EXHIBIT A
Managed Care Regulatory Compliance Guidelines

The following apply to all managed care organizations under contract with the Office of Medical Assistance Programs:

- All federal and state laws, including but not limited to 55 Pa.Code Chapters 1101-1249

- Non-compensable or non-covered services (managed care organizations may provide additional services beyond MA Fee for Service (FFS), but must cover, at a minimum, those services on the fee schedule in the same amount, duration and scope as the Fee for Service Program.)
- Scope of Benefits based on Recipient's eligibility (as determined by the County Assistance Office)
- Staff/Provider Licensing/Scope of Practice Requirements
- Frequency of service
- Program standards/quality of care standards
- Provider participation (enrolled as an MA Participating Provider)
- Utilization review
- Administrative sanctions
- Definitions

The following, which may appear in any of the above sections or Medical Assistance Bulletins, will not apply to managed care organizations:

- Maximum frequency of service limits (managed care organizations may provide more than the maximum).
- Maximum service reimbursement rates.
- Payment methodology.

CITATION/SPECIFIC EXCLUSION	REGULATORY LANGUAGE DESCRIPTION
Managed care organizations are to adhere to the provisions of 55 Pa.Code Chapter 1101, General Provisions, with the following exceptions:	
1101.21 Definition of "Prior Authorization"	Definitions
1101.21 Definition of "Shared Health Facility", (iv) and (v)	(iv) At least one practitioner receives payment on a fee for service basis. (v) A provider receiving more than $30,000 in payment from the MA Program during the 12-month period prior to the date of the initial or renewal application of the shared health facility for registration in the MA Program.
1101.21 Definition of "Medically Necessary"	A service, item, procedure or level of care that is: (i) Compensable under the MA Program. (ii) Necessary to the proper treatment or management of an illness, injury or disability. (iii) Prescribed, provided or ordered by an appropriate licensed practitioner in accordance with accepted standards of practice.
1101.31(b) (13) "…Dental Services as specified in Chapter 1149 (relating to Dentists' Services)."	Benefits, Scope for categorically needy

CITATION/SPECIFIC EXCLUSION	REGULATORY LANGUAGE DESCRIPTION
1101.31(f) Note: The managed care organizations are not required to impose limits that apply in the Fee-for-Service delivery system, although they are permitted to do so. The managed care organizations may not impose limits that are more restrictive than the limits established in the Fee-for-Service system. If the managed care organizations impose limits, their exception process cannot be more restrictive than the process established in §1101.31(f).	Benefits, Exceptions (for limits specified in subsections (b) and (e) - FFS Program Exception Process
1101.32(a) (1) "…Medically needy children referred from EPSDT are not eligible for pharmaceuticals, medical supplies, equipment or prostheses and orthoses." 1101.32(a)(2)	Coverage Variations, Expanded coverage EPSDT Coverage Variations, Expanded Coverage School Medical Program for Medically Needy school children
1101.33(a) "…If the applicant is determined to be eligible, the Department issues Medical Services Eligibility (MSE) cards that are effective from the first of the month through the last day of the month..."	Recipient Eligibility, Verification of Eligibility (issuance of card)
1101.33(b)	Recipient Eligibility, Services restricted to a single provider
1101.51(a)	Responsibilities, Ongoing responsibilities of providers, Recipient freedom of choice of providers
1101.61	Fees and Payments, Reimbursement policies.
1101.62	Maximum fees
1101.63(b)(1) through (10)	Payment in full, Copayments for MA services
1101.63(c)	Payment in full, MA deductible
1101.64(b) "…Payment will be made in accordance with established MA rates and fees."	Third-party medical resources, Persons covered by Medicare and MA
1101.65	Method of payment
1101.67	Prior Authorization (including timeframes for notice)
1101.68	Invoicing for services
1101.69	Overpayment – underpayment (related to providers)
1101.69(a)	Establishment of a uniform period for the recoupment of overpayments from providers (COBRA)
1101.72	Invoice adjustment
1101.83	Restitution and repayment (related to providers for payments that should not have been made)
Managed care organizations are not required to adhere to the provisions of 55 Pa.Code Chapter 1102, Shared Health Facilities. Managed care organizations are responsible for establishing their own provider networks.	
Managed care organizations are to adhere to the provisions of 55 Pa.Code Chapter 1121, Pharmaceutical Services, with the following exceptions:	
1121.2	Definitions of AWP, Compounded Prescription, Pricing Service, Federal Upper Limit, CMS Multi-source Drug, State MAC, and Usual and Customary Charge
1121.52(a)(6)	Payment conditions for various services (indication for "brand medically necessary")

CITATION/SPECIFIC EXCLUSION	REGULATORY LANGUAGE DESCRIPTION
1121.52(b)	Payment conditions for various services (prenatal vitamins)
1121.53(a)	Limitations on payment (not exceeding UCC to general public)
1121.53(b)(1)	Limitations on payment (conditions when limits on the State MAC will not apply)
1121.53(b)(2)	Limitations on payment (conditions when limits on the State MAC will not apply)
1121.53(c)	Limitations on payment (34 day supply or 100 units, total authorization not exceeding 6 months' or five refill supply)
1121.53(f)	Limitations on payment (Payment to pharmacy for prescriptions dispensed to a recipient in either a skilled nursing facility, an intermediate care facility or an intermediate care facility for the mentally retarded and specific scripts not included in the limitation)
1121.55	Method of payment. (relating to the Department's payment to pharmacies)
1121.56	Drug cost determination.
Managed care organizations are to adhere to the provisions of 55 Pa.Code Chapter 1123, Medical Supplies, with the following exceptions:	
1123.1 "and the MA Program fee schedule"	Policy. (Payment for medical supplies is subject to this chapter, Chapter 1101 (relating to general provisions) and the limitations established in Chapter 1150 (relating to MA Program payment policies) and the MA Program fee schedule.
1123.13(a) and (b).	Inpatient services.
1123.22(1).	Scope of benefits for the medically needy. ("Medical supplies which have been prescribed through the School Medical Program...")
1123.22(2) "who are enrolled in EPSDT, or which have been prior authorized by the Department as specified in 1123.56 (a) (2) (relating to vision aids)"	Scope of benefits for the medically needy. ("Eyeglasses which have been prescribed as treatment for individuals under 21 years of age who are enrolled in EPSDT...")
1123.51 "and the MA Program fee schedule"	Payment for Medical Supplies. General payment policy.
1123.53	Hemophilia products.
1123.54 "in accordance with the limitations described in this section and the maximum fees listed in Chapter 1150 (relating to Medical Assistance program payment policies) and the Medical Assistance Program fee schedule"	Orthopedic shoes, molded shoes and shoe inserts (Relating to payment when prescribed for eligible persons to approved MA providers)
1123.54(1) through (5).	Orthopedic shoes, molded shoes and shoe inserts (Relating to prior approval, conditions for payment, payment for modifications necessary for the application of a brace or splint, payment for repairs w/o a prescription or prior authorization, and payment for orthopedic shoes only if the recipient is 20 years of age or younger."
1123.55(a) "The prescription shall contain the cardiopulmonary diagnosis"	Oxygen and related equipment. (Relating to payment conditions)
1123.55(b) and (c).	Oxygen and related equipment. (Relating to prior authorization and prescription inclusion requirements)
1123.55(d) "and recertification shall be kept by the provider"	Oxygen and related equipment. ("A physician shall recertify orders for oxygen at least every 6 months and recertification shall be kept by the provider.")
1123.56(a)(1) through (3)	Vision aids. ("Payment for eyeglasses is made only if the recipient is 20 years of age or younger and the eyeglasses have been one of the following...")
1123.56(b)(1) through(3)	Vision aids. ("Payment for low vision aids is made only if the recipient is categorically needy or if the recipient is medically needy and the low vision aid has been one of the following...")

CITATION/SPECIFIC EXCLUSION	REGULATORY LANGUAGE DESCRIPTION
1123.56(c)	Vision aids. ("Payment for eye prostheses will be made only if the recipient is categorically needy.")
1123.57(a) and (b)	Hearing aids. (Relating to payment for hearing aids only if recipient is 20 years of age or younger and have been prescribed through the EPSDT program, and for repairs to hearing aids owned by the recipient when the invoice is accompanied by an itemized statement.)
1123.58(1) and (2)	Prostheses and orthoses.
1123.60(a) through (i)	Limitations on payments.
1123.61 (1) through (8) and (10)	Noncompensable services and items. (Relating to when payment will not be made. (9) is not excluded, as it relates to items prescribed or ordered by a practitioner who has been barred or suspended during an administrative action from participation in the MA Program.)
1123.62	Method of payment.
Managed care organizations are not required to adhere to the provisions of Medical Assistance Bulletin 05-86-02, Durable Medical Equipment Warranties.	
Managed care organizations are required to adhere to the provisions of Medical Assistance Bulletin 05-87-02, Coverage of Motorized Wheelchairs, with the following exceptions: - requiring Prior Authorization at the State level. - Page 2, number 7.	
Managed care organizations are to adhere to the provisions of Medical Assistance Bulletin 1123-91-01, EPSDT – OBRA '89 with the following exceptions: - Page 3 – Vision Services – the "age of 21" and the MA fee schedule do not apply. - Page 3 – Dental Services – the "age of 21" and the MA fee schedule do not apply. - Page 3 – Hearing Services – the "age of 21" and the MA fee schedule do not apply. - Page 3 – "and use of existing Medical Assistance Program Fee Schedule"	
Managed care organizations are not required to adhere to the provisions of Medical Assistance Bulletin 05-85-02, Policy Clarification for Services Provided to Hospitalized Recipients Under the DRG Payment System.	
Managed care organizations are to adhere to the provisions of 55 Pa.Code Chapter 1126, Ambulatory Surgical Center and Hospital Short Procedure Unit Services, with the following exceptions:	
1126.51(f) through (h) and (k) through (m)	Payment for Same Day Surgical Services. General payment policy. ((f-h)Relating to submission of invoices to the Department, consideration if ASC or SPU has fee schedule based on patient's ability to pay that the Department will consider it as the usual and customary charge, and the Department's payment being the lesser of the facility's charge to general public to be the most frequent charge to the self-paying public for the same service.) and (k-m relating to payment when patient in conjunction with same day service are transferred to a hospital due to complications and when patients due to complications must be transferred to inpatient hospital care)
1126.52(a) and (b)	Payment criteria. (Relating to the Department's maximum reimbursement and developed fees.)
1126.53(b)	Limitations on covered procedures. (Relating to limits for appropriate same day surgical procedures for same day surgery but are not yet included in the established list of covered ASC/SPU services.)
1126.54(a)(7)	Procedures and medical care performed in connection with sex reassignment.

CITATION/SPECIFIC EXCLUSION	REGULATORY LANGUAGE DESCRIPTION
1126.54(a)(11) through (13) and (b)	Noncompensable services and items. ("...The Department does not pay ASCs and SPUs for services directly or indirectly related to, or in conjunction with...diagnostic tests and procedures that can be performed in a clinic or practitioner's office and diagnostic tests and procedures not related to the diagnosis"; "Services and items for which full payment equal to or in excess of the MA fee is available through Medicare or other financial resources or other health insurance programs"; "Services and items not ordinarily provided to the general public"; and "...if the admission to the ASC or SPU is not certified under the Department's utilization review process applicable to the type of provider furnishing the service".)
Managed care organizations are to adhere to the requirements of 55 Pa.Code Chapter 1127, Birth Center Services, with the following exceptions:	
1127.51(d)	Payment for Birth Center Services. General payment policy. ("Claims shall be submitted to the Department under the provider handbook.")
1127.52(a) through (c)	Payment criteria. (Relating to the Department's establishment of maximum reimbursement fees and payment methodology)
1127.52(d) "The birth center visit fee shall be the amount equal to that of the midwives' or physicians' visit fee under the MA Program fee schedule."	Payment criteria. (Relating to termination of birth center services during prenatal care)
1127.52(e) "The amount of the payment is 50% of the third trimester rate of payment."	Payment criteria (to payment if complications develop during labor and patient is transferred to a hospital)
1127.53(c)	Limitations on payment.
Managed care organizations are to adhere to the provisions of 55 Pa.Code Chapter 1128, Renal Dialysis Facilities, with the following exceptions:	
1128.51(a) "and the MA Program fee schedule"	Payment for Renal Dialysis Services. General payment policy.
1128.51(b)	General payment policy. ("A fee determined by the Department is paid for support services provided to an eligible recipient during the course of a dialysis procedure."
1128.51(c) "and for billings"	General payment policy. ("The dialysis facility is considered the provider regardless of whether the facility is operated directly by the enrolled provider or through contract between the provider and other organizations or individuals. The enrolled provider is responsible for the delivery of the service and for billings.")
1128.51(d) "up to the amount of the MA fee, if the Medicare 80% payment and the amount billed to MA does not exceed the maximum MA fee"	General payment policy. ("The Department will pay for the unsatisfied portion of the Medicare deductible and remaining 20% coinsurance up to the amount of the MA fee, if the Medicare 80% payment and the amount billed to MA does not exceed the maximum MA fee.")
1128.51(f) through (i), (k) and (l)	General payment policy. (Relating to what is included in the fee paid to the facility, procedures fees are applicable to, Department's consideration of provider's usual and customary charge if facility has a fee schedule based on patient's ability to pay, and the Department's payment for dialysis services shall be considered payment in full.)
1128.51(m) "Payment shall be made in accordance with §1128.52 (relating to payment criteria)."	General payment policy. ("If a dialysis facility voluntarily terminates the provider agreement, payment is made for services provided prior to the effective date of the termination of the provider agreement. Payment shall be made in accordance with §1128.52 (relating to payment criteria).")
1128.51(n)	General payment policy. (Relating to payment to out-of-State dialysis facility.)
1128.52	Payment criteria.
1128.53(a) through (e)	Limitations on payment.

CITATION/SPECIFIC EXCLUSION	REGULATORY LANGUAGE DESCRIPTION
1128.53(f) "Payment for backup visits to the facility is limited to no more than 15 in one calendar year"	Limitations on payment.
1128.53(g)	Limitations on payment. (Relating to payment for nonexpendable equipment or installation of equipment necessary for home dialysis)
1128.54(1)	Noncompensable services and items. ("The Department does not pay dialysis facilities for: (1) Services that do not conform to this chapter.")
1128.54(4) through (7)	Noncompensable services and items. (Relating to Diagnostic or therapeutic procedures solely for experimental, research or educational purposes; procedures not listed in the MA Program fee schedule; services that are not medically necessary; and services provided to recipients who are hospital inpatients.)
Managed care organizations are to adhere to the provisions of 55 Pa.Code Chapter 1129, Rural Health Clinic Services, with the following exceptions:	
1129.51(b) and (c)	Payment for Rural Health Clinic Services. General payment policy. (Relating to payment for rural health clinic services made on the basis of an all-inclusive visit fee established by the Medicare carrier. When the cost for a service provided by the clinic is included in the established visit fee, the practitioner rendering the service shall not bill the MA Program for it separately; and adjustment to the all-inclusive visit fee when Medicare determines the difference between the total payment due and the total payment made. The Department will make a lump sum payment for the amount due.)
1129.52	Payment policy for provider rural health clinics.
1129.53	Payment policy for independent rural health clinics.
Managed care organizations are to adhere to the provisions of 55 Pa.Code Chapter 1130, Hospice Services, with the following exceptions:	
1130.22(4) "…Department's…specified in Appendix A." ***Note: The provider must have a Certification of Terminal Illness form containing the information found in Appendix A. The provider is not required to use the Department's Certification of Terminal Illness form.***	Duration of coverage. Certification form. (Relating to certification of terminal illness carried out using the Department's certification of terminal illness form.)
1130.41(a) "…specified in Appendix B." ***NOTE: The provider must have an Election statement containing the information found in Appendix B. The provider is not required to use the Department's Election statement.***	Election of hospice care. Election statement. (Relating to filing of the Election statement by the recipient or recipient's representative.)
1130.41(c) "specified in Appendix C." ***Note: The provider must have a Change of Hospice statement containing the information found in Appendix C. The provider is not required to use the Department's Change of Hospice statement.***	Election of hospice care. Change of designated hospice. (Relating to the ability to the ability to change hospices once in each certification period.)
1130.42(a) "specified in Appendix D." ***Note: The provider must have a Revocation statement containing the information found in Appendix D. The provider is not required to use the Department's Revocation statement.***	Revocation of hospice care. Right to revoke. (Relating to the ability of the recipient or recipient's representative to revoke the election of hospice care at any time utilizing the revocation statement.)

CITATION/SPECIFIC EXCLUSION	REGULATORY LANGUAGE DESCRIPTION
1130.63(b)	Limitations on coverage. (Relating to Respite care not exceeding a total of 5 days in a 60 day certification period.)
1130.63(c) "…but it is not reimbursable."	Limitations on coverage. (Relating to Bereavement counseling being a required hospice service but it is not reimbursable.)
1130.63(d) "…participating in the MA Program."	Limitations on coverage. (Relating to general inpatient care being provided in a general hospital, skilled nursing facility or a freestanding hospice participating in the MA Program.)
1130.63(e)	Limitations on coverage. (Relating to intermediate care facilities may only provide respite services to the hospice. Eligible MA recipients residing in an intermediate care facility may elect to receive care from a participating hospice.)
1130.71(c) through (h)	Payment for Hospice Care. General payment policy. (Relating to days not covered by valid certification, limitations on inpatient respite care to 5 days in a 60 day certification period; payment limitation for general inpatient care, if lesser care was provided; no MA payments will be made directly to nursing facility for services provided to a recipient under the care of a hospice; ambulance transportation inclusion in daily rates; and the Department's reduction in payment for hospice care by the amount of income available from the recipient towards the hospice care rate established by the Department.)
1130.72.	Payment for physicians' services. (Relating to the services performed by hospice physicians that are included in the level of care rates paid for a day of hospice care."
1130.73.	Additional payment for nursing facility residents. (Relating to additional payments made to a hospice for hospice care furnished to an MA recipient who is a resident of a skilled or intermediate care facility – taking into account the cost of room and board and how room and board rates will be calculated.)
Managed care organizations are to adhere to the provisions of 55 Pa.Code Chapter 1140, Healthy Beginnings Plus Program, with the following exceptions:	
1140.52(2) "…billed to the Department…"	Payment for HBP Services. Payment Conditions.
1140.53	Limitations on Payment. (Relating to payment for the trimester component including all prenatal visits during the trimester; qualified providers may bill for either high risk maternity care package OR the basic maternity care package for each trimester; and the fee for the applicable trimester maternity care package includes payment to the practitioner performing the delivery and postpartum care.)
1140.54(1)	Noncompensable services and items.
Managed care organizations are to adhere to the requirements of 55 Pa.Code Chapter 1141, Physicians' Services, with the following exceptions:	
1141.53(a) through (c)	Payment conditions for outpatient services. (Relating to payment made in an approved SPU only if the service could not appropriately and safely be performed in the physician's office, clinic or ER of a hospital; prior authorization requirements for specialists' examinations and consultations; and services provided to recipients in skilled and intermediate care facilities by the physician administrator or medical director.)
1141.53(f) and (g)	Payment conditions for outpatient services. (Relating to all covered outpatient physicians' services billed to the Department shall be performed by such physician personally or by a registered nurse, physician's assistant, or a midwife under the physician's direct supervision; and payment by the Department of a $10 per month fee to physicians who are approved by the Department to participate in the restricted recipient program.)

