or facility is not accessible under the terms of this paragraph, the PCP or dentist may participate in the Provider Network provided that the PCP or dentist: 1) requests and is determined by the CHC-MCO to qualify for an exemption from this paragraph, consistent with the requirements of the ADA, or 2) agrees in writing to remove the barrier to make the office or facility accessible to persons with mobility impairments within one hundred-eighty (180) days after the CHC-MCO identified the barrier.

The CHC-MCO must document its efforts to determine architectural accessibility. The CHC-MCO must submit this documentation to the Department upon request.

p. Laboratory Testing Sites

The CHC-MCO must ensure that all laboratory testing sites providing services have either a Clinical Laboratory Improvement Amendment (CLIA) certificate of waiver or a certificate of registration along with a CLIA Community HealthChoices Agreement: identification number in accordance with CLIA 1988. Those laboratories with certificates of waiver will provide only the eight (8) types of tests permitted under the terms of their waiver. Laboratories with certificates of registration may perform a full range of laboratory tests. The PCP must provide all required

demographics to the laboratory when submitting a specimen for analysis.

q. CHC-MCO Discrimination

The CHC-MCO must not discriminate with respect to participation, reimbursement, or indemnification as to any Provider who is acting within the scope of the Provider's license or certification under applicable State law, solely on the basis of such license or certification. This paragraph must not be construed to prohibit a CHC-MCO from including Providers only to the extent necessary to meet the needs of the organization's Participants or from establishing any measure designed to maintain quality and control costs consistent with the responsibilities of the CHC-MCO.

r. Declined Providers

If the CHC-MCO declines to include individual Providers or groups of Providers in its Network, it must give the affected Providers written notice of the reason for its decision.

s. Second Opinions

The CHC-MCO must provide for a second opinion from a qualified Provider within the Network, at no cost to the Participant. If a qualified Provider is not available within the Network, the CHC-MCO must assist the Participant in obtaining a second opinion from a qualified Provider outside the Network, at no cost to the Participant, unless co-payments apply.

2. Appointment Standards

The CHC-MCO will require the PCP, dentist, or specialist to conduct or contact the Services Coordinator to conduct affirmative outreach whenever a Participant misses an appointment and to document this in the medical record. Such an effort shall be deemed to be reasonable if it includes three (3) attempts to contact the Participant. Such attempts may include, but are not limited to: written attempts, telephone calls and home visits. At least one (1) such attempt must be a follow-up telephone call. Service Coordinators will evaluate any barriers to Participant attendance at appointments and develop any necessary plan to facilitate with and improve Participant compliance with appointments scheduled.

a. General

PCP scheduling procedures must ensure that:

- i. Emergency Medical condition cases must be immediately seen or referred to an emergency facility.

- ii. Urgent Medical Condition cases must be scheduled within twenty-four (24) hours.
- iii. Non-Urgent Sick Visits with a PCP within seventy-two (72) hours of request, as clinically indicated.
- iv. Routine appointments must be scheduled within ten (10) business days. Health assessment/general physical examinations and first examinations must be scheduled within three (3) weeks of Enrollment.
- v. The CHC-MCO must provide the Department with its protocol for ensuring that a Participant's average office waiting time for an appointment for Routine Care is no more than thirty (30) minutes or at any time no more than up to one (1) hour when the physician encounters an unanticipated Urgent Medical Condition visit or is treating a Participant with a difficult medical need. The Participant must be informed of scheduling time frames through educational outreach efforts.
- vi. The CHC-MCO must monitor the adequacy of its appointment processes and reduce the unnecessary use of emergency room visits.

b. Specialty Referrals

For specialty referrals, the CHC-MCO must be able to provide for:

- i. Emergency Medical Condition appointments immediately upon referral.
- ii. Urgent Medical Condition care appointments within twenty-four (24) hours of referral.
- iii. Scheduling of appointments for routine care shall be scheduled to occur within thirty (30) days for all specialty Provider types.

c. Pregnant Women

Should the IEE or Participant notify the CHC-MCO that a new Participant is pregnant or there is a pregnancy indication on the files transmitted to the CHC-MCO by the Department, the CHC-MCO must contact the Participant within five (5) days of the effective date of Enrollment to assist the woman in obtaining an appointment with an OB/GYN or Certified Nurse Midwife. For maternity care, the CHC-MCO must arrange initial prenatal care appointments for enrolled pregnant Participants as follows:

- i. First trimester — within ten (10) business days of the Participant being identified as being pregnant.
- ii. Second trimester — within five (5) business days of the Participant being identified as being pregnant.
- iii. Third trimester — within four (4) business days of the Participant being identified as being pregnant.
- iv. High-risk pregnancies — within twenty-four (24) hours of identification of high risk to the CHC-MCO or maternity care Provider, or immediately if an emergency exists.

3. Policies and Procedures for Appointment Standards

The CHC-MCO will comply with the program standards regarding service accessibility standards that are set forth in this exhibit and in Section V.BB.2. of the agreement, Provider Agreements.

The CHC-MCO must have written policies and procedures for disseminating its appointment standards to all Participants through its Participant handbook and through other means. In addition, the CHC-MCO must have written policies and procedures to educate its Provider Network about appointment standard requirements. The CHC-MCO must monitor compliance with appointment standards and must have a corrective action plan when appointment standards are not met.

4. Compliance with Access Standards

a. Mandatory Compliance

The CHC-MCO must comply with the access standards in accordance with this exhibit and Section V.BB.2 of the agreement, Provider Agreements. If the CHC-MCO fails to meet any of the access standards by the dates specified by the Department, the Department may terminate this agreement.

b. Reasonable Efforts and Assurances

The CHC-MCO must make reasonable efforts to honor a Participant's choice of Providers among Network Providers as long as:

- i. The CHC-MCO's agreement with the Network Provider covers the services required by the Participant.
- ii. The CHC-MCO has not determined that the Participant's choice is clinically inappropriate.

The CHC-MCO must provide the Department adequate assurances that the CHC-MCO, with respect to this CHC zone, has the capacity to serve the expected Enrollment in this CHC zone. The CHC-MCO must provide assurances that it will offer the full scope of Covered Services as set forth in this agreement and access to preventive and Primary Care services. The CHC-MCO must also maintain a sufficient number, mix and geographic distribution of Providers and services in accordance with the standards set forth in this exhibit and Section V.BB.2 of the agreement, Provider Agreements.

c. CHC-MCO's Corrective Action

The CHC-MCO must take all necessary steps to resolve, in a timely manner, any demonstrated failure to comply with the access standards. Prior to a termination action or other sanction by the Department, the CHC-MCO will be given the opportunity to institute a corrective action plan. The CHC-MCO must submit a corrective action plan to the Department for approval within thirty (30) days of notification of such failure to comply, unless circumstances warrant and the Department demands a shorter response time. The Department's approval of the CHC-MCO's corrective action plan will not be unreasonably withheld. The Department will make its best effort to respond to the CHC-MCO within thirty (30) days from the submission date of the corrective action plan. If the Department rejects the corrective action plan, the CHC-MCO shall be notified of the deficiencies of the corrective action plan. In such event, the CHC-MCO must submit a revised corrective action plan within fifteen (15) days of notification. If the Department does not receive an acceptable corrective action plan, the Department may impose sanctions against the CHC-MCO, in accordance with Section VIII.H. of the agreement, Sanctions. Failure to implement the corrective action plan may result in the imposition of a sanction as provided in this agreement.

EXHIBIT CC

OUTPATIENT DRUG (PHARMACY) SERVICES

1. General Requirements

- a. The CHC-MCO must cover all Covered Pharmacies listed on the Center for Medicare and Medicaid Services (CMS) Quarterly Drug Information File when determined to be Medically Necessary, unless otherwise excluded from coverage. (Sec. 2. Coverage Exclusions below for exclusions.) This includes brand name and generic drugs, and over-the-counter drugs (OTCs), prescribed by licensed Providers enrolled in the Medical Assistance program, and sold or distributed by drug manufacturers that participate in the Medicaid Drug Rebate Program.
- b. The CHC-MCO must provide coverage for all medically accepted indications, as described in Section 1927(k)(6) of the Social Security Act, 42 U.S.C.A. 1396r-8(k)(6). This includes any use which is approved under the Federal Food, Drug, and Cosmetic Act, 21 U.S.C.A. 301 et seq. or whose use is supported by the nationally recognized pharmacy compendia, or peer- reviewed medical literature.
- c. Unless financial responsibility is otherwise assigned, all Covered Pharmacies are the payment responsibility of the Participant's CHC-MCO. The only exception is that the BH-MCO is responsible for the payment of methadone when used in the treatment of substance abuse disorders and when prescribed and dispensed by BH-MCO Service Providers.
- d. All Covered Pharmacies must be dispensed through CHC-MCO Network Providers. This includes Covered Pharmacies prescribed by both the CHC-MCO and the BH-MCO Providers.
- e. Under no circumstances will the CHC-MCO permit the therapeutic substitution of a pharmacy by a pharmacist without explicit authorization from the licensed prescriber.
- f. All proposed pharmacy programs and drug Utilization Management programs, such as Prior Authorization, Step Therapy, partial fills, specialty pharmacy, pill-splitting, etc. must be submitted to the Department for review and approval prior to implementation.
- g. The CHC-MCO must include in its written policies and procedures an assurance that all requirements and conditions governing coverage and payment for Covered Pharmacies, such as, but not limited to, Prior Authorization (including Step Therapy), medical necessity guidelines, age

edits, drug rebate Encounter submission, reporting, notices of decision, etc. will:

- i. Apply, regardless of whether the Covered Pharmacy is provided as a pharmacy benefit or as a “medical benefit” incident to a medical service and billed by the prescribing Provider using codes such as the Healthcare Common Procedure Coding System (HCPCS).
 - ii. Ensure access for all medically accepted indications as documented by package labeling, nationally recognized pharmacy compendia, peer-reviewed medical literature, and FFS guidelines to determine medical necessity of drugs that require Prior Authorization in the Medical Assistance FFS Program, when designated by the Department.
- h. The CHC-MCO must agree to adopt the same guidelines to determine medical necessity of selected drugs or classes of drugs as those adopted by the Medical Assistance FFS Program when designated by the Department by publication of Managed Care Operations Memoranda (MC OPS Memos).
- i. The CHC-MCO must comply with Section 2117 of Article XXI of the Insurance Company Law of 1921, as amended, 40 P.S. 991.2117 regarding continuity of care requirements and 28 PA Code Ch. 9. The CHC-MCO must also comply with the procedures outlined in Medical Assistance Bulletin 99-03-13 and Medical Assistance Bulletin # 99-96-01. The CHC-MCO policy and procedures for continuity of care for pharmacies, and all subsequent changes to the Department-approved policy and procedures, must be submitted to the Department for review and approval prior to implementation. The policy and procedures must address how the CHC- MCO will ensure no interruption in drug therapy and the course of treatment, and continued access to pharmacies that the Participant was prescribed before enrolling in the CHC-MCO.

2. Coverage Exclusions

- a. In accordance with Section 1927 of the Social Security Act, 42 U.S.C.A. 1396r-8, the CHC-MCO must exclude coverage for any drug marketed by a drug company (or labeler) who does not participate in the Medicaid Drug Rebate Program. The CHC-MCO is not permitted to provide coverage for any drug product, brand name or generic, legend or non-legend, sold or distributed by a company that did not sign an agreement with the federal government to provide rebates to the Medicaid agency. This requirement does not apply to vaccines, compounding materials, certain vitamins and minerals or diabetic supplies.
- b. The CHC-MCO must not provide coverage for Drug Efficacy Study Implementation (DESI) drugs under any circumstances.

- c. The CHC-MCO must exclude coverage of noncompensable drugs in accordance with 55 PA Code §1121.54.

3. Formularies and Preferred Drug Lists (PDLs)

- a. The CHC-MCO may use a Formulary or a PDL. All drugs must be covered drugs.
- b. The Formulary or PDL must be developed and reviewed at least annually by an appropriate Pharmacy and Therapeutics (P&T) Committee.
- c. The Formulary or PDL must meet the clinical needs of the Medical Assistance population. The Formulary or PDL must include a range of drugs in each therapeutic drug class represented. The Department reserves the right to determine if the Formulary or PDL meets the clinical needs of the Medical Assistance population.
- d. The Formulary or PDL must be clinically based. Only those drugs that do not have a significant, clinically meaningful therapeutic advantage, in terms of safety, effectiveness, or clinical outcomes, over other drugs included in the Formulary or PDL, may be designated as non-formulary or non-preferred.
- e. The CHC-MCO must make a satisfactory written explanation of the reason(s) for designating a drug as non-formulary or non-preferred available to the Department upon request.
- f. The CHC-MCO must allow access to all non-formulary or non-preferred drugs that are included in the CMS Quarterly Drug Information File, other than those excluded from coverage by the Department, when determined to be Medically Necessary through a process such as Prior Authorization (including Step Therapy), in accordance with Prior Authorization of Services Section V. B.1. and Exhibit G, Prior Authorization Guidelines for Participating Managed Care Organizations in the Community HealthChoices Program.
- g. The CHC-MCO must receive written approval from the Department of the Formulary or PDL, quantity limits, age edits, and the policies, procedures and guidelines to determine medical necessity of drugs that require Prior Authorization, including drugs that require Step Therapy and drugs that are designated as non-formulary or non-preferred, prior to implementation of the Formulary or PDL and the requirements.
- h. The CHC-MCO must submit all Formulary or PDL changes (other than additions) and deletions to the Department for review and written approval prior to implementation.
- i. The CHC-MCO must submit written notification of any Formulary or PDL additions to the Department within fifteen (15) days of implementation.

- j. The Formulary or PDL must be re-submitted for Department review and approval annually.
- k. The CHC-MCO must allow access to all new drugs approved by the Food and Drug Administration (FDA) and meet the definition of a Covered Pharmacy either by addition to the Formulary or PDL, or through Prior Authorization, within ten (10) days from their availability in the marketplace.

4. Prior Authorization of Pharmacies

- a. The CHC-MCO may require Prior Authorization (includes Step Therapy) as a condition of coverage or payment for a Covered Pharmacy provided that:
 - i. The CHC-MCO provides a response to the request for Prior Authorization by telephone or other telecommunication device indicating approval or denial of the prescription within twenty-four (24) hours of the request.
 - ii. If a Participant's prescription for a medication is not filled when a prescription is presented to the pharmacist due to a Prior Authorization requirement, the CHC-MCO instructs the pharmacist to dispense either a:
 - 1) Fifteen (15) day supply if the prescription qualifies as an Ongoing Medication, unless the CHC-MCO or its designated subcontractor issued a proper written notice of benefit reduction or termination at least ten (10) days prior to the end of the period for which the medication was previously authorized and a Grievance or DHS Fair Hearing request has not been filed, or
 - 2) A seventy-two (72) hour supply of a new medication.
- b. For drugs not able to be divided and dispensed into individual doses, the CHC-MCO must instruct the pharmacist to dispense the smallest amount that will provide at least a seventy-two (72) hour or fifteen (15) day supply, whichever is applicable.
- c. The requirement that the Participant be given at least a seventy-two (72) hour supply for a new medication or a fifteen (15) day supply for an Ongoing Medication does not apply when a pharmacist determines that the taking of the prescribed medication, either alone or along with other medication that the Participant may be taking, would jeopardize the health or safety of the Participant.

- d. If Prior Authorization of a drug is required, the CHC-MCO and/or its subcontractor must require that its participating dispensing Provider make good faith efforts to contact the prescriber. If the CHC-MCO denies the request for Prior Authorization, the CHC-MCO must issue a written denial notice, using the appropriate Pharmacy Denial Notice template listed on the Department's Intranet supporting CHC within twenty-four (24) hours of receiving the request for Prior Authorization.
- e. If the Participant files a Grievance or DHS Fair Hearing request from a denial of an Ongoing Medication, the CHC-MCO must authorize the medication until the Grievance or DHS Fair Hearing request is resolved. If the current prescription is for a higher dosage than previously prescribed, the prescription is for an Ongoing Medication at least to the extent of the previous dosage. When payment is authorized due to the obligation to cover pre-existing services while a Grievance or DHS Fair Hearing is pending, a request to refill that prescription, made after the Grievance or DHS Fair Hearing has been finally concluded in favor of the MCO, is not an Ongoing Medication.
- f. The CHC-MCO must establish and maintain written Prior Authorization policies, procedures, and guidelines to determine medical necessity of Covered Pharmacies that require Prior Authorization, including drugs that require Step Therapy and drugs that are designated as non-formulary or non-preferred.
- g. The CHC-MCO must comply with the requirements for Prior Authorization of Services, Section V. B. 1. and Exhibit G, Prior Authorization Guidelines for Participating Managed Care Organizations in the Community HealthChoices Program, and receive written approval from the Department prior to implementation.
- h. The CHC-MCO must submit additions, changes and deletions to Prior Authorization (including Step Therapy) policies, procedures and any associated medical necessity guidelines for Department review and written approval prior to implementation.

5. Provider and Participant Notification

The CHC-MCO must have policies and procedures for notification to Providers and Participants of changes to the Formulary or PDL and Prior Authorization requirements.

- a. Written notification for changes to the Formulary or PDL and Prior Authorization requirements must be provided to all affected Providers and Participants at least thirty (30) days prior to the effective date of the change.
- b. The CHC-MCO must provide all other Providers and Participants written notification of changes to the Formulary or PDL and Prior Authorization

requirements upon request.

- c. The CHC-MCO also must generally notify Providers and Participants of

Formulary or PDL and Prior Authorization changes through Participant and Provider newsletters, its web site, or other regularly published media of general distribution.

6. CHC-MCO Pharmacy & Therapeutics (P&T) Committee

- a. The P&T Committee membership must include physicians, including a minimum of two (2) behavioral health physicians, pharmacists, Medical Assistance program Participants and other appropriate clinicians. Medical Assistance program Participant representative membership must include the following:
 - i. One (1) physical health Participant representative. The physical health Participant representative must be a Participant enrolled in the CHC-MCO, or a physician, a pharmacist, or a physical health Participant advocate designated by Participants enrolled in the CHC-MCO to represent them.
 - ii. One (1) behavioral health Participant representative. The behavioral health Participant representative must be a Participant enrolled in the CHC-MCO, or a physician, a pharmacist, a behavioral health Participant advocate, or a family member designated by Participants enrolled in the CHC-MCO to represent them.
 - iii. One (1) LTSS Participant representative. The LTSS Participant representative must be a Participant enrolled in the CHC-MCO, or a physician, a pharmacist, a LTSS Participant advocate, or a family member designated by Participants enrolled in the CHC-MCO to represent them.
- b. The CHC-MCO must submit a P&T Committee membership list for Department review and approval upon request.
- c. When the P&T Committee addresses specific drugs or entire drug classes requiring medical expertise beyond the P&T Committee membership, specialists with knowledge appropriate to the drug(s) or class of drugs being addressed must be added as non-voting, ad hoc members.
- d. The minutes from each CHC-MCO P&T Committee meeting must be posted for public view on the CHC-MCO's website within thirty (30) days of the date of the meeting at which the minutes are approved. Minutes will include votetotals.

7. Pharmacy Provider Network - Any Willing Pharmacy

The CHC-MCO must contract on an equal basis with any pharmacy qualified to participate in the Medical Assistance program that is willing to comply with the CHC-MCO's payment rates and terms and to adhere to quality standards established by the CHC-MCO as required by 62 P.S. 449. The provisions for any willing pharmacy apply if the CHC-MCO Subcontracts with specialty pharmacies,

or designates specific Network pharmacies as the preferred Provider(s) of specialty drugs(s). CHC-MCOs are required to contract on an equal basis with any pharmacy qualified to participate in the Medical Assistance program that is willing to accept the same payment rate(s) as the preferred Provider(s) of specialty drugs and comply with the same terms and conditions for quality standards and reporting as the preferred Provider(s) of specialty drugs.

Subcontracts and agreements with specialty pharmacies and Network pharmacies designated to serve as preferred Providers of specialty drugs must be submitted to the Department for advance written approval.

8. Pharmacy Rebate Program

Under the provisions of Section 1927 of the Social Security Act 42 U.S.C.A. 1396r-8, drug companies that wish to have their products covered through the Medical Assistance program (both FFS and managed care) must sign an agreement with the federal government to provide rebates to the State. The Affordable Care Act (ACA) provides for federal drug rebates for drugs paid for by the CHC-MCOs.

- a. In order to ensure full compliance with the provisions of the ACA, CHC-MCOs must report the necessary Encounter Data in order for the Department to invoice drug manufacturers for rebates for all Covered Pharmacies. This includes physician-administered drugs, drugs dispensed by 340B covered entities or contract pharmacies, and drugs dispensed to CHC-MCO participants with private or public pharmacy coverage and the CHC-MCO provided secondary coverage.
- b. The CHC-MCO must report all pharmacy information, including National Drug Codes (NDCs) and accurate NDC units for all drug claim types, NCPDP, 837 Professional, 837 Institutional, etc. as designated by the Department.

The CHC-MCO may negotiate its own market share rebates for pharmaceutical products with drug companies.

9. Pharmacy Encounters

- a. The CHC-MCO shall submit all pharmacy Encounters to the Department within thirty (30) days of the adjudication date of the claim to the CHC-MCO for payment.
- b. The CHC-MCO shall provide all pharmacy Encounter Data and supporting information as specified below for the Department to collect rebates through the Medicaid Drug Rebate Program. For all pharmacy Encounter Data including pharmacy point-of-sale (NCPDP), physician-administered drugs (837P), outpatient hospital drugs (837I), and drugs dispensed by 340B covered entities and contract pharmacies, the following data elements are required:

- i. Valid NDC for the drug dispensed.
 - 1. The CHC-MCO shall also include the HCPCS code associated with the NDC for all 837P and 837I Encounters where payment was made by the CHC-MCO based on the HCPCS code and HCPCS code units.

2. The CHC-MCO shall also include the diagnosis codes associated with the NDC for all 837P and 837I Encounters where payment was made by the CHC-MCO based on the HCPCS code and HCPCS code units.
- ii. Valid NDC units for the drug dispensed.
 1. The CHC-MCO shall also include the HCPCS units associated with the NDC for all 837P and 837I Encounters where payment was made by the CHC-MCO based on the HCPCS code and HCPCS code units.
- iii. Actual paid amount by the CHC-MCO to the Provider for the drug dispensed.
- iv. Actual TPL amount paid by the Participant's primary pharmacy coverage to the Provider for the drug dispensed.
- v. Actual copayment paid by the Participant to the Provider for the drug dispensed.
- vi. Actual dispensing fee paid by the CHC-MCO to the Provider for the drug dispensed.
- vii. The billing Provider's:
 1. NPI and/or Medical Assistance Identification Number.
 2. Full address and phone number associated with the NPI.
- viii. The prescribing Provider's:
 1. NPI and/or Medical Assistance Identification Number.
 2. Full address and phone number associated with the NPI.
- ix. The date of service for the dispensing of the drug by the billing Provider.
- x. The date of payment by the CHC-MCO to the Provider for the drug.
- xi. Any other data elements identified by the Department to invoice for drug rebates.
- c. The CHC-MCO shall edit and validate claim transaction submissions and pharmacy Encounter Data for completeness and accuracy in accordance with claim standards such as NCPDP. The actual paid amount by the CHC-MCO to the dispensing Provider must be accurately submitted on each pharmacy Encounter to the Department.

- d. The CHC-MCO shall ensure that the NDC on all pharmacy Encounters is appropriate for the HCPCS code based on the NDC and units billed. The NDC must represent a drug that was available to the physician in an outpatient setting for administration.
- e. The Department will review the pharmacy Encounters and remove applicable 340B covered entity Encounters from the drug rebate invoicing process.
 - i. The Department does not recognize 340B contracted pharmacies as 340B Providers and will not remove Encounters billed by contract pharmacies from the rebate invoicing process.
- f. The CHC-MCO shall meet pharmacy Encounter Data accuracy requirements by submitting CHC-MCO paid pharmacy Encounters with no more than a (three percent (3%) error rate, calculated for a month's worth of Encounter submissions. The Department will monitor the CHC-MCO's corrections to denied Encounters by random sampling performed quarterly and over the term of this agreement. The CHC-MCO shall have corrected and resubmitted seventy-five percent (75%) of the denied Encounters for services covered under this agreement included in the random sample within thirty (30) calendar days of denial.
- g. If the CHC-MCO fails to submit pharmacy Encounter data within time frames specified, the Department shall assess civil monetary penalties upon the CHC-MCO. These penalties shall be \$2,000 for each calendar day that the pharmacy Encounter Data is not submitted. The Department may waive these sanctions if it is determined that the CHC-MCO was not at fault for the late submission of the data.

10. Denied or Disputed Pharmacy Encounters

- a. The Department will review the CHC-MCO's pharmacy Encounter Data and will notify the CHC-MCO of the following:
 - i. Disputed pharmacy Encounters identified through the drug rebate invoicing process.
 - ii. CMS Terminated and miscoded/invalid NDCs in the pharmacy Encounter Data.
 - iii. Invalid NDC units for the NDC on the Encounter.
 - iv. Pharmacy Encounters that were denied by the Department's MMIS upon submission by the CHC-MCO.
- b. Within (thirty) 30 calendar days of receipt of the denied or disputed

pharmacy Encounter notification, the CHC-MCO shall, if needed, correct and resubmit any disputed pharmacy Encounters and send a response file that includes:

- i. Corrected and resubmitted pharmacy Encounters or,
 - ii. Detailed explanation of reasons why the disputed pharmacy Encounters could not be corrected. This will include documentation of all attempts to correct the disputed Encounters at the claim level detail.
- c. Failure to submit accurate and complete outpatient Encounter Data will result in the Department assessing civil monetary penalties. If the CHC-MCO fails to correct and resubmit a deficiency in submitted pharmacy Encounter Data upon notification and within the time frames specified in a corrective action plan approved by the Department, the Department will assess civil monetary penalties. These penalties shall be \$2,000 for each calendar day that exceeds the time frames specified in the corrective action plan. The Department may waive these sanctions if it is determined that the CHC-MCO was not at fault for the failure to correct the deficiency within the time period specified in the approved corrective action plan.