CITATION/SPECIFIC EXCLUSION	REGULATORY LANGUAGE DESCRIPTION
1141.54(a)(1) through (3)	Payment conditions for inpatient services. (Relating to when a physician is eligible to bill the Department for services provided to a hospitalized recipient.)
1141.54(f)	Payment conditions for inpatient services. (Relating to inpatient physicians' services billed to the Department shall be performed by the physician, an RN, PA or midwife under the physician's direct supervision.)
1141.55(b)(1) "MA 31"; "in accordance with all instructions in the Provider Handbook"; and "See Appendix A for a facsimile of the Consent Form and the Provider Handbook for detailed instructions on its completion." ***NOTE: A consent form is required and must contain all the information found in Appendix A.***	Payment conditions for sterilizations. (Relating to consent requirements and use of the MA31 Consent Form.)
1141.55(c) "MA 31" 1141.55(c)(2) "in accordance with instructions in the Provider Handbook" 1141.55(c)(3) "in accordance with instructions in the Provider Handbook"	Payment conditions for sterilizations. ("A Consent Form, MA 31, is considered to be completed correctly only if all of the following requirements are met:") Payment conditions for sterilizations. ("The person obtaining informed consent has properly signed the Consent Form in accordance with instructions in the Provider Handbook on the same date that informed consent is given." Payment conditions for sterilizations. ("Any other witness or interpreter has properly signed the Consent Form in accordance with instructions in the Provider Handbook on the same date that informed consent is given.")
1141.56(a)(3) "See the Provider Handbook for a facsimile of the Patient Acknowledgement Form for Hysterectomy, MA 30, and for instructions on its completion."	Payment conditions for hysterectomies. (Relating to Patient Acknowledgement Form for Hysterectomy MA 30)
1141.57(a)(2) "and the incident was reported to a law enforcement agency or to a public health service within 72 hours of its occurrence in the case of rape and within 72 hours of the time the physician notified the patient that she was pregnant in the case of incest. A law enforcement agency means an agency or part of an agency that is responsible for the enforcement of the criminal laws, such as a local police department or sheriff's office. A public health service means an agency of the Federal, State, or local government or a facility certified by the Federal government as a Rural Health Clinic that provides health or medical services except for those agencies whose principal function is the performance of abortions."	Payment conditions for necessary abortions (Where the recipient was the victim of rape or incest)

CITATION/SPECIFIC EXCLUSION	REGULATORY LANGUAGE DESCRIPTION
1141.57(a)(2)(i) "with the Medical Services Invoice along with documentation signed by an official of the law enforcement agency or public health service to which the rape or incest was reported. The documentation shall include the following": 1141.57(a)(2)(i)(A) and (B)	Payment conditions for necessary abortions (Payment will be made only if a licensed physician submits a signed ‘‘Physician Certification for an Abortion’’ form, as set forth in Appendix B,) (A) All of the information specified in subparagraph (ii). (B) A statement that the report was signed by the person making the report.
1141.57(a)(2)(ii)(A) through (D)	Payment conditions for necessary abortions (report of rape or incest)
1141.57(c)	Abortions after the first 12 weeks
1141.59(1) through (5)	Payment for Physician Services, Noncompensable services, Procedures not listed in the Medical Assistance program fee schedule. Medical services or surgical procedures performed on an inpatient basis that could have been performed in the physician’s office, the clinic, the emergency room, or a short procedure unit without endangering the life or health of the patient, Medical or surgical procedures designated in the Medical Assistance program fee schedule as outpatient procedures, Dental rehabilitation and restorative services, Diagnostic tests, for which a patient was admitted, that may be performed on an outpatient basis; tests not related to the diagnosis and treatment of the illness for which the patient was admitted; tests for which there is no medical justification.
1141.59(7) and (8)	Payment for Physician Services, Noncompensable services, Hysterectomy performed solely for the purpose of rendering an individual incapable of reproducing, Acupuncture, medically unnecessary surgery, insertion of penile prosthesis, gastroplasty for morbid obesity, gastric stapling or ileo-jejunal shunt—except when all other types of treatment of morbid obesity have failed—
1141.59(10) and (11)	Services to inpatients who no longer require acute inpatient care and surgical procedures and medical care provided in connection with sex reassignment.
1141.59 (14) through (16)	Diagnostic pathological examinations of body fluids or tissues, Services and procedures related to the delivery within the antepartum period and postpartum period, Medical services or surgical procedures performed in a short procedure unit that could have been appropriately and safely performed in the physician’s office, the clinic, or the emergency room without endangering the life or health of the patient.
1141.60	Payment for medications dispensed or ordered in the course of an office visit.
Managed care organizations are to adhere to the requirements of 55 Pa.Code Chapter 1142, Midwives’ Services, with the following exceptions:	
1142.51 “and the MA payment fee schedule”	General payment policy for Midwife services
1142.52(2) “billed to the Department”	General payment policy for Midwife services
1142.55(1) through (4)	Noncompensable Midwife services. Procedures not listed in the fee schedule in the MA Program fee schedule, More than 12 midwife visits per recipient per 365 days. Services and procedures furnished by the midwife for which payment is made to an enrolled physician, rural health clinic, hospital or independent medical clinic. Services and procedures for which payment is available through other public agencies or private insurance plans as described in § 1101.64 (relating to third party medical resources (TPR)).
Managed care organizations are to adhere to the requirements of 55 Pa.Code Chapter 1143, Podiatrists’ Services, with the following exceptions:	

CITATION/SPECIFIC EXCLUSION	REGULATORY LANGUAGE DESCRIPTION
1143.2 Definition of "Medically-necessary"	A term used to describe those medical conditions for which treatment is necessary, as determined by the Department, and which are compensable under the MA Program.
1143.2 Definition of "Non-emergency medical services."	A compensable podiatrists' service provided for conditions not requiring immediate medical intervention in order to sustain the life of the person or to prevent damage to health.
1143.51 "and the MA Program fee schedule" and "as specified in §1101.62(relating to maximum fees)."	General Payment Policy
1143.53	Payment conditions for outpatient services.
1143.54	Payment conditions for inpatient hospital services.
1143.55(1),(2) and (4)	Payment conditions for diagnostic X-ray services performed in the podiatrist's office.
1143.56	Payment conditions for orthopedic shoes, molded shoes and shoe inserts (enrolled medical suppliers). Refers to 1123.54
1143.57	Limitations on payment for podiatrist visits and x-rays.
1143.58(a)(1) through (12) 1143.58(a)(13) "as specified in § 1101.62 (relating to maximum fees)"	Noncompensable services and items for podiatry services. (1) Services and items not listed in the MA Program fee schedule. (2) Fabricating or dispensing orthopedic shoes, shoe inserts and other supportive devices for the feet. (3) Casting for shoe inserts. (4) Medical services or surgical procedures performed on an inpatient basis that could have been performed in the podiatrist's office, the emergency room, or a short procedure unit without endangering the life or health of the patient. (5) Medical or surgical procedures designated in the fee schedule in Chapter 1150 (relating to MA Program payment policies) and the MA Program fee schedule as outpatient procedures. (6) Medical services or surgical procedures performed on an inpatient basis if the Department denies payment to the hospital for the days during which the podiatrist's care is rendered. (7) Services rendered in the emergency room of a hospital if the recipient is admitted to the hospital as an inpatient on the same day or the service is a nonemergency medical service. (8) Treatment of flat foot. (9) Treatment of subluxations of the foot. (10) Routine foot care, including the cutting or removal of corns, callouses, the trimming of nails and other routine hygienic care. (11) Physical therapy. (12) Diagnostic or therapeutic procedures for experimental, research or educational purposes. Compensable podiatrist services if full payment is available from another agency, insurance or health program.
1143.58(b)	Noncompensable services and items. Payment is not made for sneakers, sandals etc, even if prescribed by a podiatrist.
Managed care organizations are to adhere to the requirements of 55 Pa.Code Chapter 1144, Certified Registered Nurse Practitioner Services, with the following exceptions:	
1144.42(b) "to the Department"	Ongoing responsibilities of providers
1144.52(1) 1144.52(2) "billed to the Department" 1144.52(3)	Payment conditions for CRNP services. CRNP employee Payment conditions for CRNP services. CRNP employee Payment conditions for CRNP services. CRNP employee
1144.53(1), (2), and (4)	Noncompensable services. Procedures not listed in the MA Program fee schedule. Services and procedures furnished by the CRNP for which payment is made to an enrolled medical service provider or practitioner. The same service and procedure furnished to the same recipient by a CRNP and physician.

CITATION/SPECIFIC EXCLUSION	REGULATORY LANGUAGE DESCRIPTION
Managed care organizations are to adhere to the requirements of 55 Pa.Code Chapter 1145, Chiropractor's Services, with the following exceptions:	
1145.11	Types of services covered. Evaluation by means of examination. Treatment by means of manual manipulation of the spine.
1145.12	Services are covered when rendered in the chiropractors' office, the home of the patient or in a skilled nursing or intermediate care facility.
1145.13	Chiropractors' services are not covered when rendered in a location in a hospital.
1145.14	Payment will not be made for treatment other than manipulation of the spine, physical therapy, traction, physical examinations, and consultations.
1145.51 "and the MA Program fee schedule" and "Chiropractors' services shall be billed in the name of the chiropractor providing the services."	Payment policy for chiropractor services.
1145.54	Noncompensable services. Payment will not be made to a chiropractor for 1) Orthotics, 2) Prosthetics, 3) Medical supplies, 4) X-rays, 5) Services not included in Chapter 1150
Managed care organizations are to adhere to the requirements of 55 Pa.Code Chapter 1147, Optometrists' Services, with the following exceptions:	
1147.2 Delete the following portion included in the definition of eyeglasses: "untinted."	Definitions - *Eyeglasses*—A pair of untinted prescription lenses and a frame.
1147.12 "Outpatient optometric services are compensable when provided in the optometrist's office, the office of another optometrist during the other optometrist's temporary absence from practice, a hospital, a nursing home or in the patient's home when the patient is physically incapable of coming to the optometrist's office." "and the MA Program Fee Schedule"	Outpatient services
1147.13 "and the MA Program Fee Schedule"	Inpatient services
1147.14(1)	Non-covered services: Orthoptic training.
1147.21 "They are not eligible for eyeglasses unless they are 20 years of age or younger and the eyeglasses have been: " 1147.21(1) through (3)	Scope of benefits for the categorically needy: eyeglasses. Eyeglasses prescribed through EPSDT program, school medical program, and prior authorized by Department through EPSDT program.
1147.22 "They are not eligible for eyeglasses, low vision aids or prostheses unless they are 20 years of age or younger and the eyeglasses, low vision aids or prostheses have been:" 1147.22 (1) through (3)	Scope of benefits for the medically needy: eyeglasses. Eyeglasses prescribed through EPSDT program, school medical program, and prior authorized by Department through EPSDT program.
1147.23 "only" and "They are not eligible for eyeglasses, low vision aids or eye prostheses. However, State Blind Pension recipients are eligible for eye prostheses if they are also categorically needy."	Scope of benefits for State Blind pension recipients.

CITATION/SPECIFIC EXCLUSION	REGULATORY LANGUAGE DESCRIPTION
1147.51 “and §§ 1147.53 and 1147.54 (relating to limitations on payment; and noncompensable services and items)” and “and the MA Program fee schedule” and "Optometric services shall be billed in the name of the optometrist providing the service."	General payment policy for optometric services
1147.53	Limitations on payments for optometric services
1147.54	Noncompensable optometric services and items
Managed care organizations are to adhere to the requirements of 55 Pa.Code Chapter 1149, Dentists’ Services, with the following exceptions:	
1149.1 "and the MA Program Fee Schedule"	Dental services general policy
1149.43(6)	Radiographs are requested by the Department for prior authorization purposes
1149.43(9) through (11)	Pathology reports are required for surgical excision services. Pre-operative X-rays are required for surgical services. Postoperative X-rays are required for endodontic procedures.
1149.51 "and the MA Program Fee Schedule" and “The following payment policies are applicable for dental services:”	General payment policy for dental services
1149.51(1) and (2)	General payment policy for dental services
1149.52	Payment conditions for various dental services
1149.54 "and the MA Program Fee Schedule" 1149.54 (1) through (7) 1149.54(10)	Payment policies for orthodontic services
1149.55(1) 1149.55(5) through (8)	Payment conditions for orthodontic services
1149.56	Payment limitations for orthodontic services
1149.57	Noncompensable dental services and items
Managed care organizations are to adhere to the requirements of 55 Pa.Code Chapter 1150, MA Program Payment Policies, with the following exceptions:	
1150.2 Definitions of PSR and Second Opinion program	Definitions

CITATION/SPECIFIC EXCLUSION	REGULATORY LANGUAGE DESCRIPTION
1150.51(a) "Payment will be made to providers. Payment may be made to practitioners' professional corporations or partnerships if the professional corporation or partnership is composed of like practitioners. Payment will be made directly to practitioners if they are members of professional corporations or partnerships composed of unlike practitioners. Practitioners who render services at eligible provider hospitals, either through direct employment or through contract, may direct that payment be made to the eligible provider hospital." **and** "Payment will not be made for services that are not medically necessary." 1150.51(b) 1150.51(c) “facilities and practitioners rendering services which require a PSR or second opinion, or both” and “funeral directors” 1150.51(d) “which is contained in the Provider’s Handbook” and the following” 1150.51(d)(1) “all-inclusive” 1150.51(d) (2) through (8) 1150.51(e) through (h)	General MA Program Payment policies
1150.52	Payment for Anesthesia services
1150.54	Payment for Surgical Services
1150.55	Payment for Obstetrical Services
1150.56	Payment for Medical Services
1150.56a	Payment Policy for Consultations
1150.57	Payment for Diagnostic Services and Radiation Therapy
1150.58	Prior authorization for services in the MA Program Fee Schedule
1150.59	PSR Program
1150.60	Second Opinion Program
1150.61	Guidelines for Fee Schedule changes
1150.62	Payment levels and notice of rate setting changes

CITATION/SPECIFIC EXCLUSION	REGULATORY LANGUAGE DESCRIPTION
1150.63 1150.63(a) Delete the word “Department” 1150.63(b) Delete the word “Department”. Also delete in second sentence “the practitioner may either …by mail.” 1150.63(c) Delete the first two sentences: The CAO shall …consultants. The office of MA…decision.” 1150.63(d)Delete the word “Department”	Waiver of General Payment Policies. The plan must adhere to the following section, except:
Managed care organizations are to adhere to the requirements of 55 Pa.Code Chapter 1151, Inpatient Psychiatric Services, with the following exceptions:	
1151.34	Inpatient Psychiatric Services, Provider Participation, Changes of ownership or control
1151.41(b)	Payment for inpatient psychiatric services, Readmission within 24 hours after discharge
1151.41(c) (1) and (2)	Payment for Inpatient Psychiatric Services, Admitted and discharged the same calendar day
1151.41(d), (i) and (j)	Payment for Preadmission diagnostics, transfer to another facility due to strike, payment for studies related to the patient’s condition not preprinted regimen.
1151.42 (a), (c) and (d)	Payment methods and rates
1151.43(a) and (b)	Limitations on payments
1151.45(2) and (3)	Nonallowable costs, costs related to a noncompensable item, costs related to preadmission diagnostics
1151.46	Payment rate calculations for FY 1993-94 and 1994 - 95
1151.48(a)(2)through (6), (9) through (16) and (18) through (20)	Noncompensable services and items, experimental procedures and services, inpatient treatment for diagnostic testing that could be done as outpatient, inpatient care if payment is available from another source, services not normally provided to the public, methadone maintenance, days of inpatient care that the patient was absent due to training, meetings or conferences, unnecessary inpatient care, and days of care that are not certified or failure to apply for a court-ordered commitment.
1151.52	Payment for capital costs not included in the base year
1151.53	Billing requirements for inpatient psychiatric services
1151.54	Disproportionate share payments
Managed care organizations are to adhere to the requirements of 55 Pa.Code Chapter 1153, Outpatient Psychiatric Services, with the following exceptions:	
1153.1 “and the MA Program fee schedule”	Outpatient psychiatric services, general policy
1153.2 Psychiatric outpatient clinic services -- "listed in the MA Program Fee Schedule"	Definitions
1153.2 Psychiatric partial hospitalization -- "listed in the MA Program Fee Schedule" and "and a maximum of six hours in a 24 hour period"	Definitions
1153.11 "as specified in the MA Program Fee Schedule"	Types of Outpatient Psychiatric Services
1153.12 "specified in the MA Program Fee Schedule"	Coverage of outpatient Psychiatric services

CITATION/SPECIFIC EXCLUSION	REGULATORY LANGUAGE DESCRIPTION
1153.14(2), (3), (9) and(13)	Noncovered services: cancelled appointments, covered services not rendered, Psychiatric outpatient clinic services and psychiatric partial hospitalization provided on the same day to the same patient, and Services not specifically included in the MA Program Fee Schedule
1153.21 "in the MA Program Fee Schedule"	Scope of benefits for the categorically needy
1153.22 "in the MA Program Fee Schedule"	Scope of benefits for the medically needy
1153.23 "in the MA Program Fee Schedule"	Scope of benefits for State Blind Pension recipients
1153.51 "and the MA Program Fee Schedule"	Payment for Outpatient Psychiatric clinic and partial hospitalization
1153.52(a)(2) "Separate billings for these additional services are not compensable."	Additional interviews with other staff may be included as part of the examination but shall be included in the psychiatric evaluation fee.
1153.52(d) "listed in the MA Program Fee Schedule"	Psychiatric clinic services provided in the home.
1153.53	Limitations on payments
1153.53a	Request for waiver of hourly limits
1153.54	Noncompensable services and items

Managed care organizations are required to adhere to the provisions of <u>Medical Assistance Bulletin 1157-95-01</u> Mental Health Services Provided in a Non-JCAHO Accredited Residential Facility for Children Under 21 Years of Age with the following exceptions:

- Page 2, A. 2. c.
- Page 3, A. 4.
- Page 3, Section B.
- Page 3, C. "To receive MA reimbursement,"
- Page 3, D. 1.
- Page 3, D. 2. "Payment will be made only for services prior approved by OMAP."
- Pages 5-7 Sections A and B.
- Attachment 2, 3.e.; 4.b.; and 4.e.
- Attachment 5
- Attachment 6
- Attachment 7
- Attachment 8
- Attachment 9
- Attachment 11