11. General Reporting Requirements

The CHC-MCO must maintain an information system that collects, analyzes, integrates and reports pharmacy claims data; including but not limited to pharmacy utilization, amounts paid to Providers and subcontractors— including Pharmacy Benefits Managers.

- a. The CHC-MCO must take the following steps to ensure that data is accurate and complete:
 - i. Verify the accuracy and timeliness of reported data.
 - ii. Screen the data for completeness and consistency.
 - iii. Collect utilization data in standardized formats as requested by the Department.
- b. The CHC-MCO will truthfully certify that the data submitted is in the manner and format established by the Department and must attest, based on the best knowledge, information and belief to the accuracy and completeness of the data being submitted.
- c. The CHC-MCO shall conduct and submit to the Commonwealth a monthly audit of pharmacy claims accuracy. The audit shall be conducted by an entity or CHC-MCO staff independent of pharmacy claims management.

- d. The audit shall utilize a statistically valid, random sample of all processed or paid pharmacy claims upon initial submission in each month. The minimum attributes to be tested for each claim selected shall include:
 - i. Claim data entered into the claims processing system.
 - ii. Claim is associated to the correct Provider.
 - iii. Prescription obtained the proper authorization.
 - iv. Participant eligibility at processing date correctly applied.
 - v. Allowed payment amount agrees with contracted rate and the terms of the Provider participation agreement.
 - vi. Duplicate payment of the same claim has not occurred.
 - vii. Denial reason applied appropriately.
 - viii. Copayment considered and applied.
 - ix. Patient liability correctly identified and applied.
 - x. Effect of modifier codes correctly applied.
 - xi. Other insurance properly considered and applied.
- e. The results of testing at a minimum should be documented to include:
 - i. Results of each attribute tested for each claim selected.
 - ii. Amount of overpayment or underpayment for claims processed or paid in error.
 - iii. Explanation of the erroneous processing for each claim processed or paid in error.
 - iv. Determination of the source of the error.
 - v. Claims processed or paid in error have been corrected.
- f. The CHC-MCO shall submit a claims payment accuracy percentage report for the claims processed by the Pharmacy Benefits Manager.
- g. CHC-MCO shall report the amount paid for pharmacy services, where such services are paid on a Fee-for-Service basis. Where the CHC-MCO pays a derived sub-capitated amount for pharmacy services, the CHC-MCO shall enter the required code and derived amount in the Encounter.

12. Drug Utilization Review (DUR) Program

The CHC-MCO must provide a DUR Program to assure that prescriptions are appropriate, Medically Necessary and not likely to result in Adverse medical outcomes, and to enhance the quality of patient care by educating prescribers, pharmacists and Participants.

a. Prospective Drug Utilization Review (Pro-DUR)

- i.** The CHC-MCO must provide for a review of drug therapy before each prescription is filled or delivered to a Participant at the point-of-sale or point-of- distribution. The review shall include screening for potential drug therapy problems due to therapeutic duplication, drug-disease contraindications, drug-drug interactions, incorrect drug dosage or duration of drug treatment, drug-allergy interactions and clinical abuse/misuse.
- i.** The CHC-MCO must provide for counseling of Participants receiving benefits from pharmacists in accordance with State Board of Pharmacy requirements.

b. Retrospective Drug Utilization Review (Retro-DUR)

- i.** The CHC-MCO must, through its drug claims processing and information retrieval system, examine claims data and other records to identify patterns of fraud, abuse, gross overuse, or inappropriate or medically unnecessary care among physicians, pharmacists and Participants.
- i.** The CHC-MCO shall, on an ongoing basis, assess data on drug use against explicit predetermined standards (using nationally recognized compendia and peer reviewed medical literature) including but not limited to monitoring for therapeutic appropriateness, overutilization and underutilization, appropriate use of generic products, therapeutic duplication, drug-disease contraindications, drug-drug interactions, incorrect drug dosage or duration of drug treatment, and clinical abuse/misuse and, as necessary, introduce remedial strategies, in order to improve the quality of care.
- i.** The CHC-MCO shall provide for active and ongoing educational outreach programs to educate practitioners on common drug therapy problems aimed at improving prescribing or dispensing practices.

c. Annual DUR Report

The CHC-MCO must submit an annual report on the operation of its Pennsylvania Medicaid Drug Utilization Review (DUR) program in a format designated by the Department. The format of the report will include a description of the nature and scope of the prospective and retrospective drug use review programs, a summary of the interventions used, an assessment

of the impact of these educational interventions on quality of care, and an estimate of the cost savings generated as a result of the DUR program.

d. Drug Utilization Review Board (DUR Board)

The Department maintains a DUR Board that reflects the structure of the healthcare delivery model that includes both a managed care and a Fee-for-Service delivery system. Each CHC-MCO and BH-MCO is required to include a representative to serve as a member of the DUR Board. The DUR Board is a standing advisory committee that recommends the application of predetermined standards related to Pro-DUR, Retro-DUR, and related administrative and educational interventions designed to protect the health and safety of the Medical Assistance program Participants. The Board reviews and evaluates pharmacy claims data and prescribing practices for efficacy, safety, and quality against predetermined standards using nationally recognized drug compendia and peer reviewed medical literature as a source. The Board recommends appropriate utilization controls and protocols including Prior Authorization, automated Prior Authorization, system edits, guidelines to determine medical necessity, generic substitution, and quantity limits for individual medications or for therapeutic categories.

13. Pharmacy Benefit Manager (PBM)

The CHC-MCO may use a PBM to process prescription Claims only if the PBM Subcontract complies with the provisions in Section XII: Subcontractual Relationships, and has received advance written approval by the Department. The standards for Network composition and adequacy for pharmacy services includes the requirements for any willing pharmacy as described above. The CHC-MCO must indicate the intent to use a PBM, identify the proposed PBM Subcontract and the ownership of the proposed PBM subcontractor. If the PBM is owned wholly or in part by a CHC-MCO, retail pharmacy Provider, chain drug store or pharmaceutical manufacturer, the CHC-MCO must submit a written description of the assurances and procedures that will be put in place under the proposed PBM Subcontract, such as an independent audit, to assure confidentiality of proprietary information. These assurances and procedures must be submitted and receive advance written approval by the Department prior to initiating the PBM Subcontract. The Department will allow the continued operation of existing PBM Subcontracts while the Department is reviewing new contracts.

14. Requirements for CHC-MCO and BH-MCO Interaction and Coordination of Pharmacy Services

- a. BH-MCO prescribing Providers must comply with the CHC-MCO requirements for Utilization Management of outpatient behavioral health drugs.

The BH-MCO will be required to issue an initial list of BH-MCO Providers to the

- CHC-MCO, and quarterly updates that include additions and terminations. Should the CHC-MCO receive a request to dispense medication prescribed by a BH Provider not listed on the BH-MCO's Provider file, the CHC-MCO must work through the appropriate BH-MCO to identify the Provider. The CHC-MCO is prohibited from denying prescribed medications solely on the basis that the BH-MCO Provider is not clearly identified on the BH-MCO Providerfile.
- b. Payment for inpatient pharmaceuticals during a BH admission is the responsibility of the BH-MCO and is included in the hospitalcharge.
 - c. The CHC-MCO may deny payment of a Claim for a Covered Pharmacy prescribed by a BH-MCO Provider only if one of the followingoccurs:
 - i. The drug is not being prescribed for the treatment of substance abuse/dependency/ addiction or mental illness and any side effects of psychopharmacological agents. Those drugs are to be prescribed by the CHC-MCO's PCP or specialists in the Participant's CHC-MCO Network.
 - ii. The prescription has been identified as a case of Fraud, Abuse, or gross overuse, or the dispensing pharmacist determined that taking the medication either alone or along with other medications that the Participant may be taking, would jeopardize the health and safety of the Participant.
 - d. The CHC-MCO must receive written approval from the Department of the policies and procedures for the CHC-MCO and BH-MCO to:
 - i. When deemed advisable, require consultation between practitioners before prescribing medication, and sharing complete, up-to-date medication records.
 - ii. Comply with any CHC-BH MCO pharmacy data exchange procedures specified by the Department.
 - iii. Timely resolve disputes which arise from the payment for or use of drugs, including a mechanism for timely, impartial mediation when resolution between the CHC-MCO and BH-MCO does not occur.
 - iv. Share independently developed Quality Management/Utilization Management information related to pharmacy services, as applicable.
 - v. Collaborate in adhering to a drug utilization review program approved by the Department. Collaborate in identifying and reducing the frequency of patterns of Fraud, Abuse, gross overuse, inappropriate or medically unnecessary care among physicians, pharmacists and Participants associated with specific drugs.

The CHC-MCO must send data files, via the Department's file transfer protocol (FTP), containing records of detailed pharmacy services as

provided to individual Participants of the BH-MCOs contracted with the Department. The CHC-MCO must adhere to the file delivery schedule established at the implementation of the data exchange process, or notify the Department in advance of schedule changes. Files must be sent directly to the Department for distribution by the Department.

EXHIBIT DD

CHC-MCO PROVIDER AGREEMENTS

The CHC-MCO is required to have written Provider Agreements with a sufficient number of Providers to ensure Participant access to all Medically Necessary services covered by the CHC Program.

The CHC-MCO's Provider Agreements must include the following provisions:

- a. A requirement that the Provider participate, as needed, in the needs screening, comprehensive needs assessment and reassessment, service planning, and Service Coordination processes;
- b. A requirement that the Provider comply with any accessibility, Cultural Competency, Linguistic Competency, or Disability Competency requirements the Department issues for meeting the needs of the CHC population.
- c. A requirement that the CHC-MCO must not exclude or terminate a Provider from participation in the CHC-MCO's Provider Network due to the fact that the Provider has a practice that includes a substantial number of patients with expensive medical conditions.
- d. A requirement that the CHC-MCO must not exclude a Provider from the CHC-MCO's Provider Network because the Provider advocated on behalf of a Participant for Medically Necessary and appropriate healthcare consistent with the degree of learning and skill ordinarily possessed by a reputable Healthcare Provider practicing according to the applicable legal standard of care.
- e. Notification of the prohibition and sanctions for submission of false Claims and statements.
- f. The definition of Medically Necessary as defined in Section II of this agreement, Definitions.
- g. A requirement that the CHC-MCO cannot prohibit or restrict a Healthcare Provider acting within the lawful scope of practice from discussing Medically Necessary care and advising or advocating appropriate medical care with or on behalf of a Participant including; information regarding the nature of treatment options; risks of treatment; alternative treatments; or the availability of alternative therapies, consultation or tests that may be self-administered.
- h. A requirement that the CHC-MCO cannot prohibit or restrict an LTSS Provider acting within the lawful scope of practice from discussing needed services and advising or advocating appropriate LTSS with or on behalf of a Participant

including; information regarding the nature of LTSS options; risks; or the availability of alternative services.

- i. A requirement that the CHC-MCO cannot prohibit or restrict a Healthcare Provider acting within the lawful scope of practice from providing information the Participant needs in order to decide among all relevant treatment options and the risks, benefits, and consequences of treatment or nontreatment.
- j. A requirement that the CHC-MCO cannot terminate a contract or employment with a Healthcare Provider for filing a Grievance on a Participant's behalf.
- k. A clause which specifies that the agreement will not be construed as requiring the CHC-MCO to provide, reimburse for, or provide coverage of, a counseling or referral service if the Provider objects to the provision of such services on moral or religious grounds.
- l. A requirement securing cooperation with the QM/UM Program standards outlined in Exhibit K(1) of this agreement, Quality Management and Utilization Management Program Requirements.
- m. A requirement for cooperation for the submission of Encounter Data for all services provided within the time frames required in Section VIII of this agreement, Reporting Requirements, no matter whether reimbursement for these services is made by the CHC-MCO either directly or indirectly through capitation.
- n. A continuation of benefits provision which states that the Provider agrees that in the event of the CHC-MCO's insolvency or other cessation of operations, the Provider must continue to provide benefits to the CHC-MCO's Participants, including Participants in an inpatient setting, through the period for which the capitation has been paid.
- o. A requirement that PCPs contact new Participants identified in the quarterly Encounter lists who have not had an Encounter during the first six (6) months of Enrollment, or who have not complied with the scheduling requirements outlined in the RFP and this agreement.
- p. A requirement that the CHC-MCO include in all capitated Provider Agreements a clause which requires that should the Provider terminate its agreement with the CHC-MCO, for any reason, that the Provider provide services to the Participants assigned to the Provider under the contract up to the end of the month in which the effective date of termination falls.
- q. A requirement that ensures each physician providing services to Participants eligible for Medical Assistance under the State Plan to have a unique identifier in accordance with the system established under section 1173(b) of the Social Security Act.
- r. Language which requires the Provider to disclose annually any Physician Incentive Plan or risk arrangements it may have with physicians either within its group

practice or other physicians not associated with the group practice even if there is no Substantial Financial Risk between the CHC-MCO and the physician or physician group.

- s. A requirement for cooperation with the CHC-MCO's and DHS' Recipient Restriction Program.
- t. A requirement that healthcare facilities and ambulatory surgical facilities develop and implement, in accordance with P.L.154, No. 13 known as the Medical Care Availability and Reduction of Error (Mare) Act, an internal infection control plan that is established for the purpose of improving the health and safety of patients and healthcare workers and includes effective measures for the detection, control and prevention of Healthcare-Associated Infections.

A provision that the CHC-MCO's Utilization Management (UM) Departments are mandated by the Department to monitor the progress of a Participant's inpatient hospital stay. This must be accomplished by the CHC-MCO's UM department receiving appropriate clinical information from the hospital that details the Participant's admission information, progress to date, and any pertinent data within two (2) business days from the time of admission. The CHC-MCO's Provider must agree to the CHC-MCO's UM Department's monitoring of the appropriateness of a continued inpatient stay beyond approved days according to established criteria, under the direction of the CHC-MCO's Medical Director. As part of the concurrent review process and in order for the UM Department to coordinate the discharge plan and assist in arranging additional services, special diagnostics, home care and durable medical equipment, the CHC-MCO must receive all clinical information on the inpatient stay in a timely manner which allows for decision and appropriate management of care.

- u. Language requiring the Provider to hold harmless all CHC-MCO Participants in the event of nonpayment by the CHC-MCO for failure to obtain prior authorization or failure to follow any other CHC-MCO rules. CHC-MCO Participants may not be billed or balanced billed for covered services.
- v. Requirements regarding coordination with Behavioral Health Providers (if applicable):
 - Comply with all applicable laws and regulations pertaining to the confidentiality of Participant medical records, including obtaining any required written Participant consents to disclose confidential medical records.
 - Make referrals for social, vocational, education or human services when a need for such service is identified through assessment.
 - Provide health records if requested by the Behavioral Health Provider.

- Notify BH Provider of all prescriptions, and when advisable, check deemed with BH Provider before prescribing medication. Make certain BH clinicians have complete, up-to-date record of medications.
 - Be available to the BH Provider on a timely basis for consultations.
- w. The CHC-MCO must require that Network Providers know and comply with the procedures for reporting suspected abuse and neglect under the Older Adult Protective Services Act and the Adult Protective Services Act and for performing exams for the county.
- x. Requirements that Providers follow CHC-MCO requirements for ongoing communication with Participants' Service Coordinators.
- y. Requirements that Providers return Participant calls within three (3) business days of receipt.

The CHC-MCO may not enter into a Provider Agreement that prohibits the Provider from contracting with another CHC-MCO or that prohibits or penalizes the CHC-MCO for contracting with other Providers.

The CHC-MCO must make all necessary revisions to its Provider Agreements to be in compliance with the requirements set forth in this section. Revisions may be completed as Provider Agreements become due for renewal provided that all Provider Agreements are amended within one (1) year of the effective date of this agreement with the exception of the Encounter Data requirements which must be amended immediately, if necessary, to ensure that all Providers are submitting Encounter Data to the CHC-MCO within the time frames specified in Section VIII.B.1 of this agreement, Encounter Data Reporting

EXHIBIT EE(1) COVERED SERVICES LIST

The CHC Program Service Package includes but is not limited to all Medicaid FFS physical health services identified in the Medicaid State Plan and CHC 1915(c) Waiver services. In the event that a conflict arises between this Agreement and the content of the CHC 1915b/c waivers approved by the Centers for Medicare & Medicaid Services, the 1915b/c waivers shall take precedence.”

CHC Covered Physical Health Services	
Category	Category
Inpatient Hospital Services	Clinic Services
Inpatient Acute Hospital	Independent Clinic
Inpatient Rehab Hospital	Maternity – Physician, Certified Nurse Midwives, Birth Centers
Outpatient Hospital Clinic Services	Renal Dialysis Services
Outpatient Hospital Clinic	Ambulatory Surgical Center (ASC) Services
Outpatient Hospital Short Procedure Unit	Dental Services
Federally Qualified Health Center / Rural Health Clinic	Physical Therapy, Occupational Therapy, and Services for Individuals with Speech, Hearing, and Language Disorders
Other Laboratory and X-ray Service	Prescribed Drugs, Dentures, and Prosthetic Devices; and eyeglasses prescribed by a physician skilled in diseases of the eye or by an optometrist
Laboratory	Prescribed Drugs
Radiology (For example: X-rays, MRIs, CTs)	Dentures
Nursing Facility Services	Prosthetic Devices
Skilled Nursing Facility	Eyeglasses
Family Planning Clinic Services, and Supplies	Diagnostic, Screening, Preventive, and Rehabilitative Services
Physician Services	Tobacco Cessation
Primary Care Provider	Therapy (Physical, Occupational, Speech) - Rehabilitative
Physician Services and Medical and Surgical Services provided by a Dentist	Certified Registered Nurse Practitioner Services
Medical care and any other type of remedial care	Any other medical care and any other type of remedial care recognized under state law, specified by the Secretary
Podiatrist Services	Ambulance Transportation
Optometrist Services	Non-Emergency Medical Transport
Chiropractor Services	Emergency Room

Home Health Services	Hospice Care
Home Healthcare Including Nursing, Aide and Therapy	
Medical Supplies	
Durable Medical Equipment	
CHC Covered Physical Health Services	
Category	Category
Therapy (Physical, Occupational, Speech)	Definitions for Physical Health Services may be found in the Pennsylvania Medicaid State Plan at: http://www.dhs.state.pa.us/publications/medicaidstateplan/
Community HealthChoices LTSS Benefits	
Adult Daily Living	Participant-Directed Community Supports
Assistive Technology	Participant-Directed Goods and Services
Benefits Counseling	
Career Assessment	Personal Assistance Services
Community Integration	Personal Emergency Response System
Community Transition Services	Pest Eradication
Employment Skills Development	Residential Habilitation
Exceptional DME	Respite
Financial Management Services	Specialized Medical Equipment and Supplies
Home Adaptations	Structured Day Habilitation
Home Delivered Meals	TeleCare
Home Health Services (including	Therapeutic and Counseling Services
Job Coaching	Vehicle Modifications
Job Finding	
Non-Medical Transportation	
Nursing Facility Services	

EXHIBIT EE(2)
COVERED
SERVICES
Long-Term Services and Supports
Service Definitions

Adult Daily Living

Adult Daily Living services are designed to assist participants in meeting, at a minimum, personal care, social, nutritional and therapeutic needs. Adult Daily Living services are generally furnished for four (4) or more hours per day on a regularly scheduled basis for one (1) or more days per week, or as specified in the service plan, in a non-institutional, community-based center encompassing both health and social services needed to ensure the optimal functioning of the participant. Adult Daily Living includes two (2) components: Basic Adult Daily Living services and Enhanced Adult Daily Living services.

Basic Adult Daily Living services are comprehensive services provided to meet the needs noted above in a licensed center. Per licensing regulations under Title 6 PA Code, Chapter 11, Subchapter A, and 11.123 Core Services (Older Adult Daily Living Center or OADLC Regulations § 11.123 (2)), the required core services for these settings include personal assistance, nursing in accordance with regulation, social and therapeutic services, nutrition and therapeutic diets and emergency care for participants. Basic Adult Daily Living services can be provided as either a full day or a half day. The individual's service plan initiates and directs the services they receive while at the center.

In addition to providing Basic Adult Daily Living services, Enhanced Adult Daily Living services must include the following additional service elements:

- **Nursing Services:** In addition to the requirements found in the OADLC Regulations § 11.123 (2), a Registered Nurse (RN) must be available on-site one (1) hour weekly for each enrolled waiver participant. At a minimum, each waiver participant must be observed every other week by the RN with the appropriate notations recorded in the participant's service plan, with the corresponding follow-ups being made with the participant, family, or physician.
- **Staff to Participant Ratio of 1:5.**
- **Operating Hours:** open a minimum of eleven (11) hours daily during the normal work week. A normal work week is defined as Monday through Friday.
- The guidelines for the required specialized services for the OADLC provider to include physical therapy, occupational therapy, speech therapy, and medical services can be found in Subchapter B, § 11.402.
- Enhanced Adult Daily Living services can be provided as either a full day or a half day.
- Adult Daily Living providers that are certified as Enhanced receive the Enhanced full day or Enhanced half day rate for all participants attending the Enhanced center.

As necessary, Adult Daily Living may include assistance in completing activities of daily living and instrumental activities of daily living. This service also includes assistance with medication administration and the performance of health-related tasks to the extent State law permits.

This service must be provided in accordance with 42 CFR §441.301(c)(4) and (5), which outlines allowable settings for home and community-based waiver services. Services can be provided as either a full day or half day. Providers may bill for one (1) day when Basic or Enhanced Adult Daily Living services are provided for four (4) or more hours in a day. Providers must bill for a half day when Basic or Enhanced services are provided for fewer than four (4) hours in a day.

Assistive Technology

Assistive Technology service is an item, piece of equipment or product system — whether acquired commercially, modified or customized — that is needed by the Participant, as specified in the Participant's PCSP and determined necessary in accordance with the Participant's assessment. The service is intended to ensure the health, welfare and safety of the Participant and to increase, maintain or improve a Participant's functioning in communication, self-help, self-direction, life-supports or adaptive capabilities. All items shall meet the applicable standards of manufacture, design and installation. Assistive Technology is limited to:

- Services consisting of purchasing, leasing or otherwise providing for the acquisition of Assistive Technology devices for Participants.
- Services consisting of selecting, designing, fitting, customizing, adapting, applying, maintaining, repairing or replacing Assistive Technology devices. Repairs are covered when it is more cost effective than purchasing a new device.
- Electronic systems that enable someone with limited mobility to control various appliances, lights, telephone, doors and security systems in their room, home or other surroundings.
- Training or technical assistance for the Participant, paid caregiver and unpaid caregiver.
- An independent evaluation of the Assistive Technology needs of a participant. This includes a functional evaluation of the Assistive Technology needs and appropriate services for the participant in his/her customary environment
- Extended warranties.
- Ancillary supplies, software and equipment necessary for the proper functioning of Assistive Technology devices, such as replacement batteries and materials necessary to adapt low-tech devices. This includes applications for electronic devices that assist Participants with a need identified through the evaluation described below

If the Participant receives Speech, Occupational or Physical Therapy or Behavior Support services that may relate to, or are impacted by, the use of the Assistive Technology, the Assistive Technology must be consistent with the Participant's behavior support plan or Speech, Occupational or Physical Therapy service. Assistive Technology devices must be recommended by an independent evaluation or physician's prescription. This service excludes those items that are not of direct medical or remedial benefit to the Participant. Recreational items are also excluded.

Benefits Counseling

Benefits Counseling is a service designed to inform, and answer questions from, a Participant about competitive integrated employment and how and whether it will result in increased economic self-sufficiency and/or net financial benefit through the use of various

work incentives. This service provides an accurate, individualized assessment. The service provides information to the individual regarding the full array of available work incentives for essential benefit programs including SSI, SSDI, Medicaid, Medicare, housing subsidies, food stamps, etc. The service also will provide information and education to the Participant regarding income reporting requirements for public benefit programs, including the Social Security Administration.

Benefits counseling provides work incentives counseling and planning services to persons actively considering or seeking competitive integrated employment or career advancement.

Benefits Counseling may not be rendered under the waiver to a Participant under a program funded by either the Rehabilitation Act of 1973 as amended or the Individuals with Disabilities Education Act (IDEA) or any other small business development resource available to the Participant. Initial Benefits Counseling may only be provided if it is documented in the service plan that Benefits Counseling services provided by a Certified Work Incentives Counselor through a Pennsylvania-based federal Work Incentives Planning and Assistance (WIPA) program were sought and it was determined that such services were not available either because of ineligibility or because of wait lists that would result in services not being available within 30 calendar days.

Career Assessment

Career Assessment is an individualized employment assessment used to assist in the identification of potential career options based upon the interests and strengths of the Participant. Services support the Participant to live and work successfully in home and community-based settings, enable the Participant to integrate more fully into the community and ensure the health, welfare and safety of the Participant.