CITATION/SPECIFIC EXCLUSION	REGULATORY LANGUAGE DESCRIPTION
Managed care organizations are to adhere to the requirements of 55 Pa.Code Chapter 1163, Inpatient Hospital Services, Subchapter A, Acute Care General Hospitals Under the Prospective Payment System, with the following exceptions:	
1163.32	Hospital Units excluded from the DRG prospective payment system
1163.41	General participation requirements for general hospitals and out of state hospitals for Commonwealth recipients
1163.51 (a) through (s)	General payment policy for hospital services
1163.52 through 1163.59	Prospective payment methodology, assignment of DRG, prospective capital reimbursement system, payments for direct medical education, outliers, payment policy for readmissions and transfers, and noncompensable services and items and outlier days.
1163.60(b)(1) "in accordance with the instructions in the Provider Handbook".	Informed consent for voluntary sterilization
1163.60(c)(2) "in accordance with the instructions in the Provider Handbook".	The person obtaining informed consent signs and dates the form on same day informed consent was obtained.
1163.60(c)(3) "in accordance with the instructions in the Provider Handbook".	Another witness or interpreter must sign the consent form.
1163.62 (a) (2) through 1163.65	Payment conditions for abortions if the recipient was a victim of rape or incest, billing, cost reports and payment for out of state services.
1163.67	Disproportionate share payments
1163.70 through 1163.71	Changes of ownership or control and scope of utilization review process
1163.72 (a), (c) through (g)	General utilization review, admissions, day and cost outliers.
1163.73 through 1163.75 (6) and (8) through (12)	Hospital utilization review plan, requirements for hospital utilization review committees, and responsibilities for hospital utilization review committees.
1163.76 through 1163.77	Written plan of care within 2 days of admission and Admission review requirements within 24 hours of admission
1163.78a and 1163.78b	Review requirements for day outliers and cost outliers
1163.92 (a) through (f)	Administrative sanctions
1163.122	Determination of DRG relative values
1163.126	Computation of hospital specific computation rates
Managed care organizations are to adhere to the requirements of 55 Pa.Code Chapter 1163, Inpatient Hospital Services, Subchapter B, Hospitals and Hospital Units Under Cost Reimbursement Principles, with the following exceptions:	
1163.402 Definition of "certified day"	Definitions
1163.451 (a) through (g), (i), (k) through (o)	General payment policy
1163.452	Payment methods and rates
1163.453 (a) and (c)	Allowable and nonallowable costs, allowable costs for inpatient services, payment not higher than hospital's customary charge
1163.453 (d) (2) through (9)	Costs not allowable under the MA Program
1163.453 (e) and (f)	Allowable costs
1163.454	Limitations on payment
1163.455 (a)(1) through (5) and (7) through (16)	Noncompensable inpatient services
1163.455 (b) and (c)	Noncompensable inpatient services
1163.457	Payment policies relating to out of state hospitals
1163.458	Payment policies relating to same calendar day admissions and discharges
1163.459	Disproportionate share payments
1163.481(b) and (c)	Utilization review sanctions
1163.511	Change of ownership or control

CITATION/SPECIFIC EXCLUSION	REGULATORY LANGUAGE DESCRIPTION
Managed care organizations are required to adhere to the provisions of <u>Medical Assistance Bulletin 1165-93-07</u> Payment for Mental Health Services Provided in a Residential Treatment Facility for Eligible Individuals Under 21 Years of Age with the following exceptions: ▪ Page 1 - Beginning with the second sentence "The procedures described in this Bulletin apply to every child." up to "A separate bulletin will describe the procedures necessary to seek reimbursement for other mental health services not on the Medical Assistance Fee Schedule." ▪ Page 2, Section A.4. ▪ Pages 3 - 4, Sections C through E ▪ Attachment 6 ▪ Attachment 7 ▪ Attachment 8 ▪ Attachment 9	
Managed care organizations are required to adhere to the provisions of <u>Medical Assistance Bulletin 1165-95-01</u> Update JCAHO-Accredited RTF Services with the following exceptions: ▪ Page 2 - The two paragraphs following item c. "If a child is admitted . . . alternative to RTF." ▪ Page 2 - The third complete paragraph, "All admissions are subject," through the end of 3. ▪ Page 3, number 4.	
Managed care organizations are to adhere to the requirements of 55 Pa.Code Chapter 1221, Clinic and Emergency Room Services, with the following exceptions:	
1221.43 through 1221.45	Participation requirements for hospital clinics and emergency rooms for higher reimbursement rate, additional participation requirements for independent clinics, and additional participation requirements for medical school clinics.
1221.51 and 1221.52	General payment policy for clinic and emergency room services and payment conditions for various services.
1221.55 (b) (1). NOTE: A consent form is required and must contain all of the information found in Appendix A to 55 PA Code Chapter 1141	Voluntary informed consent for sterilizations
1221.57(a) (2) and 1221.57(c). NOTE: PH-MCO must comply with MA Bulletin 99-95-09	Payment conditions for necessary abortions for victims of rape or incest
1221.58 and 1221.59	Limitations on payments and noncompensable services and items
Managed care organizations are required to adhere to the provisions of Medical Assistance Bulletins related to 55 PA Code Chapter 1221, Clinic and Emergency Room Services, with the following exceptions: ▪ 11-95-04 ▪ 11-95-10 ▪ 11-95-12	

CITATION/SPECIFIC EXCLUSION	REGULATORY LANGUAGE DESCRIPTION
Managed care organizations are to adhere to the requirements of 55 Pa.Code Chapter 1223, Outpatient Drug and Alcohol Clinic Services, with the following exceptions:	
1223.1 “and the MA fee schedule”	Payment for specific medically necessary outpatient drug and alcohol clinic services rendered to eligible recipients by drug/alcohol outpatient clinics.
1223.11 “as specified in the fee schedule in the Medical Assistance program fee schedule”	Medical Assistance Program coverage for outpatient drug/alcohol clinics is limited to professional medical and psychiatric services.
1223.12 "specified in the Medical Assistance program fee schedule"; "and the Medical Assistance program fee schedule"; and "fee for service"	Outpatient drug and alcohol clinic services
1223.14 (3) and (4)	Noncovered services: Cancelled appointments and Covered services that have not been rendered.
1223.14(6) “and the Medical Assistance program fee schedule”	Noncovered services: Vocational rehabilitation; day care; drug/alcohol or mental health partial hospitalization; reentry programs, occupational or recreational therapy; Driving While Intoxicated (DWI) or Driving Under the Influence Programs or Schools; referral, information or education services; experimental services; training; administration; follow-up or aftercare; program evaluation; case management; central intake or records; shelter services; research; drop-in, hot-line or social services; inpatient nonhospital or occupational program services, or any other service or program not specifically identified as a covered service in Chapter 1150.
1223.14 (8) and (9)	Drug/alcohol outpatient clinic services provided to residents of treatment institutions. outpatient clinic services provided to residents of inpatient nonhospital and shelter facilities. outpatient clinic services provided to patients receiving psychiatric partial hospitalization services or drug/alcohol partial hospitalization services
1223.14(14)	Methadone maintenance clinic services provided before the date of the physician’s comprehensive medical examination, diagnosis and treatment plan.
1223.21 “in the MA Program fee schedule”	Scope of services for the categorically needy
1223.22 “in the MA Program fee schedule”	Scope of services for the medically needy
1223.23 “in the MA Program fee schedule”	Scope of services for State Blind Pension recipients
1223.51 “and the Medical Assistance program fee schedule”	General payment policy for outpatient drug/alcohol clinic services
1223.52(a)(2) and (a)(3) “Separate billings for these interviews are not compensable.”	Additional interviews with other staff
1223.52(a)(5) “listed in the Medical Assistance Program Fee Schedule”	Diagnostic psychological services
1223.52(c) “Separate billings for these interviews are not compensable.”	Interviews or consultations with family members alone, without the presence of the family member with a drug/alcohol abuse or dependence problem, are considered to be part of the family psychotherapy fee.
1223.53	Limitations on Payment for outpatient drug and alcohol clinic services
1223.54(2) “and the Medical Assistance program fee schedule”	Items and services not listed as compensable in Chapter 1150
Managed care organizations are to adhere to the requirements of 55 Pa.Code Chapter 1225, Family Planning Clinic Services, with the following exceptions:	
1225.1 “and the MA Program fee schedule”	General provisions
1225.51“and the MA Program fee schedule”	General payment policy
1225.54(2)	Noncompensable family planning services
Managed care organizations are to adhere to the requirements of 55 Pa.Code Chapter 1229, Health Maintenance Organizations Services, with the following exceptions:	
NONE	

CITATION/SPECIFIC EXCLUSION	REGULATORY LANGUAGE DESCRIPTION
Managed care organizations are to adhere to the requirements of 55 Pa.Code Chapter 1230, Portable X-Ray Services, with the following exceptions:	
1230.1 “and the MA Program fee schedule”	General provisions
1230.51 “and the MA fee schedule”	General payment policy for portable x-ray services
1230.52(b) “and the MA Program fee schedule”	Payment for transporting portable X-ray equipment from the provider’s office to the place of service
1230.53 (a) through (c)	Portable x-ray services, provider maximum payment, payment for transportation of portable x-ray equipment and electrocardiogram services
1230.54 (1)	Noncompensable services, procedures not listed in the MA Program fee schedule
Managed care organizations are to adhere to the requirements of Medical Assistance Bulletin 99-94-08 (relating to 55 Pa. Code Chapter 1239, Medical Case Management), Medical Assistance Case Management Services for Recipients Under the Age of 21, with the following exceptions: ▪ Discussion ▪ Page 2, paragraph 3 "The OMAP reserves the right to limit the number of recipients in a case manager's caseload." ▪ Page 3, Payment for case management services covered by this bulletin, 1 through 3 and 4 c through f	
Managed care organizations are to adhere to the requirements of 55 Pa.Code Chapter 1241, Early and Periodic Screening, Diagnosis and Treatment Program, with the following exceptions:	
1241.2 Definition of “Administrative contractors”	Definitions
1241.42(1) “or to the CAO for supportive help in locating an appropriate provider”	If not licensed or equipped to render the necessary treatment or further diagnosis, the screening provider shall refer the individual to an appropriate enrolled practitioner or facility.
1241.51	Payment to the provider
1241.53	Limitations on payments
1241.54 (a) (1) through (5)	Noncompensable services and items
1241.54 (b) (1) through (5)	Noncompensable services and items
Managed care organizations are to adhere to the requirements of 55 Pa.Code Chapter 1243, Outpatient Laboratory Services, with the following exceptions:	
1243.51 “and the MA Program fee schedule”	General payment policy for outpatient laboratory services
1243.52(b) “billed to the Department”	Laboratory services billed to the Department will be based on the written request of the practitioner
1243.53 (a)	The fees listed in the MA Program fee schedule are the maximum allowed
1243.54 (1) and (2)	Noncompensable services
Managed care organizations are to adhere to the requirements of 55 Pa.Code Chapter 1245, Ambulance Transportation, with the following exceptions:	
1245.1 “and the MA Program fee schedule”	General provisions for payment of ambulance transportation to eligible beneficiaries
1245.21 “and the MA Program fee schedule”	Scope of services for the categorically needy
1245.22 “and the MA Program fee schedule”	Scope of services for the medically needy
1245.23 “and the MA Program fee schedule”	Scope of services for State Blind Pension recipients

CITATION/SPECIFIC EXCLUSION	REGULATORY LANGUAGE DESCRIPTION
1245.51 (b)	Ambulance services which obtain Voluntary Ambulance Service Certification (VASC) from the Department of Health will be reimbursed at a higher rate than non-VASC certified services
1245.52(1)	Payment conditions for ambulance transportation, medically necessary
1245.52(3) through (5)	Transportation to the nearest appropriate medical facility and medical services/supplies invoice.
1245.53	Limitations on payment for ambulance service when more than one patient is transported. Payment is made for transportation of the patient whose destination is the greatest distance. No additional payment is allowed for the additional person.
1245.54(1) through (7)	Noncompensable services and items relating to ambulance transportation.
Managed care organizations are to adhere to the requirements of 55 Pa.Code Chapter 1249, Home Health Agency Services, with the following exceptions:	
1249.51 “and the MA Program fee schedule”	General payment policy for Home Health Services
1249.55(b)	Payment conditions for medical supplies. Home health agencies are not reimbursed for supplies routinely needed as part of furnishing home health care services. Payment for these supplies is included in the comprehensive fee.
1249.57	Payment conditions for maternal/child services
1249.58	Payment conditions for travel costs
1249.59	Limitations on payments for home health agency services

EXHIBIT B (1)
HEALTHCHOICES MCO PAY FOR PERFORMANCE PROGRAM

This Exhibit B (1) defines a potential payment obligation by the Department to the PH-MCO for Quality Performance Measures achieved per HEDIS® 2016, as defined below.

This Exhibit is effective only if the PH-MCO operates a HealthChoices program in this HealthChoices zone under this Agreement in the month of December 2016. If the PH-MCO does not operate a HealthChoices program in this HealthChoices zone under this Agreement in the month of December 2016, the Department has no payment obligation under this Exhibit.

This Exhibit supplements but does not supplant Exhibits that provide for Pay for Performance (P4P) and incorporate different dates in Section B. below.

A. Quality Performance Measures

The Department selected eight (8) HEDIS® 2016 and one (1) 2016 Pennsylvania Performance Measure (PAPM) as quality indicators (representing CY 2015 data) for the MCO P4P program. The Department chose these indicators based on an analysis of past data indicating the need for improvement across the HealthChoices Program as well as the potential to improve health care for a broad base of the HealthChoices population. The nine (9) quality indicators are:

<u>HEDIS®</u>

1. Adolescent Well-Care Visits
2. Annual Dental Visit (Ages 2 – 20 years)
3. Comprehensive Diabetes Care: HbA1c Poor Control
4. Controlling High Blood Pressure
5. Frequency of Ongoing Prenatal Care: ≥81 Percent of Expected Number of Prenatal Care Visits
6. Prenatal Care in the First Trimester
7. Postpartum Care
8. Well-Child Visits in the First 15 Months of Life, 6 or more

<u>PAPM</u>

1. Reducing Potentially Preventable Readmissions

The MCO P4P Program measures Benchmark Performance and Improvement Performance. The PAPM measure, Reducing Potentially Preventable Readmissions, will be eligible for the Improvement Performance component. In addition, the Department has set a performance goal for Reducing Potentially Preventable Readmissions. While this is not a national benchmark, the measure value will be calculated the same as HEDIS measures in the benchmark performance, Section A.1, below.

1. **Benchmark Performance***:* The Department will award a Benchmark Performance payout amount for each measure in Section A that will range from 0% up to and including 125% of the measure's value, defined as two-thirds of the PH-MCO's Maximum Program Payout amount (equivalent to 1.0% of the sum of the amounts

defined in Section B. below) divided by ten (10) (Nine (9) quality indicators with Annual Dental Visit counted twice). The Department will make Benchmark Performance payouts for performance relative to the HEDIS® 2016 (CY 2015) benchmarks, for all measures excluding Reducing Potentially Preventable Readmissions. A goal of 8.50 percent (8.50%) has been set for this measure (see Section A.1.c.). If the PH-MCO's HEDIS 2016 (CY 2015) performance rate is below the 50th Percentile Benchmark, the Department will implement a -25% off-set. The Department will distribute the payouts according to the following criteria:

a. All HEDIS® Measures

- HEDIS® 2016 rate at or above the 90th percentile benchmark: 125 percent of the measure value.
- HEDIS® 2016 rate at or above the 75th percentile and below the 90th percentile benchmark: 100 percent of the measure value.
- HEDIS® 2016 rate at or above the 50th percentile and below the 75th percentile benchmark: 25 percent of the measure value.
- HEDIS® 2016 rate below the 50th percentile benchmark: -25 percent offset

b. Annual Dental Visit Performance Only

- The Benchmark Performance measure value applicable to Annual Dental Visit Performance is equal to fifty (50) percent of the sum of double the Benchmark Performance measure value (as identified in Section A.1) and double the Improvement Performance measure value (identified in Section A.2).
- The -25% off-set will be applied to double the Benchmark Performance measure value (as identified in Section A.1).

c. Reducing Potentially Preventable Readmissions

- Performance goal at or below 8.5 percent (8.50%): 100 percent of the measure value.
- Performance goal above 8.5 percent (8.50%): No payout.

2. **Improvement Performance***:* The Department will award an Improvement Performance payout amount for each measure in Section A that will range from 0% up to and including 100% of the measure's value, defined as one-third of the PH-MCO's Maximum Program Payout amount (equivalent to 0.5% of the sum of the amounts defined in Section B. below) divided by ten (10) (Nine (9) unique quality indicators with Annual Dental Visit counted twice).

   The improvement performance payout scales will be applied contingent on benchmark percentile performance for each HEDIS 2016 measure (see Section A.2.a and A.2.b).

   - If improvement is achieved and the benchmark performance for that measure is less than the 75th percentile, Scale 1 will be applied.

- If improvement is achieved and the benchmark performance equal to or greater than the 75th percentile (see Section A.2.b), Scale 2 will be applied.
- Scale 2 applies to improvement performance for the PAPM, Reducing Potentially Preventable Readmission measure, and is not contingent on meeting the 8.50 percent (8.50%) goal.

a. Scale 1:

- The Department will make Improvement Performance payouts for incremental performance improvement from the previous year rate. Incremental performance improvements are measured comparing rates from HEDIS® 2015 (CY 2014) to HEDIS® 2016 (CY 2015).

  - ≥ 5 Percentage Point Improvement: 100 percent of the measure value.
  - ≥ 4 and < 5 Percentage Point Improvement: 80 percent the measure value.
  - ≥ 3 and < 4 Percentage Point Improvement: 60 percent the measure value.
  - ≥ 2 and < 3 Percentage Point Improvement: 40 percent the measure value.
  - ≥ 1 and < 2 Percentage Point Improvement: 20 percent the measure value.
  - < 1 Percentage Point Improvement: No payout.

b. Scale 2:

- The Department will make Improvement Performance payouts for incremental performance improvement from the previous year rate. Incremental performance improvements are measured comparing rates from HEDIS® 2015 (CY 2014) to HEDIS® 2016 (CY 2015) and PAPM 2015 (CY 2014) to PAPM 2016 (CY 2015).

  - ≥ 5 Percentage Point Improvement: 100 percent of the measure value.
  - ≥ 4 and < 5 Percentage Point Improvement: 100 percent the measure value.
  - ≥ 3 and < 4 Percentage Point Improvement: 100 percent the measure value.
  - ≥ 2 and < 3 Percentage Point Improvement: 85 percent the measure value.
  - ≥ 1 and < 2 Percentage Point Improvement: 75 percent the measure value.
  - ≥ 0.5 and < 1 Percentage Point Improvement: 50 percent the measure value.
  - < 0.5 Percentage Point Improvement: No payout.

c. Annual Dental Visit Performance Only

- The Improvement Performance measure value available for Annual Dental Visit Performance is equal to fifty percent of the sum of double the Benchmark Performance measure value (as identified in Section A.1) and double the Improvement Performance measure value (identified in Section A.2).

3. **Limitation on Payout Amounts**: The total awarded payout amount to a PH-MCO, which includes Benchmark Performance (A.1) and Improvement Performance (A.2), cannot exceed the Maximum Program Payout amount, as identified in Section B below.

B. Payment for MCO Pay for Performance

The Department will inform the PH-MCO of the Maximum Program Payout amount by November 30, 2016. For the purposes of Section B of this Exhibit B (1), the term Agreement refers to this Agreement and also any other Agreement between the PH-MCO or a predecessor PH-MCO and the Department to operate a HealthChoices program in this zone for a similar population with one or more program months between July 2015 and June 2016. If there is more than one Agreement between the PH-MCO or a predecessor PH-MCO and the Department to operate a HealthChoices program in this zone for a similar population with one or more program months between July 2015 and June 2016, the Department will make a payment only per the terms of the more recent Agreement.

The Maximum Program Payout amount will be equivalent to one and one-half (1.5) percent of the sum of the amounts defined below:

1. *Capitation Revenue*. For the purpose of this Exhibit, Capitation Revenue is defined as all Capitation revenues paid or payable by the Department to the PH-MCO in accordance with this Agreement, inclusive of Appendix 3b and Appendix 3f, for the program period July 2015 through June 2016.

2. *Maternity Care Revenue.* For the purpose of this Exhibit, Maternity Care Revenue is defined as all Maternity Care payments, paid or payable by the Department to the PH-MCO in accordance with this Agreement, for the program period July 2015 through June 2016.

3. *Home Nursing Risk Sharing Revenue*. For the purpose of this Exhibit, Home Nursing Risk Sharing Revenue is defined as the follows:

   The Department's gross Home Nursing Risk Sharing obligation for the program period January 2015 through December 2015, before the PH-MCO's Home Nursing Risk Sharing Withhold Amount obligation for the same period is taken into account. This includes only Home Nursing Risk Sharing submissions from the PH-MCO that have been processed by the Department as of October 31, 2016.