Career Assessment is an individualized employment assessment that includes:

- Conducting a review of the Participant's work and volunteer history, interests and skills, which may include information gathering or interviewing.
- Conducting situational assessments to assess the Participant's interest and aptitude in a particular type of job.
- Identifying types of jobs in the community that match the Participant's interests, strengths and skills.
- Developing a Career Assessment Report that specifies recommendations regarding the Participant's needs, interests, strengths, and characteristics of potential work environments. The Career Assessment Report must also specify training or skills development necessary to achieve the participant's employment or career goals, that could be addressed by other waiver services in the participant's service plan

This service includes Discovery for individuals who due to the impact of their disability, their skills, preferences, and potential contributions cannot be best captured through traditional, standardized means, such as functional task assessments, situational assessments, and/or traditional normative assessments which compare the individual to others or arbitrary standards of performance and/or behavior. Discovery involves a comprehensive analysis of the person in relation to following:

- Strongest interests toward one or more specific aspects of the labor market;

- Skills, strengths and other contributions likely to be valuable to employers or valuable to the community if offered through self-employment;
- Conditions necessary for successful employment or self-employment.

Discovery includes the following activities: observation of person in familiar places and activities, interviews with family, friends and others who know the person well, observation of the person in an unfamiliar place and activity, identification of the person's strong interests and existing strengths and skills that are transferable to individualized integrated employment or self-employment. Discovery also involves identification of conditions for success based on experience shared by the person and others who know the person well, and observation of the person during the Discovery process. The information developed through Discovery allows for activities of typical life to be translated into possibilities for individualized integrated employment or self-employment.

The service also includes transportation as an integral component, such as transportation to a situational assessment during the delivery of Career Assessment.

Career Assessment services may not be rendered under the waiver to a Participant under a program funded by either the Rehabilitation Act of 1973 as amended or the Individuals with Disabilities Education Act (IDEA) or any other small business development resource available to the Participant. This means that Career Assessment services may only be provided when documentation has been obtained that one of the following has occurred:

1. OVR has closed a case for the participant or has stopped providing services to the participant;
2. The participant was determined ineligible for OVR services; or
3. For anyone eligible for IDEA services, it has been verified that the services are not available in a complete and approved Individualized Education Program (IEP) developed pursuant to IDEA.

Documentation in accordance with Department requirements must be maintained in the file by the Supports Coordinator and updated with each reauthorization to satisfy the State assurance that the service is not otherwise available to the Participant under other federal programs.

Career Assessment does not include supports to continue paid or volunteer work once it is obtained. Career Assessment services may only occur once per service plan year and payment will be made only for a completed assessment.

Community Integration

Community Integration (CI) is a short-term, goal-based support service designed to assist Participants in acquiring, retaining, and improving self-help, communication, socialization and adaptive skills necessary to reside in the community. Community integration can include cueing and on-site modeling of behavior to assist the Participant in developing maximum independent functioning in community living activities.

Community Integration is goal-based and situational to assist individuals in achieving maximum function during life-changing events such as a transition from a Nursing Facility, moving to a new community or from a parent's home, or a change in condition that requires

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new skill sets. Services and training must focus on specific skills and be related to the expected outcomes outlined in the participant's service plan. Services must be provided at a 1:1 ratio.

Community Integration goals must be reviewed and/or updated at least quarterly by the Service Coordinator in conjunction with the Participant to assure that expected outcomes are met and the service plan is modified accordingly. The length of service should not exceed thirteen (13) weeks on new plans. If the Participant has not reached the goal at the end of (thirteen)13 weeks, then documentation of the justification for continued training on the desired outcome must be incorporated into the PCSP at the time of the quarterly review. If the Participant has not reached his/her CI goals by the end of twenty-six (26) weeks, the goals need to change or it is concluded that the individual will not independently complete the goal and the Service Coordinator must assess for a more appropriate service to meet the Participant's need. Each distinct goal may not remain on the PCSP for more than twenty-six (26) weeks. No more than 32 units per week for one CI goal will be approved in the PCSP. If the Participant has multiple CI goals, no more than 48 units per week will be approved in the PCSP.

Community Integration cannot be billed simultaneously with Residential Habilitation, Structured Day Habilitation or Personal Assistance Services.

Community Transition Services

Community Transition Services are one-time expenses for Participants that make the transition from an institution to their own home, apartment or family/friend living arrangement. Community Transition Services may be used to pay the necessary expenses for a Participant to establish his or her basic living arrangement and to move into that arrangement. The following are categories of expenses that may be incurred:

- Equipment, essential furnishings and initial supplies. Examples—e.g. household products, dishes, chairs, tables.
- Moving Expenses.
- Security deposits or other such one-time payments that are required to obtain or retain a lease on an apartment, home or community living arrangement.
- Set-up fees or deposits for utility or service access, Examples – e.g. telephone, electricity, heating
- Items for personal and environmental health and welfare (Examples - personal items for inclement weather, pest eradication, allergen control, one-time cleaning prior to occupancy).

Excluded items include:

- Ongoing payment for rent or mortgage expenses.
Food, regular utility charges and/or household appliances or items that are intended for purely for diversion/recreational purposes.
- Supports or activities provided to obtain the items.
Services available under Assistive Technology, Home Adaptations, and Specialized Medical Equipment and Supplies.
- Community Transition Services are limited to an aggregate of \$4,000 per Participant, per lifetime.

Employment Skills Development

Employment Skills Development services provide learning and work experiences, including volunteer work, where the participant can develop strengths and skills that contribute to employability in paid employment in integrated community settings. Services are aimed at furthering habilitation goals that will lead to greater opportunities for competitive and integrated employment and career advancement at or above minimum wage. Employment Skills Development services are necessary, as specified in the PCSP, to support the participant to live and work successfully in home and community-based settings, enable the participant to integrate more fully into the community and ensure the health, welfare and safety of the participant.

Employment Skills Development services are designed to:

- Be individually tailored to directly address the participant's employment goals as identified in the needs assessment and included in the service plan. If the participant has received a Career Assessment that has determined that the participant is in need of acquiring particular skills in order to enhance their employability, those identified skills development areas must be addressed within the participant's service plan and by the Employment Skills Development service
- Enable each participant to attain the highest level of work in the most integrated setting and with the job matched to the participant's career goals, interests, strengths, priorities, abilities and capabilities, while following applicable federal and State wage guidelines
- Support acquisition of skills needed to obtain competitive, integrated employment in the community
- Develop and teach general, translatable skills including, but not limited to, the ability to communicate effectively with supervisors, coworkers and customers; generally accepted community workplace conduct and dress; basic workplace requirements, like adherence to time and attendance expectations; ability to follow directions; ability to attend to tasks; workplace problem solving skills and strategies; general workplace safety; and training to enable the effective use of transportation resources
- Provide and support the acquisition of skills necessary to enable the participant to obtain competitive, integrated work where the compensation for the participant is at or above the minimum wage, but not less than the customary wage and level of benefits paid by the employer for the same or similar work performed by participants without disabilities, which is considered to be the optimal outcome of Employment Skills Development services

Support may be provided to participants for unpaid volunteer placement and training experiences, which may be provided in community-based settings. Skills development as a part of placement and training may occur as a one-to-one training experience or in a group setting in accordance with Department requirements.

Employment Skills Development includes transportation as an integral component of the service, for example, transportation to a volunteer or training activity. Employment Skills Development may be provided in facilities licensed under Pa. Code Chapter 2390, but only after the participant has been referred to OVR and the following is documented: the
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participant was either determined ineligible by OVR or their OVR case is closed and the provision of Employment Skills Development services has already been attempted in a competitive integrated employment setting or an unlicensed community-based setting outside the participant's home.

Participants receiving Employment Skills Development services must have measureable employment-related goals in their service plan.

Services must be delivered in a manner that supports the participant's communication needs including, but not limited to, age appropriate communication, translation services for participants that are of limited-English proficiency or who have other communication needs requiring translation, assistance with the provider's understanding and use of communication devices used by the participant.

If the participant receives Behavior Therapy services, this service includes implementation of the behavior support plan and, if necessary, the crisis support plan. The service includes collecting and recording the data necessary to support the review of the service plan, the behavior support plan and the crisis support plan, as appropriate.

The Employment Skills Development service provider must maintain documentation in accordance with Department requirements. The documentation must be available to the Service Coordinator for monitoring at all times on an ongoing basis. The Service Coordinator will monitor on a quarterly basis to see if the training objectives are being met.

Handicapped employment, as defined in 55 Pa. Code Chapter 2390, may not be funded through the waiver. Waiver funding is not available for the provision of Employment Skills Development (e.g., sheltered work performed in a facility) where participants are supervised in producing goods or performing services under contract to third parties.

'Exceptional Durable Medical Equipment

Exceptional DME is defined as DME that has an acquisition cost of \$5,000 or more and is either Specially Adapted DME or other DME that is designated as exceptional DME by the Department annually by notice in the Pennsylvania Bulletin. Exceptional DME can either be purchased or rented.

"Specially Adapted DME" is DME that is uniquely constructed or substantially adapted or modified in accordance with the written orders of a physician for the particular use of one resident, making its contemporaneous use by another resident unsuitable.

The list of exceptional DME that has been designated by the Department is as follows:

- (1) Air fluidized beds. The pressure relief provided by this therapy uses a high rate of airflow to fluidize fine particulate material (for example, beads or sand) to produce a support medium that has characteristics similar to liquid. May have a Gortex cover.
- (2) Powered air flotation bed (low air loss therapy). A semi-electric or total electric bed with a fully integrated powered pressure-reducing mattress which is characterized by all of the following:

- a. An air pump or blower with a series of interconnected woven fabric air pillows which provides sequential inflation and deflation of the air cells or a low interface pressure throughout the mattress allowing some air to escape through the support surface to the resident. May have a Gortex cover.
 - b. Inflated cell height of the air cells through which air is being circulated is 5 inches or greater.
 - c. Height of the air chambers, proximity of the air chambers to one another, frequency of air cycling (for alternating pressure mattresses) and air pressure provide adequate patient lift, reducing pressure and prevent bottoming out.
 - d. A surface designed to reduce friction and shear.
 - e. May be placed directly on a hospital bed frame.
 - f. Automatically readjusts inflation pressures with change in position of bed (for example, head elevation, and the like).
- (3) Augmentative communication devices. Used by residents who are unable to use natural oral speech as a primary means of communication. The specific device requested must be appropriate for use by the resident and the resident must demonstrate the abilities or potential abilities to use the device selected. Portable devices need to supplement, aid or serve as an alternative to natural speech for residents with severe expressive communication disorders. Nonportable devices may be covered only if required for visual enhancement or physical access needs that cannot be accommodated by a portable device.
- (4) Ventilators (and related supplies).
- a. Used by residents 21 years of age and older who require full ventilator support for a minimum of 8 hours per day to sustain life.
 - b. Used by residents 20 years of age and younger who require ventilator support to sustain life (no minimum time requirement).

Financial Management Services

Financial Management Services (FMS) include fiscal-related services to Participants choosing to exercise employer and/or budget authority. FMS reduce the employer-related burden for Participants while making sure Medicaid and Commonwealth funds used to pay for services and supports as outlined in the Participant's PCSP are managed and disbursed appropriately as authorized. The FMS provider must operate as either a qualified Vendor Fiscal/Employer Agent (F/EA) or as a qualified Government Fiscal/Employer Agent (F/EA). The F/EA must:

- Have an FMS policies and procedures manual, that includes the policies, procedures and internal controls that describe the proper operation of the F/EA, that are in accordance with federal, state, and local tax, labor, workers compensation and program rules and regulations.
- Enroll Participants in FMS and apply for and receive approval from the IRS to act as an agent on behalf of the Participant.
- Provide orientation and skills training to Participants on required documentation for all directly hired support workers, including the completion of federal and State forms; the completion of timesheets; good hiring and firing practices; establishing work

schedules; developing job descriptions; training and supervision of workers; effective management of workplace injuries; and workers compensation.

- Conduct criminal background checks and when applicable, child abuse clearances, on potential employees.
- Distribute, collect and process support worker timesheets as verified and approved by the Participant.
- Prepare and issue support workers' payroll checks, as approved in the Participant's PCSP.
- Withhold, file and deposit federal, state and local income taxes in accordance with federal IRS and state Department of Revenue rules and regulations.
- Broker workers' compensation for all support workers through an appropriate agency.
- Process all judgments, garnishments, tax levies, or any related holds on workers' pay as may be required by federal, state or local laws.
- Prepare and disburse IRS Forms W-2's and/or 1099's, wage and tax statements and related documentation annually.
- Assist in implementing the state's quality management strategy related to FMS.
- Establish an accessible customer service system for the Participant and the Service Coordinator.
- Assist Participants in verifying support workers citizenship or alien status.
- Receive, verify and process all invoices for Participant Goods and Services as approved in the Participant's Spending Plan (Budget Authority only).
- Provide written financial reports to the Participant, the Service Coordinator and OLTL on a monthly and quarterly basis, and as requested by the Participant, Service Coordinator, and OLTL.

FMS is reimbursed on a per-member per-month basis with a one-time start-up fee for all new Participants that enroll for FMS. The one-time start-up fee applies to new Participants and will only be paid once in a lifetime per Participant. The initial start-up fee covers the lengthy process of enrolling Participants as a common law employee. The one-time start-up fee and the ongoing per-member per-month service fee may not be billed simultaneously.

Home Adaptations

Home Adaptations are physical adaptations to the private residence of the Participant, as specified in the Participant's PCSP and determined necessary in accordance with the Participant's assessment, to ensure the health, welfare and safety of the Participant, and enable the Participant to function with greater independence in the home. This includes primary egress into and out of the home, facilitating personal hygiene, and the ability to access common shared areas within the home. Home Adaptations consist of installation, repair, maintenance, permits, necessary inspections, extended warranties for the adaptations. Adaptations to a household are limited to the following:

- Ramps from street, sidewalk or house.
- Installation of specialized electric and plumbing systems that is necessary to accommodate the medical equipment and supplies necessary for the health, welfare and safety of the Participant.

- Vertical lifts.
- Portable or track lift systems. A portable lift system is a standing structure that can be wheeled around. A track lift system involves the installation of a “track” in the ceiling for moving a Participant with a disability from one location to another.
- Handrails and grab-bars in and around the home.
- Accessible alerting systems for smoke/fire/carbon monoxide for Participants with sensory impairments.
- Outside railing to safely access the home.
- Widened doorways, landings and hallways.
- Swing-clear and expandable offset door hinges.
- Flush entries and leveled thresholds.
- Slip resistant flooring.
- Kitchen counter, sink and other cabinet modifications (including brackets for appliances).
- Bathroom adaptations for bathing, showering, toileting and personal care needs.
- Stair gliders and stair lifts. A stair lift is a chair or platform that travels on a rail, installed to follow the slope and direction of a staircase, which allows a user to ride up and down stairs safely.
- Raised electrical switches and sockets.
- Other adaptations, subject to approval, to address specific assessed needs as identified in the service plan.

All adaptations to the home shall be provided in accordance with applicable building codes. Home Adaptations shall meet standards of manufacture, design and installation. Home Adaptations must be an item of modification that the family would not be expected to provide to a family member without a disability or specialized needs. Materials and equipment must be based on the Participant’s need as documented in the ISP.

This service does not include, but requires, an independent evaluation. Depending on the type of adaptation, and in accordance with their scopes of practice and expertise, the independent evaluation may be conducted by an occupational therapist; a speech language pathologist; or physical therapist meeting all applicable Department standards, including regulations, policies and procedures relating to Provider qualifications. Such assessments may be covered through another waiver service, as appropriate. Home adaptations must be obtained at the lowest cost.

Building a new room is excluded. Specialized Medical Equipment and Supplies is excluded. Also excluded are those adaptations or improvements to the home that are of general maintenance and upkeep and are not of direct medical or remedial benefit to the Participant this includes items that are not up to code. Adaptations that add to the total square footage of the home are excluded from this benefit, except when necessary for the addition of an accessible bathroom when the cost of adding the bathroom is less than retrofitting an existing bathroom.

Rented property adaptations must meet the following:

- There is a reasonable expectation that the Participant will continue to live in the home.
- Written permission is secured from the property owner for the adaptation.

- The landlord will not increase the rent because of the adaptation.
- There is no expectation that waiver funds will be used to return the home to its original state.

This service may not be included on the same service plan as Residential Habilitation.

Home Delivered Meals

The Home Delivered Meals service provides meals that meet at least one-third (1/3) of the Dietary Reference Intakes to people in their private homes. Home Delivered Meals provides meals to Participants who cannot prepare or obtain nutritionally adequate meals for themselves, or when the provision of such meals will decrease the need for more costly supports to provide in-home meal preparation. Home Delivered Meals must be specified in the service plan, as necessary, to promote independence and to ensure the health, welfare and safety of the Participant. Participants may receive more than one meal per day, but they cannot receive meals that constitute a “full nutritional regimen” (three meals per day).

All meals must be consistent with a prescribed menu approved by a dietician and, in accordance with the menu:

- May consist of hot, cold, frozen, dried, canned, fresh or supplemental foods.
- Can either be a hot, cold, frozen or shelf-stable meal.

Home Delivered Meals are provided only during those times when neither the Participant nor anyone else in the household is able or available to provide them, and where no other relative, caregiver, community/volunteer agency or third-party payer is able to provide, or be responsible for, their provision. Meals provided as part of this service shall not constitute a full nutritional regimen (three meals per day). Transportation for the delivery of meals is included in the service cost and will not be reimbursed separately.

Home Health Services

Home Health Services consist of the following components: Home Health Aide Services, Nursing Services, Physical Therapy, Occupational Therapy and Speech and Language Therapy.

1. Home Health Aide Services

Home Health Aide services are direct services prescribed by a physician to enable the Participant to integrate more fully into the community and to ensure the health, welfare and safety of the Participant. The physician’s order must be obtained every sixty (60) days for continuation of service. Home Health Aide services are provided by a home health aide who is supervised by a registered nurse. The registered nurse supervisor must reassess the Participant’s situation in accordance with 55 PA Code Chapter 1249, §1249.54. Home Health Aide activities include, personal care, performing simple measurements and tests to monitor a participant’s medical condition, assisting with ambulation, assisting with other medical equipment and assisting with exercises taught by a registered nurse, licensed practical nurse or licensed physical therapist

Home Healthcare Aide services cannot be provided simultaneously with Personal Assistance Services, Adult Daily Living Services, or Respite Services.

2. Nursing Services

Nursing services are direct services prescribed by a physician that are needed by the Participant to integrate more fully into the community and to ensure the health, welfare and safety of the Participant. Nursing services are within the scope of the State's Nurse Practice Act and are provided by a registered professional nurse, or licensed practical nurse under the supervision of a registered nurse, licensed to practice in the State. The physician's order must be obtained every sixty (60) days for continuation of service. Nursing services are individual, and can be continuous, intermittent, or short-term based on individual's assessed need.

3. Physical Therapy

Physical Therapy services are direct services prescribed by a physician that assist Participants in the acquisition, retention or improvement of skills necessary to enable the Participant to integrate more fully into the community and to ensure the health, welfare and safety of the Participant. Training caretakers and developing a home program for caretakers to implement the recommendations of the therapist are included in the provision of services. The physician's order to reauthorize the service must be obtained every sixty (60) days for continuation of service. Physical Therapy can be provided by a licensed physical therapist or physical therapist assistant as prescribed by a physician, and in accordance with the Physical Therapy Practice Act (63 P.S. §1301 et seq.).

4. Occupational Therapy

Occupational Therapy services are direct services prescribed by a physician that assist Participants in the acquisition, retention or improvement of skills necessary to enable the Participant to integrate more fully into the community and to ensure the health, welfare and safety of the Participant. Training caretakers and developing a home program for caretakers to implement the recommendations of the therapist are included in the provision of services. The physician's order must be obtained every sixty (60) days for continuation of service. Occupational Therapy services can be provided by a licensed occupational therapist or an occupational therapist assistant in accordance with the Occupational Therapy Practice Act (63 P.S. §1501 et seq.)

5. Speech and Language Therapy

Speech and Language Therapy services are direct services prescribed by a physician that assist Participants in the acquisition, retention or improvement of skills necessary to enable the Participant to integrate more fully into the community and to ensure the health, welfare and safety of the Participant. Training caretakers and development of a home program for caretakers to implement the recommendations of the therapist are included in the

provision of Speech and Language Therapy services. The physician's order to reauthorize the service must be obtained every sixty (60) days for continuation of service. Speech and Language Therapy services are provided by a licensed American Speech Language Hearing Associate or certified speech-language pathologist in accordance with applicable State standards including the evaluation, counseling, habilitation and rehabilitation of individuals whose communicative disorders involve the functioning of speech, voice or language, including the prevention, identification, examination, diagnosis and treatment of conditions of the human speech language system. Speech and Language Therapy services also include the examination for, and adapting and use of augmentative and alternative communication strategies.

Job Coaching

Job Coaching services are individualized services providing supports to Participants who need ongoing support to learn a new job and maintain a job in a competitive employment arrangement in an integrated work setting in a position that meets job and career goals. Participants in a competitive employment arrangement receiving Job Coaching services are compensated at or above the minimum wage and receive not less than the customary wage and level of benefits paid by the employer for the same or similar work performed by individuals without disabilities. Job Coaching can also be used to support Participants who are self-employed. Job Coaching services are necessary, as specified in the service plan, to support the Participant to live and work successfully in home and community-based settings, enable the Participant to integrate more fully into the community and ensure the health, welfare and safety of the Participant. Job Coaching provides two components in accordance with an assessment: Intensive Job Coaching and Extended Follow-along.

Intensive Job Coaching includes on-the-job training and skills development; assisting the Participant with development of natural supports in the workplace; and coordinating with employers or employees, coworkers and customers, as necessary. Intensive Job Coaching includes assisting the Participant in meeting employment expectations, performing business functions, addressing issues as they arise, and also includes travel training and diversity training to the specific business where the Participant is employed. Intensive Job Coaching provides support to assist Participants in stabilizing in an integrated situation (including self-employment) and may include activities on behalf of the Participant when the Participant is not present to assist in maintaining job placement. Participants receiving Intensive Job Coaching require on-the-job support for more than twenty percent (20%) of their work week at the outset of the service, phasing down to twenty percent (20%) per week during the Intensive Job Coaching period (at which time, Extended Follow-along will be provided if ongoing support is needed). Job Coaching supports within this range should be determined based on the Participant's needs.

Intensive Job Coaching for the same employment site and/or position may only be authorized for up to 6 months and may be reauthorized for additional 6 month periods, upon review with the service planning team. Intensive Job Coaching may only be reauthorized twice, for a total of 18 consecutive months of Intensive Job Coaching support for the same employment site and/or position. Intensive Job Coaching is recommended for new employment placements or may be reauthorized for the same location after a period of

Extended Follow-along, due to change in circumstances (new work responsibilities, personal life changes, etc.).

Extended Follow-along is ongoing support available for an indefinite period as needed by the Participant to maintain their paid employment position once they have been stabilized in their position (receiving less than 20% onsite support for at least four weeks). Extended Follow-along support may include reminders of effective workplace practices and reinforcement of skills gained during the period of Intensive Job Coaching. Once transitioned to Extended Follow-along, Providers are required to make at least two (2) visits per month, up to a maximum of two-hundred forty (240) hours per service plan year. This allows an average of twenty (20) hours per month to manage difficulties which may occur in the workplace and the limit may be used for the participant over an annual basis, as needed. If circumstances require more than that amount per service plan year, the service must be billed as Intensive Job Coaching.

Job Coaching services may not be rendered under the waiver to a Participant under a program funded by either the Rehabilitation Act of 1973 as amended or the Individuals with Disabilities Education Act (IDEA) or any other small business development resource available to the participant. This means that Job Coaching may only be provided when documentation has been obtained that one of the following has occurred:

1. OVR has closed a case for the Participant or has stopped providing services to the Participant;
2. The Participant was determined ineligible for OVR services; or
3. For anyone eligible for IDEA services, it has been verified that the services are not available in a complete and approved Individualized Education Program (IEP) developed pursuant to IDEA.

Job Coaching does not include facility-based or other similar types of vocational services furnished in specialized facilities that are not a part of the general workplace.

Job Coaching does not include payment for supervision, training, support and adaptations typically available to other non-disabled workers filling similar positions in the business

Job Finding

Job Finding is an individualized service that assists Participants to obtain competitive, integrated employment paid at or above the minimum wage. Job Finding identifies and/or develops potential jobs and assists the Participant in securing a job that fits the Participant's skills and preferences and employer's needs. If the Participant has received a Career Assessment, the results of that assessment must be addressed within the PCSP and by the Job Finding service.

Job Finding may include customized job development. Customized job development is based on individualizing the employment relationship between employees and employers in a way that matches the needs of the employer with the assessed strengths, skills, needs, and interests of the participant, either through task reassignment, job carving, or job sharing.

Job Finding, which may include prospective employer relationship building, is time-limited. Job Finding requires authorization up to ninety (90) days, with re authorization every (90) days, for up to one (1) year. At each ninety (90) day interval, the PCSP team will meet to clarify employment goals and expectations and review the job finding strategy. The service also includes transportation as an integral component of the service, such as to a job interview, during the delivery of Job Finding.

Job Finding does not include activities covered through Job Coaching once employment is obtained. Job Finding does not include skills training to qualify for a job.

Job Finding services may not be rendered under the waiver to a Participant under a program funded by either the Rehabilitation Act of 1973 as amended or the Individuals with Disabilities Education Act (IDEA) or any other small business development resource available to the participant. This means that job finding may only be provided when documentation has been obtained that one of the following has occurred:

1. OVR has closed a case for the Participant or has stopped providing services to the Participant;
2. The Participant was determined ineligible for OVR services; or
3. For anyone eligible for IDEA services, it has been verified that the services are not available in a complete and approved Individualized Education Program (IEP) developed pursuant to IDEA.