MINUS The PH-MCO's Home Nursing Risk Sharing Withhold Amount obligation for the program period January 2015 through December 2015, regardless of whether this obligation has been satisfied to date.

EQUALS Home Nursing Risk Sharing Revenue, for the purpose of this Exhibit B (1). This amount may be a positive or negative number.

4. *High Cost Risk Pool Revenue.* For the purpose of this Exhibit, High Cost Risk Pool Revenue is defined as the sum of the following:

   a. The revenue paid or payable by the Department to the PH-MCO in accordance with this Agreement inclusive of Appendix 3k, for the High Cost Risk Pool for the quarter of July-September 2015; or, if applicable, the amount of a reduction applied to a future payment if the Department determined the amount payable from the High Cost Risk Pool was less than the Withhold Amounts applicable to the same quarter for the PH-MCO. If the latter applies, the High Cost Risk Pool Revenue amount for this quarter, for the purpose of this Exhibit, is a negative number.

   PLUS

   b. The revenue paid or payable by the Department to the PH-MCO in accordance with this Agreement inclusive of Appendix 3k, for the High Cost Risk Pool for the quarter of October-December 2015; or, if applicable, the amount of a reduction applied to a future payment if the Department determined the amount payable from the High Cost Risk Pool was less than the Withhold Amounts applicable to the same quarter for the PH-MCO. If the latter applies, the High Cost Risk Pool Revenue amount for this quarter, for the purpose of this Exhibit, is a negative number.

   PLUS

   c. The revenue paid or payable by the Department to the PH-MCO in accordance with this Agreement inclusive of Appendix 3k, for the High Cost Risk Pool for the quarter of January-March 2016; or, if applicable, the amount of a reduction applied to a future payment if the Department determined the amount payable from the High Cost Risk Pool was less than the Withhold Amounts applicable to the same quarter for the PH-MCO. If the latter applies, the High Cost Risk Pool Revenue amount for this quarter, for the purpose of this Exhibit, is a negative number.

   PLUS

   d. The revenue paid or payable by the Department to the PH-MCO in accordance with this Agreement inclusive of Appendix 3k, for the High Cost Risk Pool for the quarter of April-June 2016; or, if applicable, the amount of a reduction applied to a future payment if the Department determined the amount payable from the High Cost Risk Pool was less than the Withhold Amounts applicable to the same quarter for the PH-MCO. If the latter applies, the High Cost Risk Pool Revenue amount for this quarter, for the purpose of this Exhibit, is a negative number. If

this payment is not determined by October 15, 2015, then the Department will use the best estimate in place of the actual payment/reduction.

The Department will make a payment, as provided by this Exhibit B (1), only to the extent that adequate funds are included for the purpose of Exhibit B (1) payments to all PH-MCOs in the Commonwealth enacted budget for fiscal year 2017-18 within the capitation appropriation. If the Department has an obligation to the PH-MCO, the Department will issue the payment by August 31, 2017.

Exhibit B (2)

PH-MCO and BH-MCO Integrated Care Plan (ICP) Program
Pay for Performance Program

This Exhibit B (2) defines a potential payment obligation by the Department to the PH-MCOs for Quality Performance Measures achieved per HEDIS 2017 and select Pennsylvania Performance Measures (PAPMs), as defined below.

This Exhibit is effective only if the PH-MCO operates a HealthChoices program in this HealthChoices zone under this Agreement in the month of December 2016. If the PH-MCO does not operate a HealthChoices program in this HealthChoices zone under this Agreement in the month of December 2016, the Department has no payment obligation under this Exhibit.

The Department will provide financial incentives to the PH-MCOs and the Behavioral Health Managed Care Organizations (BH-MCOs) for the Integrated Care Plan (ICP) Program. The Department will provide a funding pool from which dollars will be paid to the PH-MCO based on shared PH/BH-MCO performance measures outlined in this Exhibit. The Department expects this ICP Program to improve the quality of health care and reduce Medical Assistance (MA) expenditures through enhanced coordination of care between the PH-MCOs, BH-MCOs and providers.

In order to be eligible for payments under the ICP, the PH-MCO must submit Operations Report 17 for Calendar Year (CY) 2016 following the time frames outlined within the Report Description and that contains the following specific data requirements for individuals with serious persistent mental illness (SPMI).

1. **Member stratification**- Initial baseline stratification shall be conducted on all members in the targeted SPMI population at the start of the program on January 1, 2016. New members shall have an initial stratification level established within sixty (60) days of the date of enrollment and identification that a member has SPMI. The PH-MCO will report on the member ID, initial stratification level, and six (6) month re-stratification level. Members will be stratified as follows:

    a. Four (4) = high PH/high BH needs
    b. Three (3) = high PH/low BH needs
    c. Two (2) = low PH/high BH needs
    d. One (1) = low PH/low BH needs

2. **Integrated Care Plan/Member Profile**- At least **500 members** must receive an ICP that has been used in care management activity by both the PH and BH MCO. For purposes of this requirement, the Department considers an ICP or member profile, to be the collection, integration and documentation of key

physical and behavioral health information that is easily accessible in a timely manner to persons with designated access.

3. **Hospitalization Notification and Coordination-** Each PH-MCO and BH-MCO will jointly share responsibility for notification of a hospital admission and will coordinate discharge and follow-up. This includes but is not limited to, sharing discharge instructions, medications, and recommended follow-up appointments to respective PH-MCO, BH-MCO as appropriate per HIPAA and regulatory standards. Notification to the partner MCO of hospital admissions shall occur within one (1) business day of when the responsible MCO partner learns of the admission (e.g., if the PH-MCO knows of an admission, it will notify the BH-MCO within one (1) business day and vice versa). Each PH-MCO will attest on the Operations 17 report that 90% of the admission notifications occurred within one (1) business day of the PH-MCO learning of the admission. The PH-MCO must maintain documentation to support the attestation of 90% admissions notifications.

The Operations Report 17 will be audited to verify the accuracy of the stratification, integrated care plan and hospital notification information.

Performance Measures

The performance measures for the 2016 ICP Program include the following:

1. Initiation and Engagement of Alcohol and Other Drug Dependence Treatment *
    a. Initiation rate*
    b. Engagement rate*

2. Adherence to Antipsychotic Mediations for Individuals with Schizophrenia *

3. Combined BH-PH Inpatient 30 Day Readmission Rate for Individuals with Serious Persistent Mental Illness (SPMI)**

4. Emergency Department Utilization for Individuals with Serious Persistent Mental Illness (SPMI)**

5. Combined BH-PH Inpatient Admission Utilization for Individuals with Serious Persistent Mental Illness (SPMI)**

NCQA HEDIS measure* * Pennsylvania Performance measure defined by EQRO*

Payment for MCO Performance

Ten million dollars ($10M) will be allocated for the ICP Program in CY 2016 for the PH-MCO. The funding will be allocated to each PH-MCO according to its overall percent of HealthChoices member months for CY 2016.

Each of the measures defined below will be weighted equally and receive 20% of the allocated funding. Each component of the Initiation and Engagement of Alcohol and Other Drug Dependence Treatment will receive 10% of the allocated funding. Payments will be based on incremental improvement calculated from the base clinical care measurement year of 2015 (HEDIS/PAPM 2016) to the initial intervention year of 2016 (HEDIS/PAPM 2017).

1. Initiation and Engagement of Alcohol and Other Drug Dependence Treatment - **20%***
    a. Initiation rate-10%
    b. Engagement rate- 10%

2. Adherence to Antipsychotic Mediations for Individuals with Schizophrenia-**20%** *

3. Combined BH-PH Inpatient 30 Day Readmission Rate for Individuals with Serious Persistent Mental Illness (SPMI)-**20**%**

4. Emergency Department Utilization for Individuals with Serious Persistent Mental Illness (SPMI)- **20**%**

5. Combined BH-PH Inpatient Admission Utilization for Individuals with Serious Persistent Mental Illness (SPMI)-**20**%**

NCQA HEDIS measure* * Pennsylvania Performance measure defined by EQRO*

The incremental payments will be based on the following scale for measures 1, 2 and 3.

Incremental Improvement	**% Payout**
≥ 3 Percentage Point Improvement	100.0%
≥ 2 and < 3 Percentage Point Improvement	85.0%
≥ 1 and < 2 Percentage Point Improvement	75.0%
0.5 - < 1 Percentage Point Improvement	50.0%

For measures 4 and 5, 100% payout will be made if there is a reduction of ≤3.0 events per 1000 member months and a 75% payout if there is a reduction in ≤2.0 events per 1000 member months.

The Department will make a payment, as provided by this Exhibit B (2), only to the extent that adequate funds are included for the purpose of Exhibit B (2) payments to all PH-MCOs and BH-MCOs in the Commonwealth enacted budget for fiscal year 2017-18 within the capitation appropriation. If the Department has an obligation to the PH-MCO and BH-MCO the Department will issue the payment by August 31, 2018.

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Exhibit B (3)
Provider Pay for Performance Program and Community Based Care Management Program

The Provider Pay-for-Performance (P4P) program described in this Exhibit B(3) is for services rendered by providers during a Calendar Year (CY) and defined in the PH-MCO specific Quality Performance Program approved by the Department for Section I below. The Community Based Care Management (CBCM) Program requirements described in this Exhibit B(3) is for care rendered during a CY and defined in the PH-MCO specific CBCM Program approved by the Department for Section II below.

I. Provider P4P Program Requirements

All Provider P4P programs must target improvements in the quality of or access to health care services for HealthChoices members and must not limit the appropriate use of services by members.

Quality Performance Program (QPP):

A. The PH-MCO is required to develop a QPP using the following **mandatory eight (8)** HEDIS Quality Measures (per HEDIS® 2016 Technical Specifications, Vol. 2) and one (1) **electronic quality measure**:
   1. Adolescent Well-Care Visit
   2. Annual Dental Visit (Age 2 – 20 Years)
      a. Part of the incentive for the Annual Dental Visit measure must include payments to dental providers.
   3. Controlling High Blood Pressure
   4. Comprehensive Diabetes Care: HbA1c Poorly Controlled (>9%)
   5. Frequency of Ongoing Prenatal Care: ≥81 Percent of the Expected Number of Prenatal Care Visits
   6. Prenatal Care in the First Trimester
   7. Postpartum Care
   8. Well-Child Visits in the First 15 Months of Life, 6 or more
   9. Payment for electronic submission of any mandatory measure, optional measure, the Obstetrical Needs Assessment Form (ONAF), or any Clinical Quality Measure (CQM) approved by the current CMS meaningful use electronic health record program rules. Information on these CQMs may be found at the following link:

http://cms.gov/Regulations-and-Guidance/Legislation/EHRIncentivePrograms/eCQM_Library.html

B. The PH-MCO has the option of including any or all of the following **optional three (3)** HEDIS Quality Measures and **one (1)** Pennsylvania Performance Measure (PA PM):
   1. Breast Cancer Screening (Ages 50 – 74)
   2. Cervical Cancer Screening (Ages 21 – 64)
   3. Emergency Room (ER) Utilization
   4. Readmissions

C. The PH-MCO is required to develop and submit a proposal to the Department prior to implementing its QPP. PH-MCO must complete and submit proposals using template B (3)(b), the QPP Submission Template. Proposals are due no later than December 1, 2015 and must be submitted to the appropriate folder on DocuShare. The QPP proposal must include:

1. A detailed description of the program, including the mandatory HEDIS Quality Measures, electronic quality measures and any optional HEDIS/PA PM Quality Measures;
2. Targeted providers for each measure;
3. Proposed payout amount and payout schedule to provider(s) for each specific measure;
4. Description of the specific requirements the provider(s) must complete to receive the incentive;
5. How Provider(s) success or compliance will be measured;
6. Brief description of the roll-out strategy to notify and educate providers about the Provider P4P program;
7. How the PH-MCO will evaluate the effectiveness of its Provider P4P program;
8. PH-MCO single point of contact name, email and phone number responsible for submission of template B (3)(a), Provider P4P Submission Change form; and
9. Attestation from the Medical Director.

D. A PH-MCO's approved QPP will remain in effect until December 31 of each calendar year. The PH-MCO may submit quarterly revisions only to the provider payout amounts for the Department's review and approval. The PH-MCO must complete and submit template B(3)(a), Provider P4P Submission Change Form. Payout revisions must be submitted no later than close of business on the last day of each calendar quarter. No other revisions to the QPP will be accepted.

E. The PH-MCO must annually evaluate the effectiveness of its approved QPP. The results of this analysis must be submitted to the Department no later than August 31st of the subsequent calendar year to the appropriate folder on DocuShare. The analysis must include, at a minimum, the following:

1. A description of the provider education done on the Provider P4P program and any modifications that may have been made over the year where improvements were identified and put into place;
2. A separate list of the top 25 providers for each zone in which the PH-MCO operates with the highest dollar payout for each incentive offered;
3. A brief explanation of the effectiveness of the electronic quality measure submission to include but not be limited to:
   a. What were the measures;

b. Who were the providers;
c. Amount of payouts;
d. Accomplishments;
e. Opportunities for Improvement;

4. Identify next steps and potential revisions for the next CY Provider P4P program.

F. The Department may request that PH-MCOs share QPP findings with other HealthChoices PH-MCOs to identify best practices and improve the overall HealthChoices Program.

II. Community Based Care Management (CBCM) Program Requirements

A. CBCM activities and funding must primarily be focused on reducing preventable admissions, readmissions, non-emergent visits to the emergency department (ED), enhancing behavioral and physical health coordination of services, target providers/organizations that serve a large volume of complex MA recipients including high risk pregnant women and increasing access to pediatric dental preventive and restorative services. **Funding used for approved CBCM services only, as defined in the approval letter from the Department.**

B. A member of the CBCM team must spend the majority of time in face-to face-encounters with members either in the community setting, provider outpatient setting, hospital, or ED. They can be embedded in one outpatient service site, float between multiple outpatient sites, provide transition of care services from the hospital or ED setting, and provide home based care coordination.

C. CBCM activity can involve care coordination by licensed and non-licensed team members as defined by the latest version of the Operations 15 report. Examples of licensed providers include but are not limited to: physicians, dentists, dental hygienists, public health dental hygienists, physician's assistants, Certified Registered Nurse Practitioners (CRNPs), nurse midwives, RNs, LPNs, MSWs, dieticians, psychologists, and pharmacists. Examples of non-licensed team members include but are not limited to: medical assistants/technicians, community health workers, doulas, paramedics/EMTs, faith-based ministries, and peer specialists. This list of examples is not fully inclusive. These team members' activities need to be accounted for on the Operations 15 report.

D. Members of the CBCM team can be employed by the PH-MCO, employed by a provider organization, or hired by a third party through a contract with the PH-MCO. The PH-MCO will be responsible for reporting the targeted

providers/organizations, targeted recipients, and define the financial spending for each arrangement (see more details below). Because of limited funding, the PH-MCO should target providers/organizations that serve a large volume of complex MA recipients including high risk pregnant women. Preference should be given to large health systems, FQHCs and high volume dental providers. Preference should be given to programs that focus on co-location of care management services for consumers with persistent serious mental illness (PSMI) and substance use disorder (SUD).

E. Payment arrangements can include but not be limited to: practice PMPM payments for care management services, payment for direct or contractual employment costs for FTEs, payment of care management CPT codes including transition of care codes, payment for special needs transportation to access MA services, and payment of pharmacy medication management codes.

F. When selecting providers/organizations to fund CBCM, the PH-MCO must require that the provider/organizations make use of electronic medical records with the intent of achieving Meaningful Use under the CMS specifications for Medicare or Medicaid. Providers/organizations that receive direct or indirect funding must be willing to participate in best practice collaborative learning sessions.

G. If the PH-MCO does business in multiple HealthChoices zones, CBCM Program funds can be allocated across any zone in which they are licensed.

H. The PH-MCO is required to develop and submit a proposal to the Department prior to implementing its CBCM Program. The CBCM Program may include multiple programs for use of the CBCM funds. If multiple programs are identified, each one must follow the requirements below. Proposals are due no later than December 1, 2015 and must be submitted to the appropriate folder in Docushare using template B(3)(c), CBCM Proposal template. Each CBCM proposal must include:

1. An initial CBCM program description that lists targeted providers/organizations, an initial six (6) and twelve (12) month budget, and an operations timeline that outlines the startup of the program from January 1, 2016 through December 31, 2016.
2. The targeted providers/organizations, larger volume health systems, FQHC's, or co-location of services being involved with CBCM. The PH-

MCO will be responsible for reporting the targeted providers/organizations, targeted recipients, and define the financial spending for each arrangement.

3. The number of FTE's involved with or employed as a CBCM worker whether the FTE is full or part-time, licensed or unlicensed, contracted or part of the PH-MCO staff.
4. An outline of interventions that the CBCM worker will be performing for each of the targeted providers.
5. Outline payment mechanisms and time frames to providers for CBCM.
6. Program Budget, which should include the payment terms.

I. Should the PH-MCO need to request a change to a currently approved CBCM program and/or replace a CBCM program with another program, please submit your proposal changes on template B(3)(d), CBCM Proposal Change Form, that is available on Docushare.

III. Payments to the PH-MCO

A. The Department will make payments for Provider P4P and CBCM based on a per member per month (PMPM) rate, noted in Appendix 3f. This payment is separate from the monthly capitation process, as identified in Appendix 3b, and will be made via Gross Adjustment.

B. If this payment is subject to the Gross Receipts Tax (GRT), the payment amount will increase by 6.27%. This increase recognizes the legitimate and marginal administrative cost to the PH-MCO of this tax. If the Department has notified the PH-MCO that the GRT is reduced or ended, the increase to the Provider P4P payment for GRT will be appropriately reduced or ended.

C. If the Commonwealth replaces GRT with another tax on PH-MCO revenue or if a new tax is implemented in addition to the GRT, then the Department will adjust the percentage in contained III.B, above, to accurately reflect the effect of the tax obligation on revenue provided.

D. The Department will make these payments only to the extent that adequate funds are included for the purpose of these Exhibit B (3) payments to all PH-MCOs in the Commonwealth's enacted budget for the capitation appropriation.

E. Provider Pay-for-Performance

1. The Department will process a quarterly Provider P4P payment in the second subsequent month following the quarter end.
2. Payments made to the PH-MCO under the Provider P4P program are intended to fund all mandatory measures first prior to funding optional measures.
3. If the PH-MCO has unspent Provider P4P funds after all final disbursements have been made for the approved QPP above, upon advanced written notice to the PH-MCO, the Department may reduce a future Provider P4P payment by the unspent amount.
4. If at any time the Department determines Provider P4P funds were not disbursed in accordance with the approved QPP above, upon advanced written notice to the PH-MCO, the Department may elect to reduce a future Provider P4P payment by the amount identified.

F. Community Based Care Management

1. The Department will process a monthly payment for CBCM in the month subsequent to the month in which capitation was paid.
2. If the PH-MCO has unspent CBCM funds, determined as of March 31 of the subsequent calendar year, the PH-MCO will return the unspent funds to the Department upon request. Alternatively, the Department may choose to reduce a future CBCM payment in the amount of unspent funds.
3. If the PH-MCO does business in multiple HealthChoices zones, CBCM funds can be allocated across any and/or all of the zones, in which the PH-MCO operates.
4. Payments for the CBCM program cannot exceed more than 110.0 percent (110.0%) of the approved budget, as identified in Section II.H.7 above, without prior approval by the Department.

IV. Payments to Providers

A. Provider Pay-for-Performance

1. All Provider P4P funds received from the Department for this HealthChoices Agreement should be paid to network providers in accordance with the approved QPP above.
2. The PH-MCO is required to develop and maintain a separate accounting process of the receipts and disbursements of Provider P4P funds. The PH-MCO must be able to separately identify and track each payment to a provider on a per-claim basis for each specific mandatory and optional HEDIS Quality Measure identified in the QPP.

3. Each PH-MCO may determine the frequency of issuing payments to its providers. However, the Department recommends, at a minimum, quarterly payouts. The PH-MCO must issue Provider P4P payments to its providers for services rendered under approved terms of this Exhibit B (3) to be paid out in full no later than June 30 of the subsequent calendar year.

B. Community Based Care Management

1. The PH-MCO should make payment to providers within the approved time period in the approved CBCM program, as identified in Section II.H.7 above.

V. Reporting

A. Provider Pay-for-Performance

1. The PH-MCO is required to meet the Department's reporting requirements relative to Annual Report #40 (Provider P4P). Instructions for completing Annual Report #40 can be found in the applicable Financial Reporting and Requirements issued separately by the Department.

B. Community Based Care Management

1. All PH-MCO must submit an analysis of their Enhanced Medical Home/Case Management in addition to submitting a sub-analysis of the Community Based Case Management program. These analysis must be submitted as part of Operations Report #15 to the Department on the scheduled reporting due date(s).
2. An analysis of CBCM services should be a subset of the Enhanced Medical Home Program which details each provider involved as well as the Community Based Care Management interventions utilized during member interactions that impacted or reduced preventable readmissions or non-emergent visits to the ED, or enhanced coordination of BH/PH services. For dental related services, MCO will report the impact of CBCM activity to increase the CMS 416 rate of preventive dental services as well as the HEDIS pediatric dental rate.

3. The PH-MCO will report on the clinical and financial outcomes of the program. The analysis should be a subset of the Operations 15 report and must describe the program's return on investment (ROI).
4. Beginning with July 31 of the current calendar year, the PH-MCO must submit the first of three financial reports with payment activity for all approved CBCM programs for the current CBCM program year. A second report will be due 30 days after the end of the calendar year, and will be cumulative in nature. The last report will be due to the Department no later than March 31, and will contain all payments made for the approved CBCM program for the previous calendar year. In future years, the Department may choose to make the first two reports part of Operations Report #15.

VI. Clinical Review

The Department may choose to perform a clinical review of the Provider Pay-for-Performance or Community Based Care Management program. The PH-MCO must reasonably cooperate with Department staff during the clinical review process.

EXHIBIT C

PH-MCO REQUIREMENTS FOR PROVIDER TERMINATIONS

The PH-MCO must comply with the requirements outlined in this Exhibit when they experience a termination with a provider. The requirements have been delineated to identify the requirements for terminations that are initiated by the PH-MCO and terminations that are initiated by the provider. Also provided in this Exhibit are the requirements for submission of workplans and supporting documentation that is to be submitted to the Department for hospital terminations, terminations of a specialty unit within a facility and terminations with large provider groups, which would negatively impact the ability of members to access services.

1. Termination by the PH-MCO

A. Notification to Department

The PH-MCO must notify the Department in writing of its intent to terminate a Network Provider and services provided by a Network Provider (which includes a hospital, specialty unit within a facility, and/or a large provider group) sixty (60) days prior to the effective date of the termination.

The PH-MCO must submit a Provider termination work plan and supporting documentation within ten (10) Business Days of the PH-MCO notifying the Department of the termination and must provide weekly updates to this information. The requirements for the workplan and supporting documentation are found in this Exhibit, under 3. Workplans and Supporting Documentation.

B. Continuity of Care

The PH-MCO must comply with both this section and the PA Department of Health (DOH) requirements found at 28 Pa. Code § 9.684.

Unless the Provider is being terminated for cause as described in 40 P.S. § 991.2117(b), the PH-MCO must allow a Member to continue an ongoing course of treatment from the Provider for up to sixty (60) days from the date the Member is notified by the PH-MCO of the termination or pending termination of the Provider, or for up to sixty (60) days from the date of Provider termination, whichever is greater. A Member is considered to be receiving an ongoing course of treatment from a Provider if during the previous twelve (12) months the Member was treated by the Provider for a condition that requires follow-up care or additional treatment or the services have been Prior Authorized**.** Any adult member with a previously scheduled appointment shall be determined to be in receipt of an ongoing course of treatment from the provider, unless the

appointment is for a well adult check-up. Any child (under age 21) with a previously scheduled appointment, including an appointment for well child care, shall be determined to be in receipt of an ongoing course of treatment from the provider. Per Department of Health regulation Title 28, §9.684(d), the transitional period may be extended by the PH-MCO if the extension is determined to be clinically appropriate. The PH-MCO shall consult with the Member and the health care provider in making the determination. The PH-MCO must also allow a Member who is pregnant to continue to receive care from the Provider that is being terminated through the completion of the Member's postpartum care.

The PH-MCO must review each request to continue an ongoing course of treatment and notify the Member of the decision as expeditiously as the Member's health condition requires, but no later than 2 business days. If the PH-MCO determines what the Member is requesting is not an ongoing course of treatment, the PH-MCO must issue the Member a denial notice using the template notice titled C(4) Continuity of Care Denial Notice found on the HealthChoices and ACCESS Plus Intranet site.

The PH-MCO must also inform the Provider that to be eligible for payment for services provided to a Member after the Provider is terminated from the Network, the Provider must agree to meet the same terms and conditions as participating Providers.

C. Notification to Members

If the Provider that is being terminated from the Network is a PCP, the PH-MCO, using the template notice titled C(1) Provider Termination Template For PCPs found on the HealthChoices and ACCESS Plus Intranet site, must notify all Members who receive primary care services from the Provider thirty (30) days prior to the effective date of the Provider's termination. Members who are receiving an ongoing course of treatment from the Provider may continue to receive this treatment for up to sixty (60) days from the date the Member is notified of the termination or pending termination of the Provider, or for up to sixty (60) days from the date of Provider termination, whichever is greater.

If the Provider that is being terminated from the Network is not a PCP or a hospital, the PH-MCO, using the template notice titled C(3) Provider Termination Template for Specialist and FQHC Providers Who Are Not PCPs, found on the HealthChoices and ACCESS Plus Intranet site, must notify all Members who have received services from the Provider during the previous twelve (12) months, as identified through referral and claims data; all Members who are scheduled to receive services from the Provider; and all Members who have a pending or approved prior authorization request for services from the Provider thirty (30) days prior to the effective date of the Provider's termination. Members who are receiving an ongoing course of treatment from the Provider may continue to receive this treatment for up to sixty (60) days from the date the Member is

notified of the termination or pending termination of the Provider, or for up to sixty (60) days from the date of Provider termination, whichever is greater.

If the Provider that is being terminated from the Network is a hospital (including a specialty unit within a facility or hospital), the PH-MCO, using the template notice titled C(2) Hospital/Specialty Unit Within a Facility or Hospital Termination found on the HealthChoices and ACCESS Plus Intranet site, must notify all Members assigned to a PCP with admitting privileges at the hospital, all Members assigned to a PCP that is owned by the hospital, and all Members who have utilized the hospital's services within the past twelve (12) months thirty (30) days prior to the effective date of the hospital's termination. The MCO must utilize claims data to identify these Members.

If the PH-MCO is terminating a specialty unit within a facility or hospital**,** the Department may require the PH-MCO to provide thirty (30) day advance written notice to a specific Member population or to all of its Members, based on the impact of the termination.

The Department, at its sole discretion, may allow exceptions to the thirty (30) day advance written notice depending upon verified status of contract negotiations between the PH-MCO and Provider.

The Department, in coordination with DOH, may require the PH-MCO to include additional information in the notice of a termination to Members.

The thirty (30) day advance written notice requirement does not apply to terminations by the PH-MCO for cause in accordance with 40 P.S. Section 991.2117(b). The PH-MCO must notify Members within five (5) Business Days using the template notice titled C(1) Provider Termination Template For PCPs, found on the HealthChoices and ACCESS Plus Intranet site.

The PH-MCO must update hard copy and web-based Provider directories to reflect changes in the Provider Network as required in Section V.F.16, Provider Directories, of this Agreement.

2. Termination by the Provider

A. Notification to Department

If the PH-MCO is informed by a Provider that the Provider intends to no longer participate in the PH-MCO's Network, the PH-MCO must notify the Department in writing sixty (60) days prior to the date the Provider will no longer participate in the PH-MCO's Network. If the PH-MCO receives less than sixty (60) days notice that a Provider will no longer participate in the PH-MCO's Network, the PH-MCO must notify the Department by the next Business Day after receiving notice from the Provider.

The PH-MCO must submit a Provider termination work plan within ten (10) Business Days of the PH-MCO notifying the Department of the termination and must provide weekly status updates to the workplan. The requirements for the workplan are found in this Exhibit, under 3. Workplans and Supporting Documentation.

The PH-MCO must comply with both this section and the PA Department of Health (DOH) requirements found at 28 Pa. Code § 9.684.

B. Notification to Members

If the Provider that is terminating its participation in the Network is a PCP, the PH-MCO, using the template notice titled C(1) Provider Termination Template For PCPs, found on the HealthChoices and ACCESS Plus Intranet site, must notify all Members who receive primary care services from the Provider.

If the Provider that is terminating its participation in the Network is not a PCP or a hospital, the PH-MCO, using the template notice titled C(3) Provider Termination Template for Specialist and FQHC Providers Who Are Not PCPs, found on the HealthChoices and ACCESS Plus Intranet site, must notify all Members, who have received services from the Provider during the previous twelve (12) months; all Members who were scheduled to receive services from the terminating Provider; and all Members who have a pending or approved Prior Authorization request for services from the Provider thirty (30) days prior to the effective date of the Provider's termination. The PH-MCO must use referral and claims data to identify these Members.

If the Provider that is terminating its participation in the Network is a hospital or specialty unit within a facility, the PH-MCO, using the template notice titled C(2) Hospital/Specialty Unit Within a Facility or Hospital Termination, found on the HealthChoices and ACCESS Plus Intranet site, must notify all Members assigned to a PCP with admitting privileges at the hospital, all Members assigned to a PCP that is owned by the hospital, and all members who have utilized the terminating hospital's services within the past twelve (12) months thirty (30) days prior to the effective date of the Hospital's termination. The MCO must use referral and claims data to identify these Members.

If the Provider that is terminating its participation in the Network is a specialty unit within a facility or hospital**,** the Department may require the PH-MCO to provide thirty (30) days advance written notice to a specific Member population or to <u>all</u> of its Members ,based on the impact of the termination.

The Department, in coordination with DOH, may require additional information be included in the notice of a termination to Members.

The PH-MCO must update hard copy and web-based Provider directories to reflect changes in the Provider Network as required in Section V.F.16, Provider Directories, of this Agreement.

3. Workplans and Supporting Documentation

A. Workplan Submission

The PH-MCO must submit a Provider termination work plan within ten (10) Business Days of the PH-MCO notifying the Department of the termination and must provide weekly updates to the workplan. The workplan must provide detailed information on the tasks that will take place to ensure the termination is tracked from the time it is first identified until the termination effective date. The workplan should be organized by Task, Responsible Person(s), Target Dates, Completed Date and Status. The workplan should define the steps within each of the Tasks. The Tasks may include, but not be limited to:

- Commonwealth Notifications (DHS and DOH)
- Provider Impact and Analysis
- Provider Notification of the Termination
- Member Impact and Analysis
- Member Notification of the Termination
- Member Transition
- Member Continuity of Care
- Systems Changes
- Provider Directory Updates for Enrollment Contractor (include date when all updates will appear on Provider files sent to enrollment broker)
- PH-MCO Online Directory Updates
- Member Service and Provider Service Script Updates
- Submission of Required Documents to the Department (member notices and scripts for prior approval)
- Submission of Final Member Notices to the Department (also include date that DOH received the final notices)
- Communication with the Public Related to the Termination
- Termination Retraction Plan, if necessary

B. Supporting Documentation

The Department is also requesting the PH-MCO submit the following supporting documentation, in addition to the workplan, within ten (10) Business Days of the PH-MCO notifying the Department of the termination and must provide weekly updates as appropriate. The Department is not prescribing the format for the supporting documentation. However, it is required to be submitted through electronic means, if possible.

1) Background Information

a) Submit a summary of issues/reasons for termination.
b) Submit information on negotiations or outreach that has occurred between the PH-MCO and the Provider including dates, parties present and outcomes.

2) Member Access to Provider Services

a) Submit information that identifies Providers remaining in the Network by Provider type and location that would be available within the appropriate travel times for those members once the termination is effective. Provide the travel times for the remaining providers based upon the travel standards outlined in Exhibit AAA of the contract. For PCPs also list current panel sizes and the number of additional members that are able to be assigned to those PCPs.
b) Submit geographic access reports and maps documenting that all Members currently accessing terminating providers can access services being provided by the terminating Provider from remaining Network Providers who are accepting new Members. This documentation must be broken out by Provider type.
c) Submit a comprehensive list of all Providers, broken out by Provider type, who are affected by the termination and that also Indicates the current number of members either assigned (for PCPs) or utilizing these providers.
d) Submit information that includes the admitting privileges at other hospitals or facilities for each affected Provider and whether each affected Provider can serve the PH-MCO's Members at another hospital or facility.
e) Submit a copy of the final provider notices to the Department.

3) Member Identification and Notification Process

a) Submit information that identifies the total number of Members affected by the termination, i.e., assigned to an owned/affiliated PCP or utilizing the hospital or owned/affiliated provider within the twelve (12) months preceding the termination date, broken down by Provider.
b) Submit information on the number of members with prior authorizations in place that will extend beyond the provider termination date.
c) Submit draft and final Member notices, utilizing the templates included as C(1) – C(4), Provider and Hospital Termination Templates and Continuity of Care Denial Notice, found on the HealthChoices and ACCESS Plus Intranet site, as appropriate, for Department review and prior approval.

4) Member Services

a) Submit for Department prior approval, the call center script to be used for the termination.

b) Identify the plan for handling increased call volume in the call center while maintaining call center standards.
c) Submit to the Department a call center report for the reporting of summary call center statistics, if requested as part of the termination. This call center report should include, at a minimum, the following elements:

- Total Number of Inbound Member Services Calls (broken out by PCP, Specialist, and Hospital)
- Termination Call Reasons (broken out by Inquiries, PCP Change, Opt Out/Plan Change)

5) Affected Members in Care Management

a) Submit the total number of members in Care Management affected by the termination with sub-breakdowns by members who are pregnant (broken out by total number of pregnant members in care management, those who will deliver before the termination and those members whose due date is past the termination); members with HIV/AIDS; Children in Substitute Care; and members identified as high risk.
b) Submit the criteria to the Department that the PH-MCO will utilize for continuity of care for members affected by the termination.
c) Submit an outreach plan and outreach script to the Department for prior approval if outbound calls are to be made to inform members in care management about the termination.

6) Enrollment Services

a) Submit final, approved member notices to the Department, the member notices should be on PH-MCO letterhead.

7) News Releases

Any news releases related to the termination must be submitted to the Department for prior approval.

8) Website Update

Indicate when the PH-MCO's web-based Provider directories will be updated, and what if any additional information will be posted to the PH-MCO website.

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EXHIBIT C(1)

PROVIDER TERMINATION TEMPLATE—For PCPs

IMPORTANT NOTICE ABOUT YOUR DOCTOR

[Date]

[Member name] **[Member ID]**
[Member address] **[Member date of birth]**

Dear Member:

Soon there will be an important change for **[PH-MCO]** members. On **[Effective Date]** the following doctor will stop treating **[PH-MCO]** members.

[Name of Provider and Address of Provider]

What you must do now
You must do one of these two things:

1. Stay with your doctor and choose a new health plan. You can choose a new health plan that works with your doctor by calling PA Enrollment Services: 1-800-440-3989 (Toll-free TTY: 1-800-618-4225). You can call Monday through Friday, 8:00 A.M. to 6 P.M., and Saturday 8:00 A.M. to 12 P.M.

OR

2. Stay with your health plan and choose a new doctor. If you need help, call our Member Services Department at **[PH-MCO number]** and ask for a list of doctors. You can also find a list of doctors by visiting our website at **[insert link here]**. Please call our Member Services Department to tell us the name of your new **[PCP/FQHC]** by **[date]**.

It is important to have a doctor when you need one. If you have not chosen a new **[PCP/ FQHC]** by **[date],** we will choose one for you. If we choose a new **[PCP/ FQHC]** for you, we will send you a letter telling you the name, address and telephone number of your new **[PCP/ FQHC]**. If we choose your new **[PCP/ FQHC]** for you, you can still change your **[PCP/ FQHC]** at any time.

Two exceptions

1. **You are pregnant.** If you are pregnant, you may continue to receive services from your doctor throughout your pregnancy and post-partum care, if that doctor is willing to continue to see you.

2. **You need continuing care.** If you've been treated by your doctor within the last twelve (12) months for a medical condition that requires follow-up care or more treatment; or if treatment services have been Prior Authorized for after **[date]**, you can get *continuing care* treatment. *Continuing care* means treatment for up to 60 days from the date on this letter, or for 60 days from **[provider termination date]**-whichever is longer.

You may ask for continuing care by calling Member Services at **[PH-MCO number]**. Tell Member Services the name of the doctor you go to, and tell them what treatment you need.

[PH-MCO] will send you and your doctor a letter telling you if your request is approved or denied. If your request is denied, we will tell you how you can appeal that decision. If you do not get a letter from **[PH-MCO]** within two weeks, please call the Member Services Department at **[PH-MCO number]**. TTY users, please call **[Toll-free TTY number]**.

If you get services from **[PCP/FQHC]** after **[Effective Date]** without approval from **[PH-MCO], [PH-MCO]** will not pay, and **[PCP/FQHC]** could send you a bill.

→Your Behavioral Health Managed Care Plan will not change. Call your Behavioral Health Managed Care Plan if you have questions about behavioral health coverage.

Questions?If you have any questions, please call our Member Services Department at **[PH-MCONumber]**. TTY users, please call **[Toll-free TTY Number]**. You can call **[insert days and hours]**.

Sincerely,

[PH-MCO Name]

TAG Lines:
PH-MCO, the following statement must appear in English, Russian, Cambodian, Vietnamese, Spanish, Chinese, and any other language as required by the contract:]

The information in this notice is available in other languages and formats by calling [PH-MCO Name] at [Phone #/Toll-free TTY #].

EXHIBIT C(2)

HOSPITAL/SPECIALTY UNIT WITHIN A FACILITY OR HOSPITAL TERMINATION TEMPLATE

IMPORTANT NOTICE ABOUT YOUR [HOSPITAL/SPECIALTY UNIT WITHIN A FACILITY OR HOSPITAL]
Use if PH-MCO is terminating Hospital or Specialty Unit within a Facility or Hospital

[Date]

[Member name] **[Member ID]**
[Member address] **[Member date of birth]**

Dear Member,

Soon there will be an important change for **[PH-MCO]** members. On **[Effective Date], the following [Hospital/Specialty Unit within a Facility or Hospital]** will stop treating **[PH-MCO]** members:

[Name and address of Hospital/Specialty Unit within a Facility or Hospital]

→You will not be able to use **[Hospital/Specialty Unit within a Facility or Hospital]** after **[Date]** unless you have a medical emergency. **If you have a medical emergency,** you should always go to the nearest hospital emergency room.