Non-Medical Transportation

Non-Medical Transportation services enable Participants to gain access to LTSS services as specified in the PCSP. This service is offered in addition to medical transportation services required under 42 CFR 440.170 (a) (if applicable), and shall not replace them. Non-Medical Transportation services include mileage reimbursement for drivers and others to transport a Participant and/or the purchase of tickets or tokens to secure transportation for a Participant. Non-Medical Transportation must be billed per one-way trip or billed per item, for example a monthly bus pass. Transportation services must be tied to a specific objective identified on the PCSP.

Non-medical Transportation services may only be authorized on the PCSP after an individualized determination that the method is the most cost-effective manner to provide needed Transportation services to the Participant, and that all other non-Medicaid sources of transportation which can provide this service without charge (such as family, neighbors, friends, community agencies) have been exhausted.

Non-Medical Transportation does not cover reimbursement to the Participant or another individual when driving the Participant's vehicle. Non-Medical Transportation does not pay for vehicle purchases, rentals, modifications or repairs. Non-Medical Transportation cannot be provided at the same time as Adult Daily Living services with transportation. An individual cannot provide both Personal Assistance Services and Non-Medical Transportation simultaneously.

Nursing Facility Services

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Professionally supervised nursing care and related medical and other health services furnished by a health care facility licensed by the Pennsylvania Department of Health as long-term care nursing facility under Chapter 8 of the Health Care Facilities Act (35 P.S. §§ 448.801—448.821) and certified as a nursing facility provider in the MA Program (other than a facility owned or operated by the state or federal government or agency thereof). Nursing facility services include services that are skilled nursing and rehabilitation services under the Medicare Program and health-related care and services that may not be as inherently complex as skilled nursing or rehabilitation services but which are needed and provided on a regular basis in the context of a planned program or health care and management. A Participant must be NFCE to receive nursing facility services under the CHC Program.

Nursing Facility Services includes at least the items and services specified in 42 CFR 438.1(c)(8)(i). Nursing facility services are covered as defined in 55 PA Code 1187.51.

Participant-Directed Community Supports

Participant-Directed Community Supports will be offered to Participants utilizing budget authority. Participant-Directed Community Supports are specified by the PCSP, as necessary, to promote independence and to ensure the health, welfare and safety of the Participant. The Participant is the common law employer of the individual worker(s) providing services; workers are recruited, selected, hired and managed by the Participant. Services include assisting the Participant with the following:

- Basic living skills such as eating, drinking, toileting, personal hygiene, dressing, transferring and other activities of daily living.
- Health maintenance activities such as bowel and bladder routines, assistance with medication, ostomy care, catheter care, wound care and range of motion activities.
- Improving and maintaining mobility and physical functioning.
- Maintaining health and personal safety.
- Carrying out household chores such as shopping, laundry, cleaning and seasonal chores.
- Preparation of meals and snacks.
- Accessing and using transportation (If providing transportation, the support services worker must have a valid driver's license and liability coverage as verified by the F/EA).
- Participating in community experiences and activities.

Participant-Directed Community Supports may not be provided at the same time as Home Health Aide Services, Respite, Personal Assistance Services and Participant-Directed Goods and Services.

Participant-Directed Goods and Services

Participant-Directed Goods and Services are services, equipment or supplies limited to Participants that are utilizing Budget Authority for Participant-directed service. Participant-directed goods and services are purchased from the Participant's Individual Spending Plan.

These items must address an identified need in the Participant's traditional service plan (including improving and maintaining the individual's opportunities for full participation in the community) and meet the following requirements. The item or service would meet one or more of the following:

- Decrease the need for other Medicaid services.
- Promote or maintain inclusion in the community.
- Promote the independence of the Participant.
- Increase the individual's health and safety in the home environment.
- Develop or maintain personal, social, physical or work-related skills.
- Increase the ability of unpaid family members and friends to receive training and education needed to provide support or
- Fulfill a medical, social or functional need as identified in the Participant's PCSP.

Participant-Direct Goods and Services does not include personal items and services not related to the disability, groceries, rent or mortgage payments, entertainment activities, or utility payments; may not be provided at the same time as Home Health Aide Services, Personal Assistance Services, and Participant-Directed Community Supports; and are limited to instances when the Participant does not have personal funds to purchase the item or service and the item or service is not available through another source.

Personal Assistance Services

Personal Assistance Services primarily provide hands-on assistance to Participants that are necessary, as specified in the PCSP, to enable the Participant to integrate more fully into the community and ensure the health, welfare and safety of the Participant. This service will be provided to meet the Participant's needs, as determined by an assessment, in accordance with Department requirements and as outlined in the Participant's PCSP. Personal Assistance Services are aimed at assisting the individual to complete tasks of daily living that would be performed independently if the individual had no disability. These services include: Care to assist with activities of daily living (e.g., eating, bathing, dressing, personal hygiene), cueing to prompt the Participant to perform a task, and providing supervision to assist a Participant who cannot be safely left alone. Health maintenance activities provided for the Participant, such as bowel and bladder routines, ostomy care, catheter, wound care and range of motion as indicated in the individual's PCSP and permitted under applicable State requirements. Routine support services, such as meal planning, keeping of medical appointments and other health regimens needed to support the Participant. Assistance and implementation of prescribed therapies. Overnight Personal Assistance Services provide intermittent or ongoing awake, overnight assistance to a Participant in their home for up to eight hours. Overnight Personal Assistance Services require awake staff.

Personal Assistance may include assistance with the following activities when incidental to personal assistance and necessary to complete activities of daily living: Activities that are incidental to the delivery of Personal Assistance include services such as changing linens, doing the dishes associated with the preparation of a meal, laundering of towels from bathing may be provided and must not comprise the majority of the service.

Services, as documented in the PCSP, to accompany the Participant into the community for purposes related to personal care, such as shopping in a grocery store, picking up medications and providing assistance with any of the activities noted above to enable the completion of those tasks.

This service must be provided in accordance with 42 CFR §441.301(c) (4) and (5), which outlines allowable setting for home and community-based waiver services. Settings cannot be located on the grounds of a Nursing Facility, Intermediate Care Facility (ICF), Institute for Mental Disease or Hospital. Instead they must be located in residential neighborhoods in the community.

Personal Emergency Response System (PERS)

PERS is an electronic device which enables CHC-MCO Participants to secure help in an emergency. The individual may also wear a portable “help” button to allow formobility. The system is connected to the person’s phone and programmed to signal a response center once a “help” button is activated. The response center is staffed by trained professionals, as specified. The PERS vendor must provide 24 hour staffing, by trained operators of the emergency response center, 365 days a year.

PERS services are limited to those individuals who: Live alone, are alone for significant parts of the day as determined in consideration of their health status, disability, risk factors, support needs and other circumstances., live with an individual that may be limited in their ability to access a telephone quickly when a Participant has an emergency, or would otherwise require extensive in-person routine monitoring and assistance. Installation, repairs, monitoring and maintenance are included in this service.

Pest Eradication

Pest eradication services will be available to make a Participant’s home fit for the Participant to live there. Pest Eradication Services are intended to aid in maintaining an environment free of insects, rodents and other potential disease carriers to enhance safety, sanitation and cleanliness of the Participant’s residence. The service may be considered for inclusion in the PCSP for a Participant transitioning to the community. It can also be made available on an ongoing basis if necessary as determined by the Service Coordinator (SC) and documented in the PCSP. That documentation needs to include the amount, duration and scope of services as determined by the SC. The service cannot be made available as a preference of the Participant to remove something on a property that has no impact on the Participant living there.

Residential Habilitation

Residential Habilitation Services are delivered in provider owned, rented/leased or operated settings. They can be provided in Licensed and unlicensed settings.

Licensed Settings are settings in which four or more individuals reside and are licensed as Personal Care Homes (reference 55 Pa. Code Chapter 2600) or Assisted Living
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Residences (reference 55 Pa. Code Chapter 2800). Unlicensed settings are provider owned, rented/leased or operated settings with no more than three residents.

Residential Habilitation services are provided for up to 24 hours a day. Residential Habilitation includes supports that assist participants with acquiring, retaining, and improving the self-help, socialization, and adaptive skills necessary to reside successfully in the community. These services are individually tailored supports that can include activities in environments designed to foster the acquisition of skills, appropriate behavior, greater independence and personal choice. Supports include cueing, on-site modeling of behavior, and/or assistance in developing or maintaining maximum independent functioning in community living activities, including domestic and leisure activities. Residential Habilitation also includes community integration, personal assistance services and night-time assistance. This includes any necessary assistance in performing activities of daily living (i.e., bathing, dressing, eating, mobility, and toileting) and instrumental activities of daily living (i.e., cooking, housework, and shopping).

Transportation is provided as a component of the Residential Habilitation service, and is therefore reflected in the rate for Residential Habilitation. Providers of (unlicensed and licensed) Residential Habilitation are responsible for the full range of transportation services needed by the individuals they serve to participate in services and activities specified in their PCSPs. This includes transportation to and from day habilitation and employment services.

Licensed settings may not exceed a licensed capacity of more than 8 unrelated individuals. Both licensed and unlicensed settings must be community-based as well as maintain a home-like environment. A home-like environment provides full access to typical facilities found in a home such as a kitchen and dining area, provides for privacy, allows visitors at times convenient to the individual, and offers easy access to resources and activities in the community. Residences are expected to be located in residential neighborhoods in the community. Participants have access to community activities, employment, schools or day programs.

This service must be provided in accordance with 42 CFR §441.301(c) (4) and (5), which outlines allowable setting for home and community-based services. Settings cannot be located on the grounds of a Nursing Facility, Intermediate Care Facility (ICF), Institute for Mental Disease or Hospital. Instead they must be located in residential neighborhoods in the community.

Individual considerations may be available for those individuals that require continual assistance as identified on their needs assessment to ensure their medical or behavioral stability. By the nature of their behaviors, individuals are not able to participate in activities or are unable to access the community without direct staff support. Residential Enhanced Staffing is treated as an add-on to the Residential Habilitation service and is only available when participants require additional behavioral supports.

Residential Enhanced Staffing may be provided at the following levels:

- Level 1: staff-to-individual ratio of 1:1.
- Level 2: staff-to-individual ratio of 2:1 or greater.

Respite

Respite services are provided to support individuals on a short-term basis due to the absence or need for relief of unpaid caregivers normally providing care. Respite Services are provided to individuals in their own home, the home of relative, friend, or other family, and are provided in quarter hour units. Respite may also be provided in a facility. Respite Services may be provided by a relative or family member as long as the relative or family member is not a legal guardian, power of attorney, or reside in the home.

Specialized Medical Equipment and Supplies

Specialized Medical Equipment and Supplies are services or items that provide direct medical or remedial benefit to the Participant and are directly related to a Participant's disability. These services or items are necessary to ensure health, welfare and safety of the Participant and enable the Participant to function in the home, community, or nursing facility with greater independence. This service is intended to enable Participants to increase, maintain, or improve their ability to perform activities of daily living. Specialized Medical Equipment and Supplies are specified in the Participant's PCSP and determined necessary in accordance with the Participant's assessment.

Specialized Medical Equipment and Supplies includes: Devices, controls or appliances, specified in the PCSP, that enable Participants to increase, maintain or improve their ability to perform activities of daily living, equipment repair and maintenance, unless covered by the manufacturer warranty, items that exceed the limits set for Medicaid State plan covered services, rental Equipment. In certain circumstances, needs for equipment or supplies may be time-limited.

Non-Covered Items: All prescription and over-the-counter medications, compounds and solutions (except wipes and barrier cream), items covered under third party payer liability, items that do not provide direct medical or remedial benefit to the Participant and/or are not directly related to a participant's disability, food, food supplements, food substitutes (including formulas), and thickening agents; eyeglasses, frames, and lenses; dentures, any item labeled as experimental that has been denied by Medicare and/or Medicaid, recreational or exercise equipment and adaptive devices for such.

This service does not include, but requires, an independent evaluation and a physician's prescription. The independent evaluation may be conducted by an occupational therapist; a speech language pathologist; or physical therapist meeting all applicable Department standards, including regulations, policies and procedures relating to provider qualifications. Such assessments may be covered through one of the following services offered through the waiver; Physical Therapy, Occupational Therapy, or Speech Therapy, or the State Plan as appropriate.

Hearing Aids require, but this service does not cover, an evaluation conducted by a

physician certified by the American Board of Otolaryngology. Hearing aids must be purchased from and fitted by a licensed audiologist, licensed physician, or registered hearing aid fitter in association with a registered hearing aid dealer.

Specialized Medical Equipment and Supplies exclude Assistive Technology

Structured Day Habilitation

Structured Day Habilitation Services provide assistance with acquisition, retention, or improvement in self-help, socialization and adaptive skills. Structured Day Habilitation Services provide waiver Participants comprehensive day programming to acquire more independent functioning and improved cognition, communication, and life skills. Activities and environments are designed to foster the acquisition of skills, appropriate behavior, greater independence, and personal choice as well as provide the supports necessary for mood and behavioral stability with therapeutic goals according to the written plan of care for the individual.