What you must do now
You must do one of these two things:

1. Continue to use[Hospital/Specialty Unit within a Facility or Hospital] by choosing a new health plan. You can choose a health plan that works with **[Hospital/Specialty Unit within a Facility or Hospital]** by calling PA Enrollment Services: 1-800-440-3989 (Toll-free TTY: 1-800-618-4225). You can call Monday through Friday, 8:00 A.M. to 6 P.M., and Saturday 8:00 A.M. to 12 P.M.

OR

2. Stay with your health plan and choose a new [Hospital/Specialty Unit within a Facility or Hospital]. If you need help, call our Member Services Department at **[PH-MCO number]** and ask for a list of hospitals. You can also find a list of hospitals by visiting our website at **[insert link here].**

Two exceptions

You may go to **[Hospital/Specialty Unit within a Facility or Hospital]** without changing health plans if:

1. **You are pregnant.** If you are pregnant, you may continue to go to **[Hospital/Specialty Unit within a Facility or Hospital]** for pregnancy and post-partum care.

2. **You need continuing care.** If you need more treatment for a medical condition that you've had treated by **[Hospital/Specialty Unit within a Facility or Hospital]** within the last twelve (12) months; or if treatment services have been Prior Authorized after **[Date]** you can get continuing care treatment. Continuing care means treatment for up to 60 days from the date on this letter, or for 60 days from **[Termination Date]** – whichever is longer.

You may ask for continuing care by calling Member Services at **[PH-MCO number].** Tell Member Services the name of the hospital you go to, and tell them what treatment you need.

[PH-MCO] will send you a letter telling you if your request is approved or denied. If your request is denied, we will tell you how you can appeal that decision. If you do not get a letter from **[PH-MCO]** within two weeks, please call our Member Services Department at **[PH-MCO number]**. TTY users, please call **[Toll-free TTY number]**.

If you receive services from **[Name of terminating Hospital/Specialty Unit within a Facility or Hospital]** after **[Effective Date]** and have not received approval from **[PH-MCO name]** to receive these services from **[Name of terminating Hospital/Specialty Unit within a Facility or Hospital]**, **[PH-MCO name]** will not pay for the services and the **[Hospital/Specialty Unit within a Facility or Hospital]** may send you a bill.

→Your Behavioral Health Managed Care Plan will not change. Call your Behavioral Health Managed Care Plan if you have questions about behavioral health coverage.

Questions?
If you have any questions, please call our Member Services Department at **[PH-MCO Number]**. TTY users, please call **[Toll-free TTY Number]**. You can call [insert days and hours].

Sincerely,

[PH-MCO name]

TAG Lines:

PH-MCO, the following statement must appear in English, Russian, Cambodian, Vietnamese, Spanish, Chinese, and any other language as required by the contract:]

The information in this notice is available in other languages and formats by calling [PH-MCO Name] at [Phone #/Toll-free TTY #].

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EXHIBIT C(3)

PROVIDER TERMINATION TEMPLATE
for Specialist and FQHC Providers Who Are Not PCPs

IMPORTANT NOTICE ABOUT YOUR DOCTOR

[Date]

[Member name] **[Member ID]**
[Member address] **[Member date of birth]**

Dear Member:

Soon there will be an important change for **[PH-MCO] members. On [Effective Date],** the following doctor will stop treating **[PH-MCO] members:**

[Name of Provider and Address of Provider]

What you must do now
You must do one of these two things:

1. Stay with your doctor and choose a new health plan. You can choose a new health plan that works with your doctor by calling PA Enrollment Services: 1-800-440-3989 (Toll-free TTY: 1-800-618-4225). You can call Monday through Friday, 8:00 A.M. to 6 P.M., and Saturday 8:00 A.M. to 12 P.M.

OR

2. Stay with your health plan and choose a new doctor. If you need help, call our Member Services Department at **[PH-MCO number]** and ask for a list of specialist doctors. You can also find a complete list of our doctors by visiting our website at **[insert link here]**. Please call our Member Services Department to tell us the name of your new **[Specialist/FQHC]** by **[Date]**.

Two exceptions

1. **You are pregnant.** If you are pregnant, you may continue to receive services from your specialist throughout your pregnancy and post-partum care, if that specialist is willing to continue to see you.

2. **You need continuing care.** If you have been treated by your doctor within the last twelve (12) months for a medical condition that requires follow-up care or more treatment; or if treatment services have been Prior Authorized after **[Date]**, you can get

continuing care treatment. *Continuing care* means treatment for up to 60 days from the date on this letter, or for 60 days from **[Termination date]** – whichever is longer.

You may ask for continuing care by calling Member Services at **[PH-MCO number]**. TTY users call: **[Toll-free TTY number].** Tell Member Services the name of the doctor you go to, and tell them what treatment you need.

[PH-MCO] will send you and your doctor a letter telling you if your request is approved or denied. If your request is denied, we will tell you how you can appeal that decision. If you do not get a letter from **[PH-MCO]** within two weeks, please call the Member Services Department at **[PH-MCO number].**

If you get services from **[Specialist/FQHC]** after **[Effective Date]** without approval from **[PH-MCO], [PH-MCO]** will not pay, and **[Specialist/FQHC]** could send you a bill.

→Your Behavioral Health Managed Care Plan will not change. Call your Behavioral Health Managed Care Plan if you have questions about behavioral health coverage.

Questions?

If you have any questions, please call our Member Services Department at **[PH-MCO Number]**. TTY users, please call **[Toll-free TTY Number]**. You can call **[insert hours and days]**.

Sincerely,

[PH-MCO Name]

TAG Lines:
PH-MCO, the following statement must appear in English, Russian, Cambodian, Vietnamese, Spanish, Chinese, and any other language as required by the contract:]

The information in this notice is available in other languages and formats by calling [PH-MCO Name] at [Phone #/Toll-free TTY #].

EXHIBIT C(4)

CONTINUITY OF CARE DENIAL NOTICE

[DATE] [This MUST be the date the notice is mailed]

RE: [*Member's name and DOB*]

Dear **[Member Name]:**

[PH-MCO Name] has reviewed your request for continuation of **[*identify SPECIFIC service/item*]** care provided by **[*Provider's name*]** who will no longer be serving **[PH-MCO Name]** members beginning **[Effective *date*]**. After PH-MCO review, your request for continuity of care is:

Denied because**: *[Explain in detail every reason for denial. In addition to explanation for decision, include specific references to approved criteria, rules or protocols on which decision is based. If denied because of insufficient information, identify all additional information needed to render decision.]***

This decision will take effect on [Effective *date*].

IF YOU DO NOT AGREE WITH THIS DECISION, YOU MAY DO ONE OR ALL OF THE FOLLOWING:

1) Request Criteria

You may request a copy of the medical necessity criteria or other rules on which the decision was based by sending a written request to:

PH-MCO Name and Address

2) File a Complaint or Grievance

You may file a complaint or grievance with **[PH-MCO Name] within 45 days from the date you get this notice**. Your complaint or grievance will be decided no later than ( ) days *[PH-MCO: Insert 30 unless PH-MCO will be using a shorter timeframe.]* from when we receive it.

To file a complaint or grievance:

- Call **[PH-MCO Name]** at **[Phone #/Toll-free TTY #]**; or
- Send your complaint or grievance to **[PH-MCO Name]** at the following address:

PH-MCO Address for filing complaint or grievance

To ask for an early decision

If your doctor or dentist believes that waiting ( ) days *[PH-MCO: Insert 30 unless PH-MCO will be using a shorter timeframe.]* to get a decision could harm your health, you may ask that your complaint or grievance be decided more quickly. To do this:

- Call **[PH-MCO Name]** at **[Phone #/Toll-free TTY #];**

AND

- Your doctor or dentist must fax a signed letter to **[PH-MCO fax #]** explaining why taking 30 days to decide your complaint or grievance could harm your health.

[PH-MCO Name] will notify you of the decision within 48 hours from when we receive your doctor's or dentist's letter, or within 3 business days from when we receive your request for an early decision, whichever is sooner.

3) Request a Fair Hearing

You may ask for a Fair Hearing from the Department of Human Services. Your request for a Fair Hearing must be in writing and must be postmarked **within 30 days from the date on this notice**. Your request should include the following information:

- Your (the Member's) name, social security number, and date of birth;
- A telephone number where you can be reached during the day;
- Whether you want to have a hearing in person or by telephone;
- A copy of this notice.

Your request for a Fair Hearing must be sent to the following address:

Department of Human Services
Office of Medical Assistance Programs
HealthChoices Program/Complaint, Grievance and Fair Hearing
P.O. Box 2675
Harrisburg, PA 17105-2675

The Department will issue a decision between 60 and 90 days from when it receives your request (see your Member handbook for more details).

To ask for an early decision

If your doctor or dentist believes that the usual time frame for deciding your request for a Fair Hearing could harm your health, you may ask that the Fair Hearing take place more quickly. To do this:

- Call the Department at 1-800-798-2339, or fax your request to the Department at 1-717-772-6328
- Your doctor or dentist must fax a signed letter to 717-772-6328 explaining why taking the usual amount of time to decide your request for a Fair Hearing could harm your health. If your doctor or dentist does not send a written

letter, your doctor or dentist must testify at the Fair Hearing to explain why taking the usual amount of time to decide your request for a Fair Hearing could harm your health.

The Department will schedule a telephone hearing and notify you of its decision within three business days from when it receives your request.

You have the right to be present either in person or by telephone at the complaint review, grievance review, or Fair Hearing and to bring a family member, friend, lawyer or other person to help you.

If you file a complaint, grievance, or request for a Fair Hearing, you may request all documents relevant to this decision by sending a written request for the information to the following address:

PH-MCO Address for records information

4) Get Help with Grievances, Complaints, or Fair Hearings

If you need help filing a grievance, complaint, or request a Fair Hearing, you can call:

- [PH MCO Name] at [Phone #/Toll-freeTTY#]

To ask for free legal help with your grievance, complaint, or Fair Hearing, or with filing your grievance, complaint or request for Fair Hearing, you can call:

- Pennsylvania Health Law Project at 1-800-274-3258 (www.phlp.org) <OR>
- Pennsylvania Legal Aid Network at 1-800-322-7572 (www.palegalaid.net)

Sincerely,

[PH-MCO Name]

cc: Terminating Provider

PH-MCO, the following statement must appear in English, Russian, Cambodian, Vietnamese, Spanish, Chinese, and any other language as required by the contract:]

The information in this notice is available in other languages and formats by calling [PH-MCO Name] at [Phone #/Toll-free TTY #].

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STANDARD GRANT TERMS AND CONDITIONS FOR SERVICES

1. TERM OF GRANT

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

2. INDEPENDENT GRANTEE

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

3. COMPLIANCE WITH LAW

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

4. ENVIRONMENTAL PROVISIONS

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

5. POST-CONSUMER RECYCLED CONTENT

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

6. COMPENSATION/EXPENSES

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

7. INVOICES

Unless the Grantee has been authorized by the Commonwealth for Evaluated Receipt Settlement or Vendor Self-Invoicing, the Grantee shall send an ***invoice itemized bv line item*** to the address referenced on the purchase order promptly after services are satisfactorily completed. The invoice should include only amounts due under the Grant/purchase order. The purchase order number must be included on all invoices. In addition, the Commonwealth shall have the right to require the Grantee to prepare and submit a "Work In Progress" sheet that contains, at a minimum, the tasks performed, number of hours, hourly rate, and the purchase order or task order to which it refers.

8. PAYMENT

a. The Commonwealth shall put forth reasonable efforts to make payment by the required payment date. The required payment date is: (a) the date on which payment is due under the terms of the Grant; (b) thirty (30) days after a proper invoice actually is received at the "Provide Service and Bill To" address if a date on which payment is due is not specified in the Grant (a "proper" invoice is not received until the Commonwealth

accepts the service as satisfactorily performed); or (c) the payment date specified on the invoice if later than the dates established by (a) and (b) above. Payment may be delayed if the payment amount on an invoice is not based upon the price(s) as stated in the Grant. If any payment is not made within fifteen (15) days after the required payment date, the Commonwealth may pay interest as determined by the Secretary of Budget in accordance with Act No. 266 of 1982 and regulations promulgated pursuant thereto. Payment should not be construed by the Grantee as acceptance of the service performed by the Grantee. The Commonwealth reserves the right to conduct further testing and inspection after payment, but within a reasonable time after performance, and to reject the service if such post payment testing or inspection discloses a defect or a failure to meet specifications. The Grantee agrees that the Commonwealth may set off the amount of any state tax liability or other obligation of the Grantee or its subsidiaries to the Commonwealth against any payments due the Grantee under any Grant with the Commonwealth.

b. The Commonwealth shall have the option of using the Commonwealth purchasing card to make purchases under the Grant or purchase order. The Commonwealth's purchasing card is similar to a credit card in that there will be a small fee which the Grantee will be required to pay and the Grantee will receive payment directly from the card issuer rather than the Commonwealth. Any and all fees related to this type of payment are the responsibility of the Grantee. In no case will the Commonwealth allow increases in prices to offset credit card fees paid by the Grantee or any other charges incurred by the Grantee, unless specifically stated in the terms of the Grant or purchase order.

9. TAXES

The Commonwealth is exempt from all excise taxes imposed by the Internal Revenue Service and has accordingly registered with the Internal Revenue Service to make tax free purchases under Registration No. 23740001-K. With the exception of purchases of the following items, no exemption certificates are required and none will be issued: undyed diesel fuel, tires, trucks, gas guzzler emergency vehicles, and sports fishing equipment. The Commonwealth is also exempt from Pennsylvania state sales tax, local sales tax, public transportation assistance taxes and fees and vehicle rental tax. The Department of Revenue regulations provide that exemption certificates are not required for sales made to governmental entities and none will be issued. Nothing in this paragraph is meant to exempt a construction Grantee from the payment of any of these taxes or fees which are required to be paid with respect to the purchase, use, rental, or lease of tangible personal property or taxable services used or transferred in connection with the performance of a construction Grant.

10. WARRANTY

The Grantee warrants that all services performed by the Grantee, its agents and subGrantees shall be free and clear of any defects in workmanship or materials. Unless otherwise stated in the Grant, all services and parts are warranted for a period of one year following completion of performance by the Grantee and acceptance by the Commonwealth. The Grantee shall correct any problem with the service and/or replace any defective part with a part of equivalent or superior quality without any additional cost to the Commonwealth.

11. PATENT, COPYRIGHT, AND TRADEMARK INDEMNITY

The Grantee warrants that it is the sole owner or author of, or has entered into a suitable legal agreement concerning either: a) the design of any product or process provided or used in the performance of the Grant which is covered by a patent, copyright, or trademark registration or other right duly authorized by state or federal law or b) any copyrighted matter in any report document or other material provided to the commonwealth under the Grant. The Grantee shall defend any suit or proceeding brought against the Commonwealth on account of any alleged patent, copyright or trademark infringement in the United States of any of the products provided or used in the performance of the Grant. This is upon condition that the Commonwealth shall provide prompt notification in writing of such suit or proceeding; full right, authorization and opportunity to conduct the defense thereof; and full information and all reasonable cooperation for the defense of same. As principles of governmental or public law are involved, the Commonwealth may participate in or choose to conduct, in its sole discretion, the defense of any such action. If information and assistance are furnished by the Commonwealth at the Grantee's written request, it shall be at the Grantee's expense, but the responsibility for such expense shall be only that within the Grantee's written authorization. The Grantee shall indemnify and hold the Commonwealth harmless from all damages, costs, and expenses, including attorney's fees that the Grantee or the Commonwealth may pay or incur by reason of any infringement or violation of the rights occurring to any holder of copyright, trademark, or patent interests and rights in any products provided or used in the performance of the Grant. If any of the products provided by the Grantee in such suit or proceeding are held to constitute infringement and the use is enjoined, the Grantee shall, at its own expense and at its option, either procure the right to continue use of such infringement products, replace them with non-infringement equal

performance products or modify them so that they are no longer infringing. If the Grantee is unable to do any of the preceding, the Grantee agrees to remove all the equipment or software which are obtained contemporaneously with the infringing product, or, at the option of the Commonwealth, only those items of equipment or software which are held to be infringing, and to pay the Commonwealth: 1) any amounts paid by the Commonwealth towards the purchase of the product, less straight line depreciation; 2) any license fee paid by the Commonwealth for the use of any software, less an amount for the period of usage; and 3) the pro rata portion of any maintenance fee representing the time remaining in any period of maintenance paid for. The obligations of the Grantee under this paragraph continue without time limit. No costs or expenses shall be incurred for the account of the Grantee without its written consent.

12. OWNERSHIP RIGHTS

The Commonwealth shall have unrestricted authority to reproduce, distribute, and use any submitted report, data, or material, and any software or modifications and any associated documentation that is designed or developed and delivered to the Commonwealth as part of the performance of the Grant.

13. ASSIGNMENT OF ANTITRUST CLAIMS

The Grantee and the Commonwealth recognize that in actual economic practice, overcharges by the Grantee's suppliers resulting from violations of state or federal antitrust laws are in fact borne by the Commonwealth. As part of the consideration for the award of the Grant, and intending to be legally bound, the Grantee assigns to the Commonwealth all right, title and interest in and to any claims the Grantee now has, or may acquire, under state or federal antitrust laws relating to the products and services which are the subject of this Grant.

14. HOLD HARMLESS PROVISION

The Grantee shall hold the Commonwealth harmless from and indemnify the Commonwealth against any and all claims, demands and actions based upon or arising out of any activities performed by the Grantee and its employees and agents under this Grant and shall, at the request of the Commonwealth, defend any and all actions brought against the Commonwealth based upon any such claims or demands.

15. AUDIT PROVISIONS

The Commonwealth shall have the right, at reasonable times and at a site designated by the Commonwealth, to audit the books, documents and records of the Grantee to the extent that the books, documents and records relate to costs or pricing data for the Grant. The Grantee agrees to maintain records which will support the prices charged and costs incurred for the Grant. The Grantee shall preserve books, documents, and records that relate to costs or pricing data for the Grant for a period of three (3) years from date of final payment. The Grantee shall give full and free access to all records to the Commonwealth and/or their authorized representatives.

16. DEFAULT

a. The Commonwealth may, subject to the provisions of Paragraph 17, Force Majeure, and in addition to its other rights under the Grant, declare the Grantee in default by written notice thereof to the Grantee, and terminate (as provided in Paragraph 18, Termination Provisions) the whole or any part of this Grant for any of the following reasons:

1) Failure to begin work within the time specified in the Grant or as otherwise specified;
2) Failure to perform the work with sufficient labor, equipment, or material to insure the completion of the specified work in accordance with the Grant terms;
3) Unsatisfactory performance of the work;
4) Failure or refusal to remove material, or remove and replace any work rejected as defective or unsatisfactory;
5) Discontinuance of work without approval;
6) Failure to resume work, which has been discontinued, within a reasonable time after notice to do so;
7) Insolvency or bankruptcy;
8) Assignment made for the benefit of creditors;
9) Failure or refusal within 10 days after written notice by the Granting Officer, to make payment or show cause why payment should not be made, of any amounts due for materials furnished, labor supplied or performed, for equipment rentals, or for utility services rendered;
10) Failure to protect, to repair, or to make good any damage or injury to property; or
11) Breach of any provision of this Grant.

b. In the event that the Commonwealth terminates this Grant in whole or in part as provided in Subparagraph a. above, the Commonwealth may procure, upon such terms and in such manner as it determines, services similar or identical to those so terminated,

and the Grantee shall be liable to the Commonwealth for any reasonable excess costs for such similar or identical services included within the terminated part of the Grant.

c. If the Grant is terminated as provided in Subparagraph a. above, the Commonwealth, in addition to any other rights provided in this paragraph, may require the Grantee to transfer title and deliver immediately to the Commonwealth in the manner and to the extent directed by the Issuing Office, such partially completed work, including, where applicable, reports, working papers and other documentation, as the Grantee has specifically produced or specifically acquired for the performance of such part of the Grant as has been terminated. Except as provided below, payment for completed work accepted by the Commonwealth shall be at the Grant price. Except as provided below, payment for partially completed work including, where applicable, reports and working papers, delivered to and accepted by the Commonwealth shall be in an amount agreed upon by the Grantee and Granting Officer. The Commonwealth may withhold from amounts otherwise due the Grantee for such completed or partially completed works, such sum as the Granting Officer determines to be necessary to protect the Commonwealth against loss.

d. The rights and remedies of the Commonwealth provided in this paragraph shall not be exclusive and are in addition to any other rights and remedies provided by law or under this Grant.

e. The Commonwealth's failure to exercise any rights or remedies provided in this paragraph shall not be construed to be a waiver by the Commonwealth of its rights and remedies in regard to the event of default or any succeeding event of default.

f. Following exhaustion of the Grantee's administrative remedies as set forth in Paragraph 19, the Grantee's exclusive remedy shall be to seek damages in the Board of Claims.