Services include social skills training, sensory/motor development, and education/elimination of maladaptive behavior. Services are directed at preparing the Participant for community reintegration, such as teaching concepts such as compliance, attending to task, task completion, problem solving, safety, communication skills, money management, and shall be coordinated with all services in the service plan. Services include assistance with activities of daily living including whatever assistance is necessary for the purpose of maintaining personal hygiene.

Services must be separate from the Participant's private residence or other residential living arrangement. Providers may, however, provide Structured Day Habilitation Services in the community, a Participant's private residence or other residential living arrangement if the room used is used for the sole purpose of these services. The provider must operate the Structured Day Habilitation Services for a minimum of four (4) hours per day up to a maximum of eight (8) hours per day on a regularly scheduled basis for one (1) or more days per week or as specified in the Participant's service plan. Structured Day Habilitation Services are distinguished from Adult Daily Living Services by the therapeutic nature of the program. Structured day habilitation services include the direct services provided by direct care staff and any supervision of the licensed care staff. The direct services must be personal care or directed toward the acquisition of skills. Supervision of Participants is not Medicaid reimbursable.

CHCs must consider enhanced staffing levels for those individuals that require continual assistance, as identified on their needs assessment, to ensure their medical or behavioral stability. These individuals, by the nature of their behaviors, are not able to participate in activities or are unable to access the community without direct staff support. Enhanced Structured Day Habilitation Services is an add-on to the Structured Day Habilitation Services and is only available when participants require additional behavioral supports.

Enhanced Structured Day Habilitation Staffing may be provided at the following levels:

- Level 1: staff-to-individual ratio of 1:1.
- Level 2: staff-to-individual ratio of 2:1 or greater.

Telecare

TeleCare integrates social and healthcare services supported by innovative technologies to sustain and promote independence, quality of life and reduce the need for nursing home placement. By utilizing in-home technology, more options are available to assist and support individuals so that they can remain in their own homes and reduce the need for re-hospitalization. TeleCare services are specified by the service plan, as necessary to enable the Participant to promote independence and to ensure the health, welfare and safety of the Participant and are provided pursuant to consumer choice. TeleCare includes: 1) Health Status Measuring and Monitoring TeleCare Service, 2) Activity and Sensor Monitoring TeleCare Service, and 3) Medication Dispensing and Monitoring TeleCare Services.

Health Status Measuring and Monitoring TeleCare Services: uses wireless technology or a phone line, including electronic communication between the Participant and healthcare provider focused on collecting health related data, i.e., vital signs information such as pulse/ox and blood pressure that assists the healthcare provider in assessing the Participant's condition) and providing education and consultation; must be ordered by a primary physician, physician assistant, or nurse practitioner; includes installation, daily rental, daily monitoring and training of the Participant, their representative and/or employees who have direct Participant contact; monitoring service activities must be provided by trained and qualified home health staff in accordance with required provider qualifications; and have a system in place for notification of emergency events to designated individuals or entities.

Activity and Sensor Monitoring TeleCare Service: employs sensor-based technology on a 24 hour/7 day basis by remotely monitoring and passively tracking Participants' daily routines and may report on the following: wake up times, overnight bathroom usage, bathroom falls, medication usage, meal preparation and room temperature; includes installation, monthly rental, monthly monitoring, and training of employees who have direct Participant contact; and ensures there is a system in place for notification of emergency events to designated individuals.

Medication Dispensing and Monitoring TeleCare Service: assists Participants by dispensing and monitoring medication compliance; and utilizes a remote monitoring system personally pre-programmed for each Participant to dispense, monitor compliance and provide notification to the provider or family caregiver of missed doses or non-compliance with medication therapy.

Therapeutic and Counseling Services

Therapeutic and counseling services are services that assist individuals to improve functioning and independence, are not covered by the Medicaid State Plan, and are necessary to improve the individual's inclusion in their community. Therapeutic and counseling services are provided by professionals and/or paraprofessionals in cognitive rehabilitation therapy, counseling, nutritional counseling and behavior management. The service may include assessing the individual, developing a home treatment/support plan, training family members/staff and providing technical assistance to carry out the plan, and monitoring of the Participant in the implementation of the plan. This service may be delivered in the Participant's home or in the community as described in the service plan.

- Cognitive rehabilitation therapy services focus on the attainment/re-attainment of
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cognitive skills. The aim of therapy is the enhancement of the Participant's functional competence in real-world situations. The process includes the use of compensatory strategies, and use of cognitive orthotics and prostheses. Services include consultation, ongoing counseling, and coaching/cueing. Services are provided by an occupational therapist, licensed psychologist, licensed social worker, licensed professional counselor, or a home health agency that employs them. Individuals with a bachelor's or master's degree in communication disorders, counseling, education, psychology, physical therapy, occupational therapy, recreation therapy, social work, or special education who are not licensed or certified, may practice under the supervision of a practitioner who is licensed.

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- Counseling services are non-medical counseling services provided to Participants in order to resolve individual or social conflicts and family issues. While counseling services may include family members, the therapy must be on behalf of the Participant and documented in his/her service plan. Services include initial consultation and ongoing counseling performed by a licensed psychologist, licensed social worker, or licensed professional counselor. If there is a mental health or substance abuse diagnosis, including adjustment disorder, the State Plan, through the Office of Mental Health and Substance Abuse Services, will cover the visit outside of the home and community-based services waiver up to pre-specified limits. Counseling services are utilized only once State Plan limitations have been reached, no diagnosis is present or the service is deemed to not be Medically Necessary or not making meaningful progress under State Plan standards.
- Nutritional Consultation assists the Participant and/or their paid and unpaid caregivers in developing a diet and planning meals that meet the Participant's nutritional needs, while avoiding any problem foods that have been identified by a physician. The service may include initial assessment and reassessment, the development of a home treatment/support plan, training and technical assistance to carry out the plan, and monitoring of the Participant, caregiver and any providers in the implementation of the plan. Services include counseling performed by a Registered Dietitian or a Certified Nutrition Specialist. Nutritional Consultation services may be delivered in the Participant's home or in the community, as specified in the service plan. The purpose of Nutritional Consultation services is to improve the ability of Participants, paid and/or unpaid caregivers and providers to carry out nutritional interventions. Nutritional counseling services are limited to 90-minutes (6 units) of nutritional consultations per month. Plans may exceed the 90-minute limit at their discretion and own cost. Home health agencies that employ licensed and registered dietitians may provide nutritional counseling. A provider of nutrition services should be a registered dietitian /nutritionist or a PA licensed dietitian / nutritionist.
- Behavior therapy services include the completion of a functional behavioral assessment; the development of an individualized, comprehensive behavioral support plan; and the provision of training to individuals, family members and direct service providers. Services include consultation, monitoring the implementation of the behavioral support plan and revising the plan as necessary. Behavior therapy services are provided by a licensed psychologist, licensed social worker, licensed

behavior specialist, or licensed professional counselor. A masters level clinician without licensure, certification or registration, must be supervised by a licensed psychologist, licensed social worker, licensed professional counselor or licensed behavior analyst.

Vehicle Modifications

Vehicle modifications are modifications or alterations to an automobile or van that is the participant's means of transportation in order to accommodate the special needs of the participant. Vehicle modifications are modifications needed by the participant, as specified in the service plan and determined necessary in accordance with the participant's assessment, to ensure the health, welfare and safety of the participant and enable the participant to integrate more fully into the community.

The following are specifically excluded: modifications or improvements to the vehicle that are of general utility and are not of direct medical or remedial benefit to the participant, purchase or lease of a vehicle with or without existing adaptations, regularly scheduled upkeep and maintenance of a vehicle, except upkeep and maintenance of the modifications, the waiver cannot be used to purchase vehicles for participants, their families or legal guardians.

Vehicle modifications funded through the waiver are limited to the following: vehicular lifts, portable ramps when the sole purpose of the ramp is for the participant to access the vehicle, interior alterations to seats, head and leg rests and belts, customized devices necessary for the participant to be transported safely in the community, including driver control devices, modifications needed to accommodate a participant's special sensitivity to sound, light or other environmental conditions, raising the roof or lowering the floor to accommodate wheelchairs, the vehicle must be less than five (5) years old, and have less than 50,000 miles for vehicle modification requests over \$3,000. All vehicle modifications shall meet applicable standards of manufacture, design and installation.

Exhibit FF
Participants' Rights and Responsibilities

PARTICIPANTS' RIGHTS

Each CHC-MCO must have written policies regarding the enrollee rights specified in this Exhibit

Each CHC-MCO must comply with any applicable Federal and State laws that pertain to enrollee rights, and its staff and affiliated providers must take those rights into account when furnishing services to enrollees.

A participant has the right to:

- Receive accurate, easily understood information and assistance in making informed health care and LTSS decisions about their health plans, professionals, and facilities.
- A choice of health care and LTSS providers that is sufficient to ensure access to appropriate high-quality health care.
- Access emergency health care services when and where the need arises.
- Responsibility to fully participate in all decisions related to their health care and LTSS. Participants who are unable to fully participate in treatment decisions have the right to be represented by parents, guardians, family members, or other conservators.
- Considerate, respectful care from all members of the health care and LTSS system at all times and under all circumstances.
- Communicate with health care providers in confidence and to have the confidentiality of their individually identifiable health care and LTSS information protected. Participants also have the right to review and copy their own medical and LTSS records and request amendments to their records.
- A fair and efficient process for resolving differences with their health plans, health care and LTSS providers, and the institutions that serve them, including a rigorous system of internal review and an independent system of external review.
- 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 restraints and seclusion;

The information requirements for services that are not covered under the contract because of moral or religious objections are set forth in 42 C.F.R. § 438.10(f)(6)(xii)(relating to State Plan benefits).

Each Participant is free to exercise his or her rights, and the exercise of those rights may not adversely affect the way the CHC-MCO and its providers treat the enrollee.

CHC-MCO must comply with any other applicable Federal and State laws (such as: title VI of the Civil Rights Act of 1964 as implemented by regulations at 45 CFR part 80; the Age Discrimination Act of 1975 as implemented by regulations at 45 CFR part 91; the Community HealthChoices Agreement Effective January 1, 2017

Rehabilitation Act of 1973; and titles II and III of the Americans with Disabilities Act; and other laws regarding privacy and confidentiality).

PARTICIPANTS' RESPONSIBILITIES

CHC Participants have the following responsibilities:

- Take responsibility for maximizing healthy habits, such as exercising, not smoking, and eating a healthy diet.
- Become involved in specific health care decisions.
- Work collaboratively with health care and LTSS providers in developing and carrying out agreed-upon treatment plans.
- Disclose relevant information and clearly communicate wants and needs.
- Use the health plan's internal complaint and appeal processes to address concerns that may arise.
- Avoid knowingly spreading disease.
- Recognize the reality of risks and limits of the science of medical care and the human fallibility of the health care professional.
- Be aware of a health care and LTSS provider's obligation to be reasonably efficient and equitable in providing care to other patients and the community.
- Become knowledgeable about his or her health plan and LTSS coverage and health plan and LTSS options (when available) including all covered benefits, limitations, and exclusions, rules regarding use of network providers, coverage and referral rules, appropriate processes to secure additional information, and the process to appeal coverage decisions.
- Show respect for other patients, health workers, and LTSS workers.
- Make a good-faith effort to meet financial obligations.
- Abide by administrative and operational procedures of health plans, health care and LTSS providers, and Government health benefit programs.
- Report wrongdoing and fraud to appropriate resources or legal authorities.

Exhibit GG
MIPPA Agreement Requirements

The CHC-MCO must operate an aligned D-SNP concurrently with its CHC-MCO. For the Southwest zone, the CHC-MCO must be in process in January 2017 to have a D-SNP operating by and must have a CMS-approved D-SNP operating by January 1, 2018. For other zones, the CHC-MCO must have a D-SNP operating at the time of implementation for the zone. This D-SNP will be required to enter into a MIPPA Agreement with the Department. The MIPPA Agreement will address the eight elements required of all MIPAA agreements,¹ and will also include additional requirements to ensure the greatest possible coordination between the CHC-MCO and the D-SNP including, but not limited to, the following.

General Provisions

- a. CHC-MCOs will be required to have a companion D-SNP in place and ready to enroll as of the same dates and service areas as the CHC-MCOs with the exception of the Southwest zone. For the Southwest zone, the CHC-MCO must be in process in January 2017 to have a D-SNP operating by and must have a CMS-approved D-SNP operating by January 1, 2018.
- b. The goal of the CHC-MCO and its companion D-SNP is to provide a coordinated experience from the perspective of Full Dual Eligible Participants who enroll in both. This includes, but is not limited to, an integrated assessment and care coordination process that spans all Medicaid and Medicare services.
- c. Administrative integration is expected to evolve over the life of the CHC program. The CHC-MCO will cooperate fully with the Department and CMS in their ongoing efforts to streamline administration of the two programs which may include, but is not limited to, coordinated readiness reviews, monitoring, enrollment, Participant materials and appeals processes.

¹ CMS Medicare Managed Care Manual, Chapter 16b, Section 40.5.1 (Revised 11/28/14). Available at: <http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/mc86c16b.pdf>
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