17. FORCE MAJEURE

Neither party will incur any liability to the other if its performance of any obligation under this Grant is prevented or delayed by causes beyond its control and without the fault or negligence of either party. Causes beyond a party's control may include, but aren't limited to, acts of God or war, changes in controlling law, regulations, orders or the requirements of any governmental entity, severe weather conditions, civil disorders, natural disasters, fire, epidemics and quarantines, general strikes throughout the trade, and freight embargoes.

The Grantee shall notify the Commonwealth orally within five (5) days and in writing within ten (10) days of the date on which the Grantee becomes aware, or should have reasonably become aware, that such cause would prevent or delay its performance. Such notification shall (i) describe fully such cause(s) and its effect on performance, (ii) state whether performance under the Grant is prevented or delayed and (iii) if performance is delayed, state a reasonable estimate of the duration of the delay. The Grantee shall have the burden of proving that such cause(s) delayed or prevented its performance despite its diligent efforts to perform and shall produce such supporting documentation as the Commonwealth may reasonably request. After receipt of such notification, the Commonwealth may elect either to cancel the Grant or to extend the time for performance as reasonably necessary to compensate for the Grantee's delay.

In the event of a declared emergency by competent governmental authorities, the Commonwealth by notice to the Grantee, may suspend all or a portion of the Grant.

18. TERMINATION PROVISIONS

The Commonwealth has the right to terminate this Grant for any of the following reasons. Termination shall be effective upon written notice to the Grantee.

a. **TERMINATION FOR CONVENIENCE:** The Commonwealth shall have the right to terminate the Grant for its convenience if the Commonwealth determines termination to be in its best interest. The Grantee shall be paid for work satisfactorily completed prior to the effective date of the termination, but in no event shall the Grantee be entitled to recover loss of profits.

b. **NON-APPROPRIATION:** The Commonwealth's obligation to make payments during any Commonwealth fiscal year succeeding the current fiscal year shall be subject to

availability and appropriation of funds. When funds (state and/or federal) are not appropriated or otherwise made available to support continuation of performance in a subsequent fiscal year period, the Commonwealth shall have the right to terminate the Grant. The Grantee shall be reimbursed for the reasonable value of any nonrecurring costs incurred but not amortized in the price of the supplies or services delivered under this Grant. Such reimbursement shall not include loss of profit, loss of use of money, or administrative or overhead costs. The reimbursement amount may be paid for any appropriations available for that purpose

c. **TERMINATION FOR CAUSE:** The Commonwealth shall have the right to terminate the Grant for Grantee default under Paragraph 16, Default, upon written notice to theGrantee. The Commonwealth shall also have the right, upon written notice to the Grantee, to terminate the Grant for other cause as specified in this Grant or by law. If it is later determined that the Commonwealth erred in terminating the Grant for cause, then, at the Commonwealth's discretion, the Grant shall be deemed to have been terminated for convenience under the Subparagraph 18.a.

19. GRANT CONTROVERSIES

a. In the event of a controversy or claim arising from the Grant, the Grantee must, within six months after the cause of action accrues, file a written claim with the Granting officer for a determination. The claim shall state all grounds upon which the Grantee asserts a controversy exists. If the Grantee fails to file a claim or files an untimely claim, the Grantee is deemed to have waived its right to assert a claim in any forum.

b. The Granting officer shall review timely-filed claims and issue a final determination, in writing, regarding the claim. The final determination shall be issued within 120 days of the receipt of the claim, unless extended by consent of the Granting officer and the Grantee. The Granting officer shall send his/her written determination to the Grantee. If the Granting officer fails to issue a final determination within the 120 days (unless extended by consent of the parties), the claim shall be deemed denied. The Granting officer's determination shall be the final order of the purchasing agency.

c. Within fifteen (15) days of the mailing date of the determination denying a claim or within 135 days of filing a claim if, no extension is agreed to by the parties, whichever occurs first, the Grantee may file a statement of claim with the Commonwealth Board of Claims. Pending a final judicial resolution of a controversy or claim, the Grantee shall proceed diligently with the performance of the Grant in a manner consistent with the determination of the Granting officer and the Commonwealth shall compensate the Grantee pursuant to the terms of the Grant.

20. ASSIGNABILITY AND SUBGRANTING

a. Subject to the terms and conditions of this Paragraph 20, this Grant shall be binding upon the parties and their respective successors and assigns.

b. The Grantee shall not subGrant with any person or entity to perform all or any part of the work to be performed under this Grant without the prior written consent of the Granting Officer, which consent may be withheld at the sole and absolute discretion of the Granting Officer.

c. The Grantee may not assign, in whole or in part, this Grant or its rights, duties, obligations, or responsibilities hereunder without the prior written consent of the Granting Officer, which consent may be withheld at the sole and absolute discretion of the Granting Officer.

d. Notwithstanding the foregoing, the Grantee may, without the consent of the Granting Officer, assign its rights to payment to be received under the Grant, provided that the Grantee provides written notice of such assignment to the Granting Officer together with a written acknowledgement from the assignee that any such payments are subject to all of the terms and conditions of this Grant.

e. For the purposes of this Grant, the term "assign" shall include, but shall not be limited to, the sale, gift, assignment, pledge, or other transfer of any ownership interest in the

Grantee provided, however, that the term shall not apply to the sale or other transfer of stock of a publicly traded company.

f. Any assignment consented to by the Granting Officer shall be evidenced by a written assignment agreement executed by the Grantee and its assignee in which the assignee

agrees to be legally bound by all of the terms and conditions of the Grant and to assume the duties, obligations, and responsibilities being assigned.

g. A change of name by the Grantee, following which the Grantee's federal identification number remains unchanged, shall not be considered to be an assignment hereunder. The Grantee shall give the Granting Officer written notice of any such change of name.

21. NONDISCRIMINATION/SEXUAL HARASSMENT CLAUSE

During the term of the Grant, the Grantee agrees as follows:

a. In the hiring of any employee(s) for the manufacture of supplies, performance of work, or any other activity required under the grant agreement or any subgrant agreement, contract, or subcontract, the Grantee, a subgrantee, a contractor, a subcontractor, or any person acting on behalf of the Grantee shall not, by reason of gender, race, creed, or color, discriminate against any citizen of this commonwealth who is qualified and available to perform the work to which the employment relates.

b. The Grantee, any subgrantee, contractor or any subcontractor or any person on their behalf shall not in any manner discriminate against or intimidate any of its employees on account of gender, race, creed, or color.

c. The Grantee, any subgrantee, contractor or any subcontractor shall establish and maintain a written sexual harassment policy and shall inform their employees of the policy. The policy must contain a notice that sexual harassment will not be tolerated and employees who practice it will be disciplined.

d. The Grantee, any subgrantee, contractor or any subcontractor shall not discriminate by reason of gender, race, creed, or color against any subgrantee, contractor, subcontractor or supplier who is qualified to perform the work to which the grant relates.

e. The Grantee, any subgrantee, any contractor or any subcontractor shall, within the time periods requested by the commonwealth, furnish all necessary employment documents and records and permit access to their books, records, and accounts by the granting agency and the Bureau of Small Business Opportunities (BSBO), for purpose of ascertaining compliance with provisions of this Nondiscrimination/Sexual Harassment Clause. Within thirty (30) days after award of any grant, the Grantee shall be required to complete, sign and submit Form STD-21, the “Initial Contract Compliance Data” form. Grantees who have fewer than five employees or whose employees are all from the same family or who have completed the STD-21 form within the past 12 months may, within the 30 days, request an exemption from the STD-21 form from the granting agency.

f. The Grantee, any subgrantee, contractor or any subcontractor shall include the provisions of this Nondiscrimination/Sexual Harassment Clause in every subgrant agreement, contract or subcontract so that those provisions applicable to subgrantees, contractors or subcontractors will be binding upon each subgrantee, contractor or subcontractor.

g. The commonwealth may cancel or terminate the grant agreement and all money due or to become due under the grant agreement may be forfeited for a violation of the terms and conditions of this Nondiscrimination/Sexual Harassment Clause. In addition, the granting agency may proceed with debarment or suspension and may place the Grantee, subgrantee, contractor, or subcontractor in the Contractor Responsibility File.

22. CONTRACTOR INTEGRITY PROVISIONS

It is essential that those who seek to Grant with the Commonwealth observe high standards of honesty and integrity. They must conduct themselves in a manner that fosters public confidence in the integrity of the Commonwealth procurement process. In furtherance of this policy, Grantee agrees to the following:

a. Grantee shall maintain the highest standards of honesty and integrity during the performance of this Grant and shall take no action in violation of state or federal laws or regulations or any other

applicable laws or regulations, or other requirements applicable to Grantee or that govern Granting with the Commonwealth.

b. Grantee shall establish and implement a written business integrity policy, which includes, at a minimum, the requirements of these provisions as they relate to Grantee employee activity with the Commonwealth and Commonwealth employees, and which is distributed and made known to all Grantee employees.

c. Grantee, its affiliates, agents and employees shall not influence, or attempt to influence, any Commonwealth employee to breach the standards of ethical conduct for Commonwealth employees set forth in the *Public Official and Employees Ethics Act, 65 Pa.C.S. §§1101 et seq*.; the *State Adverse Interest Act, 71 P.S. §776.1 et seq*.; and the *Governor's Code of Conduct, Executive Order 1980-18, 4 Pa. Code §7.151 et seq*., or to breach any other state or federal law or regulation.

d. Grantee, its affiliates, agents and employees shall not offer, give, or agree or promise to give any gratuity to a Commonwealth official or employee or to any other person at the direction or request of any Commonwealth official or employee.

e. Grantee, its affiliates, agents and employees shall not offer, give, or agree or promise to give any gratuity to a Commonwealth official or employee or to any other person, the acceptance of which would violate the *Governor's Code of Conduct, Executive Order 1980-18, 4 Pa. Code §7.151 et seq.* or any statute, regulation, statement of policy, management directive or any other published standard of the Commonwealth.

f. Grantee, its affiliates, agents and employees shall not, directly or indirectly, offer, confer, or agree to confer any pecuniary benefit on anyone as consideration for the decision, opinion, recommendation, vote, other exercise of discretion, or violation of a known legal duty by any Commonwealth official or employee.

g. Grantee, its affiliates, agents, employees, or anyone in privity with him or her shall not accept or agree to accept from any person, any gratuity in connection with the performance of work under the Grant, except as provided in the Grant.

h. Grantee shall not have a financial interest in any other Grantee, subGrantee, or supplier providing services, labor, or material on this project, unless the financial interest is disclosed to the Commonwealth in writing and the Commonwealth consents to Grantee's financial interest prior to Commonwealth execution of the Grant. Grantee shall disclose the financial interest to the Commonwealth at the time of bid or proposal submission, or if no bids or proposals are solicited, no later than Grantee's submission of the Grant signed by Grantee.

i. Grantee, its affiliates, agents and employees shall not disclose to others any information, documents, reports, data, or records provided to, or prepared by, Grantee under this Grant without the prior written approval of the Commonwealth, except as required by the *Pennsylvania Right-to-Know Law, 65 P.S. §§ 67.101-3104*, or other applicable law or as otherwise provided in this Grant. Any information, documents, reports, data, or records secured by Grantee from the Commonwealth or a third party in connection with the performance of this Grant shall be kept confidential unless disclosure of such information is:

1) Approved in writing by the Commonwealth prior to its disclosure; or

2) Directed by a court or other tribunal of competent jurisdiction unless the Grant requires prior Commonwealth approval; or

3) Required for compliance with federal or state securities laws or the requirements of national securities exchanges; or
4) Necessary for purposes of Grantee's internal assessment and review; or

5) Deemed necessary by Grantee in any action to enforce the provisions of this Grant or to defend or prosecute claims by or against parties other than the Commonwealth; or

6) Permitted by the valid authorization of a third party to whom the information, documents, reports, data, or records pertain: or

7) Otherwise required by law.

j. Grantee certifies that neither it nor any of its officers, directors, associates, partners, limited partners or individual owners has been officially notified of, charged with, or convicted of any of the following and agrees to immediately notify the Commonwealth agency Granting officer in writing if and when it or any officer, director, associate, partner, limited partner or individual owner has been officially notified of, charged with, convicted of, or officially notified of a governmental determination of any of the following:

1) Commission of embezzlement, theft, forgery, bribery, falsification or destruction of records, making false statements or receiving stolen property.

2) Commission of fraud or a criminal offense or other improper conduct or knowledge of, approval of or acquiescence in such activities by Grantee or any affiliate, officer, director, associate, partner, limited partner, individual owner, or employee or other individual or entity associated with:

   a) obtaining;

   b) attempting to obtain; or

   c) performing a public Grant or subGrant.

   Grantee's acceptance of the benefits derived from the conduct shall be deemed evidence of such knowledge, approval or acquiescence.

3) Violation of federal or state antitrust statutes.

4) Violation of any federal or state law regulating campaign contributions.

5) Violation of any federal or state environmental law

6) Violation of any federal or state law regulating hours of labor, minimum wage standards or prevailing wage standards; discrimination in wages; or child labor violations.

7) Violation of the *Act of June 2, 1915 (P.L.736, No. 338)*, known as the *Workers' Compensation Act,* 77 P.S. 1 *et seq*.

8) Violation of any federal or state law prohibiting discrimination in employment.

9) Debarment by any agency or department of the federal government or by any other state.

10) Any other crime involving moral turpitude or business honesty or integrity.

Grantee acknowledges that the Commonwealth may, in its sole discretion, terminate the Grant for cause upon such notification or when the Commonwealth otherwise learns that Grantee has been officially notified, charged, or convicted.

k. If this Grant was awarded to Grantee on a non-bid basis, Grantee must, (as required by *Section 1641* of the *Pennsylvania Election Code*) file a report of political contributions with the Secretary of the Commonwealth on or before February 15 of the next calendar year. The report must include an itemized list of all political contributions known to Grantee by virtue of the knowledge possessed by every officer, director, associate, partner, limited partner, or individual owner that has been made by:

1) Any officer, director, associate, partner, limited partner, individual owner or members of the immediate family when the contributions exceed an aggregate of one thousand dollars ($1,000) by any individual during the preceding year; or

2) Any employee or members of his immediate family whose political contribution exceeded one thousand dollars ($1,000) during the preceding year.

To obtain a copy of the reporting form, Grantee shall contact the Bureau of Commissions, Elections and Legislation, Division of Campaign Finance and Lobbying Disclosure, Room 210, North Office

Building, Harrisburg, PA 17120.

l. Grantee shall comply with requirements of the *Lobbying Disclosure Act, 65 Pa.C.S. § 13A01 et seq*., and the regulations promulgated pursuant to that law. Grantee employee activities prior to or outside of formal Commonwealth procurement communication protocol are considered lobbying and subjects the Grantee employees to the registration and reporting requirements of the law. Actions by outside lobbyists on Grantee's behalf, no matter the procurement stage, are not exempt and must be reported.

m. When Grantee has reason to believe that any breach of ethical standards as set forth in law, the Governor's Code of Conduct, or in these provisions has occurred or may occur, including but not limited to contact by a Commonwealth officer or employee which, if acted upon, would violate such ethical standards, Grantee shall immediately notify the Commonwealth Granting officer or Commonwealth Inspector General in writing.

n. Grantee, by submission of its bid or proposal and/or execution of this Grant and by the submission of any bills, invoices or requests for payment pursuant to the Grant, certifies and represents that it has not violated any of these Grantee integrity provisions in connection with the submission of the bid or proposal, during any Grant negotiations or during the term of the Grant.

o. Grantee shall cooperate with the Office of Inspector General in its investigation of any alleged Commonwealth employee breach of ethical standards and any alleged Grantee non-compliance with these provisions. Grantee agrees to make identified Grantee employees available for interviews at reasonable times and places. Grantee, upon the inquiry or request of the Office of Inspector General, shall provide, or if appropriate, make promptly available for inspection or copying, any information of any type or form deemed relevant by the Inspector General to Grantee's integrity and compliance with these provisions. Such information may include, but shall not be limited to, Grantee's business or financial records, documents or files of any type or form that refers to or concern this Grant.

p. For violation of any of these Grantee Integrity Provisions, the Commonwealth may terminate this and any other Grant with Grantee, claim liquidated damages in an amount equal to the value of anything received in breach of these provisions, claim damages for all additional costs and expenses incurred in obtaining another Grantee to complete performance under this Grant, and debar and suspend Grantee from doing business with the Commonwealth. These rights and remedies are cumulative, and the use or non-use of any one shall not preclude the use of all or any other. These rights and remedies are in addition to those the Commonwealth may have under law, statute, regulation, or otherwise.

q. For purposes of these Grantee Integrity Provisions, the following terms shall have the meanings found in this Paragraph.

1) "Confidential information" means information that a) is not already in the public domain; b) is not available to the public upon request; c) is not or does not become generally known to Grantee from a third party without an obligation to maintain its confidentiality; d) has not become generally known to the public through a act or omission of Grantee; or e) has not been independently developed by Grantee without the use of confidential information of the Commonwealth.
2) **"**Consent" means written permission signed by a duly authorized officer or employee of the Commonwealth, provided that where the material facts have been disclosed, in writing, by pre-qualification, bid, proposal, or Grantual terms, the Commonwealth shall be deemed to have consented by virtue of execution of this Grant.
3) **"**Grantee" means the individual or entity that has entered into this Grant with the Commonwealth, including those directors, officers, partners, managers, and owners having more than a five percent interest in Grantee.
4) "Financial interest" means:
   (a) Ownership of more than a five percent interest in any business; or
   (b) Holding a position as an officer, director, trustee, partner, employee, or holding any position of management.
5) "Gratuity" means tendering, giving or providing anything of more than nominal monetary value including, but not limited to, cash, travel, entertainment, gifts, meals, lodging, loans, subscriptions, advances, deposits of money, services, employment, or Grants of any kind. The exceptions set forth in the *Governor's Code of Conduct, Executive Order 1980-18*, the *4 Pa. Code §7.153(b)*, shall apply.
6) "Immediate family" means a spouse and any unemancipated child.

7) “Non-bid basis” means a Grant awarded or executed by the Commonwealth with Grantee without seeking bids or proposals from any other potential bidder or offeror.
8) “Political contribution” means any payment, gift, subscription, assessment, Grant, payment for services, dues, loan, forbearance, advance or deposit of money or any valuable thing, to a candidate for public office or to a political committee, including but not limited to a political action committee, made for the purpose of influencing any election in the Commonwealth of Pennsylvania or for paying debts incurred by or for a candidate or committee before or after any election.

23. GRANTEE RESPONSIBILITY PROVISIONS

a. The Grantee certifies, for itself and all its subGrantees, that as of the date of its execution of this Bid/Grant, that neither the Grantee, nor any subGrantees, nor any suppliers are under suspension or debarment by the Commonwealth or any governmental entity, instrumentality, or authority and, if the Grantee cannot so certify, then it agrees to submit, along with its Bid, a written explanation of why such certification cannot be made.

b. The Grantee also certifies, that as of the date of its execution of this Bid/Grant, it has no tax liabilities or other Commonwealth obligations.

c. The Grantee's obligations pursuant to these provisions are ongoing from and after the effective date of the Grant through the termination date thereof. Accordingly, the Grantee shall have an obligation to inform the Commonwealth if, at any time during the term of the Grant, it becomes delinquent in the payment of taxes, or other Commonwealth obligations, or if it or any of its subGrantees are suspended or debarred by the Commonwealth, the federal government, or any other state or governmental entity. Such notification shall be made within 15 days of the date of suspension or debarment.

d. The failure of the Grantee to notify the Commonwealth of its suspension or debarment by the Commonwealth, any other state, or the federal government shall constitute an event of default of the Grant with the Commonwealth.

e. The Grantee agrees to reimburse the Commonwealth for the reasonable costs of investigation incurred by the Office of State Inspector General for Investigations of the Grantee's compliance with the terms of this or any other agreement between the Grantee and the Commonwealth, which results in the suspension or debarment of the Grantee. Such costs shall include, but shall not be limited to, salaries of investigators, including overtime; travel and lodging expenses; and expert witness and documentary fees. The Grantee shall not be responsible for investigative costs for investigations that do not result in the Grantee's suspension or debarment.

f. The Grantee may obtain a current list of suspended and debarred Commonwealth Grantees by either searching the internet at **htfp://www.dgs.state.pa.us** or contacting the:

Department of General Services
Office of Chief Counsel
603 North Office Building
Harrisburg, PA 17125
Telephone No. (717) 783-6472
FAX No. (717) 787-9138

24. AMERICANS WITH DISABILITIES ACT

a. Pursuant to federal regulations promulgated under the authority of The Americans With Disabilities Act, 28 C.F.R. § 35.101 et seq., the Grantee understands and agrees that it shall not cause any individual with a disability to be excluded from participation in this Grant or from activities provided for under this Grant on the basis of the disability. As a condition of accepting this Grant, the Grantee agrees to comply with the "General Prohibitions Against Discrimination," 28 C.F.R. § 35.130, and all other regulations promulgated under Title II of The Americans With Disabilities Act which are applicable to all benefits, services, programs, and activities provided by the Commonwealth of Pennsylvania through Grants with outside Grantees.

b. The Grantee shall be responsible for and agrees to indemnify and hold harmless the Commonwealth of Pennsylvania from all losses, damages, expenses, claims, demands, suits, and actions brought by any party against the Commonwealth of Pennsylvania as a result of the Grantee's failure to comply with the provisions of subparagraph a above.

25. HAZARDOUS SUBSTANCES

The Grantee shall provide information to the Commonwealth about the identity and hazards of hazardous substances supplied or used by the Grantee in the performance of the Grant. The Grantee must comply with Act 159 of October 5, 1984, known as the "Worker and Community Right to Know Act" (the "Act") and the regulations promulgated pursuant thereto at 4 Pa. Code Section 301.1 et seq.

a. Labeling. The Grantee shall insure that each individual product (as well as the carton, container or package in which the product is shipped) of any of the following substances (as defined by the Act and the regulations) supplied by the Grantee is clearly labeled, tagged or marked with the information listed in Paragraph (1) through (4):

1) Hazardous substances:

a) The chemical name or common name,

b) A hazard warning, and

c) The name, address, and telephone number of the manufacturer.

2) Hazardous mixtures:

a) The common name, but if none exists, then the trade name,

b) The chemical or common name of special hazardous substances comprising .01% or more of the mixture,

c) The chemical or common name of hazardous substances consisting 1.0% or more of the mixture,

d) A hazard warning, and

e) The name, address, and telephone number of the manufacturer.

3) Single chemicals:

a) The chemical name or the common name,A hazard warning, if appropriate, and

b) The name, address, and telephone number of the manufacturer.

4) Chemical Mixtures:

a) The common name, but if none exists, then the trade name,

b) A hazard warning, if appropriate,

c) The name, address, and telephone number of the manufacturer, and

d) The chemical name or common name of either the top five substances by volume or those substances consisting of 5.0% or more of the mixture.

A common name or trade name may be used only if the use of the name more easily or readily identifies the true nature of the hazardous substance, hazardous mixture, single chemical, or mixture involved.

Container labels shall provide a warning as to the specific nature of the hazard arising from the substance in the container.

The hazard warning shall be given in conformity with one of the nationally recognized and accepted systems of providing warnings, and hazard warnings shall be consistent with one or more of the recognized systems throughout the workplace. Examples are:

- NFPA 704, Identification of the Fire Hazards of Materials.
- National Paint and Coatings Association: Hazardous Materials Identification System.
- American Society for Testing and Materials, Safety Alert Pictorial Chart.
- American National Standard Institute, Inc., for the Precautionary Labeling of Hazardous Industrial Chemicals.

Labels must be legible and prominently affixed to and displayed on the product and the carton, container, or package so that employees can easily identify the substance or mixture present therein.

b. Material Safety Data Sheet. The Grantee shall provide Material Safety Data Sheets (MSDS) with the information required by the Act and the regulations for each hazardous substance or hazardous mixture. The Commonwealth must be provided an appropriate MSDS with the initial shipment and with the first shipment after an MSDS is updated or product changed. For any other chemical, the Grantee shall provide an appropriate MSDS, if the manufacturer, importer, or supplier produces or possesses the MSDS. The Grantee shall also notify the Commonwealth when a substance or mixture is subject to the provisions of the Act. Material Safety Data Sheets may be attached to the carton, container, or package mailed to the Commonwealth at the time of shipment.

26. COVENANT AGAINST CONTINGENT FEES

The Grantee warrants that no person or selling agency has been employed or retained to solicit or secure the Grant upon an agreement or understanding for a commission, percentage, brokerage, or contingent fee, except bona fide employees or bona fide established commercial or selling agencies maintained by the Grantee for the purpose of securing business. For breach or violation of this warranty, the Commonwealth shall have the right to terminate the Grant without liability or in its discretion to

deduct from the Grant price or consideration, or otherwise recover the full amount of such commission, percentage, brokerage, or contingent fee.

27. APPLICABLE LAW

This Grant shall be governed by and interpreted and enforced in accordance with the laws of the Commonwealth of Pennsylvania (without regard to any conflict of laws provisions) and the decisions of the Pennsylvania courts. The Grantee consents to the jurisdiction of any court of the Commonwealth of Pennsylvania and any federal courts in Pennsylvania, waiving any claim or defense that such forum is not convenient or proper. The Grantee agrees that any such court shall have in personam jurisdiction over it, and consents to service of process in any manner authorized by Pennsylvania law.

28. INTEGRATION

The Grant, including all referenced documents, constitutes the entire agreement between the parties. No agent, representative, employee or officer of either the Commonwealth or the Grantee has authority to make, or has made, any statement, agreement or representation, oral or written, in connection with the Grant, which in any way can be deemed to modify, add to or detract from, or otherwise change or alter its terms and conditions. No negotiations between the parties, nor any custom or usage, shall be permitted to modify or contradict any of the terms and conditions of the Grant. No modifications, alterations, changes, or waiver to the Grant or any of its terms shall be valid or binding unless accomplished by a written amendment signed by both parties. All such amendments will be made using the appropriate Commonwealth form.

29. CHANGE ORDERS

The Commonwealth reserves the right to issue change orders at any time during the term of the Grant or any renewals or extensions thereof: 1) to increase or decrease the quantities resulting from variations between any

estimated quantities in the Grant and actual quantities; 2) to make changes to the services within the scope of the Grant; 3) to notify the Grantee that the Commonwealth is exercising any Grant renewal or extension option; or 4) to modify the time of performance that does not alter the scope of the Grant to extend the completion date beyond the Expiration Date of the Grant or any renewals or extensions thereof. Any such change order shall be in writing signed by the Granting Officer. The change order shall be effective as of the date appearing on the change order, unless the change order specifies a later effective date. Such increases, decreases, changes, or modifications will not invalidate the Grant, nor, if performance security is being furnished in conjunction with the Grant, release the security obligation. The Grantee agrees to provide the service in accordance with the change order. Any dispute by the Grantee in regard to the performance required under any change order shall be handled through Paragraph 19, "Grant Controversies".

For purposes of this Grant, "change order" is defined as a written order signed by the Granting Officer directing the Grantee to make changes authorized under this clause.

30. RIGHT TO KNOW LAW 8-K-1580

a. Grantee or Subgrantee understands that this Grant Agreement and records related to or arising out of the Grant Agreement are subject to requests made pursuant to the Pennsylvania Right-to-Know Law, 65 P.S. §§ 67.101-3104, ("RTKL"). For the purpose of these provisions, the term "the Commonwealth" shall refer to the granting Commonwealth agency.

b. If the Commonwealth needs the Grantee's or Subgrantee's assistance in any matter arising out of the RTKL related to this Grant Agreement, it shall notify the Grantee or Subgrantee using the legal contact information provided in the Grant Agreement. The Grantee or Subgrantee, at any time, may designate a different contact for such purpose upon reasonable prior written notice to the Commonwealth.

c. Upon written notification from the Commonwealth that it requires Grantee's or Subgrantee's assistance in responding to a request under the RTKL for information related to this Grant Agreement that may be in Grantee's or Subgrantee's possession, constituting, or alleged to constitute, a public record in accordance with the RTKL ("Requested Information"), Grantee or Subgrantee shall:

    1. Provide the Commonwealth, within ten (10) calendar days after receipt of written notification, access to, and copies of, any document or information in Grantee's or Subgrantee's possession arising out of this Grant Agreement that the Commonwealth reasonably believes is Requested Information and may be a public record under the RTKL; and

    2. Provide such other assistance as the Commonwealth may reasonably request, in order to comply with the RTKL with respect to this Grant Agreement.

d. If Grantee or Subgrantee considers the Requested Information to include a request for a Trade Secret or Confidential Proprietary Information, as those terms are defined by the RTKL, or other information that Grantee or Subgrantee considers exempt from production under the RTKL, Grantee or Subgrantee must notify the Commonwealth and provide, within seven (7) calendar days of receiving the written notification, a written statement signed by a representative of Grantee or Subgrantee explaining why the requested material is exempt from public disclosure under the RTKL.

e. The Commonwealth will rely upon the written statement from Grantee or Subgrantee in denying a RTKL request for the Requested Information unless the Commonwealth determines that the Requested Information is clearly not protected from disclosure under the RTKL. Should the Commonwealth determine that the Requested Information is clearly not exempt from disclosure, Grantee or Subgrantee shall provide the Requested Information within five (5) business days of receipt of written notification of the Commonwealth's determination.

f. If Grantee or Subgrantee fails to provide the Requested Information within the time period required by these provisions, Grantee or Subgrantee shall indemnify and hold the Commonwealth harmless for any damages, penalties, costs, detriment or harm that the Commonwealth may incur as a result of Grantee's or Subgrantee's failure, including any statutory damages assessed against the Commonwealth.

g. The Commonwealth will reimburse Grantee or Subgrantee for any costs associated with complying with these provisions only to the extent allowed under the fee schedule established by the office of Open Records or as otherwise provided by the RTKL if the fee schedule is inapplicable.

h. Grantee or Subgrantee may file a legal challenge to any Commonwealth decision to release a record to the public with the Office of Open Records, or in the Pennsylvania Courts, however, Grantee or Subgrantee shall indemnify the Commonwealth for any legal expenses incurred by the Commonwealth as a result of such a challenge and shall hold the Commonwealth harmless for any damages, penalties, costs, detriment or harm that the Commonwealth may incur as a result of Grantee's or Subgrantee's failure, including any statutory damages assessed against the Commonwealth, regardless of the outcome of such legal challenge. As between the parties, Grantee or Subgrantee agrees to waive all rights or remedies that may be available to it as a result of the Commonwealth's disclosure of Requested Information pursuant to the RTKL.

i. The Grantee's or Subgrantee's duties relating to the RTKL are continuing duties that survive the expiration of this Grant Agreement and shall continue as long as the Grantee or Subgrantee has Requested Information in its possession.

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 recipient of the services to be provided under this contract for any purpose not connected with the parties' contract responsibilities except with written consent of such recipient, recipient's attorney, or recipient's parent or legal guardian.

C. INFORMATION

During the period of this contract, all information obtained by the Contractor through work on the project will be made available to the Department immediately upon demand. If requested, the Contractor shall deliver to the Department background material prepared or obtained by the Contractor incident to the performance of this agreement. Background material is defined as original work, papers, notes and drafts prepared by the Contractor to support the data and conclusions in final reports, and includes completed questionnaires, materials in electronic data processing form, computer programs, other printed materials, pamphlets, maps, drawings and all data directly related to the services being rendered.

D. CERTIFICATION AND LICENSING

Contractor agrees to obtain all licenses, certifications and permits from Federal, State and Local authorities permitting it to carry on its activities under this contract.

E. PROGRAM SERVICES

Definitions of service, eligibility of recipients of service and other limitations in this contract are subject to modification by amendments to Federal, State and Local laws, regulations and program requirements without further notice to the Contractor hereunder.

F. CHILD PROTECTIVE SERVICE LAWS

In the event that the contract calls for services to minors, the contractor shall comply with the provisions of the Child Protective Services Law (Act of November 26, 1975, P.L. 438, No. 124; 23 P.S. SS 6301-6384, as amended by Act of July 1, 1985, P.L. 124, No. 33) and all regulations promulgated thereunder (55Pa. Code, chapter 3490).

G. PRO-CHILDREN ACT OF 1994

The Contractor agrees to comply with the requirements of the Pro-Children Act of 1994; Public Law 103-277, Part C-Environment Tobacco Smoke (also known as the Pro-Children Act of 1994) requires that smoking not be permitted in any portion of any indoor facility owned or leased or contracted by an entity and used routinely or regularly for the provision of health care services, day care and education to children under the age of 18, if the services are funded by Federal programs whether directly or through State and Local governments. Federal programs include grants, cooperative agreements, loans or loan guarantees and contracts. The law does not apply to children's services provided in private residences, facilities funded solely by Medicare or Medicaid funds, and portions of facilities used for inpatient drug and alcohol treatment.

H. MEDICARE/MEDICAID REIMBURSEMENT

1. To the extent that services are furnished by contractors, subcontractors, or organizations related to the contractor/subcontractor and such services may in whole or in part be claimed by the

Commonwealth for Medicare/Medicaid reimbursements, contractor/subcontractor agrees to comply with 42 C.F.R.,Part 420, including:

a. Preservation of books, documents and records until the expiration of four (4) years after the services are furnished under the contract.

b. Full and free access to (i) the Commonwealth, (ii) the U.S. Comptroller General, (iii) the U.S. Department of Health and Human Services, and their authorized representatives.

2. Your signature on the proposal certifies under penalty of law that you have not been suspended/ terminated from the Medicare/Medicaid Program and will notify the contracting DHS Facility or DHS Program Office immediately should a suspension/termination occur during the contract period.

I. **TRAVEL AND PER DIEM EXPENSES**

Contractor shall not be allowed or paid travel or per diem expenses except as provided for in Contractor's Budget and included in the contract amount. Any reimbursement to the Contractor for travel, lodging or meals under this contract shall be at or below state rates as provided in Management Directive 230.10, Commonwealth Travel Policy, as may be amended, unless the Contractor has higher rates which have been established by its offices/officials, and published prior to entering into this contract. Higher rates must be supported by a copy of the minutes or other official documents, and submitted to the Department. Documentation in support of travel and per diem expenses will be the same as required of state employees.

J. **INSURANCE**

1. The contractor shall accept full responsibility for the payment of premiums for Workers' Compensation, Unemployment Compensation, Social Security, and all income tax deductions required by law for its employees who are performing services under this contract. As required by law, an independent contractor is responsible for Malpractice Insurance for health care personnel. Contractor shall provide insurance Policy Number and Provider'' Name, or a copy of the policy with all renewals for the entire contract period.

2. The contractor shall, at its expense, procure and maintain during the term of the contract, the following types of insurance, issued by companies acceptable to the Department and authorized to conduct such business under the laws of the Commonwealth of Pennsylvania:

   a. Worker's Compensation Insurance for all of the Contractor's employees and those of any subcontractor, engaged in work at the site of the project as required by law.

   b. Public liability and property damage insurance to protect the Commonwealth, the Contractor, and any and all subcontractors from claim for damages for personal injury (including bodily injury), sickness or disease, accidental death and damage to property, including loss of use resulting from any property damage, which may arise from the activities performed under this contract or the failure to perform under this contract whether such performance or nonperformance be by the contractor, by any subcontractor, or by anyone directly or indirectly employed by either. The limits of such insurance shall be in an amount not less than $500,000 each person and $2,000,000 each occurrence, personal injury and property damage combined. Such policies shall be occurrence rather than claims-made policies and shall name the Commonwealth of Pennsylvania as an additional insured. The insurance shall not contain any endorsements or any other form designated to limit or restrict any action by the Commonwealth, as an additional insured, against the insurance coverage in regard to work performed for the Commonwealth.

Prior to commencement of the work under the contract and during the term of the contract, the Contractor shall provide the Department with current certificates of insurance. These certificates shall contain a provision that the coverages afforded under the policies will not be cancelled or changed until at least thirty (30) days' written notice has been given to the Department.

K. PROPERTY AND SUPPLIES

1. Contractor agrees to obtain all supplies and equipment for use in the performance of this contract at the lowest practicable cost and to purchase by means of competitive bidding whenever required by law.

2. Title to all property furnished in-kind by the Department shall remain with the Department.

3. Contractor has title to all personal property acquired by the contractor, including purchase by lease/purchase agreement, for which the contractor is to be reimbursed under this contract. Upon cancellation or termination of this contract, disposition of such purchased personal property which has a remaining useful life shall be made in accordance with the following provisions.

    a. The contractor and the Department may agree to transfer any item of such purchased property to another contractor designated by the Department. Cost of transportation shall be born by the contractor receiving the property and will be reimbursed by the Department. Title to all transferred property shall vest in the designated contractor. The Department will reimburse the Contractor for its share, if any, of the value of the remaining life of the property in the same manner as provided under subclause b of this paragraph.

    b. If the contractor wishes to retain any items of such purchased property, depreciation tables shall be used to ascertain the value of the remaining useful life of the property. The contractor shall reimburse the Department in the amount determined from the tables.

    c. When authorized by the Department in writing, the contractor may sell the property and reimburse the Department for its share. The Department reserves the right to fix the minimum sale price it will accept.

4. All property furnished by the Department or personal property acquired by the contractor, including purchase by lease-purchase contract, for which the contractor is to be reimbursed under this contract shall be deemed "Department Property" for the purposes of subsection 5, 6 and 7 of this section.

5. Contractor shall maintain and administer in accordance with sound business practice a program for the maintenance, repair, protection, preservation and insurance of Department Property so as to assure its full availability and usefulness.

6. Department property shall, unless otherwise approved in writing by the Department, be used only for the performance of this contract.

7. In the event that the contractor is indemnified, reimbursed or otherwise compensated for any loss, destruction or damage to Department Property, it shall use the proceeds to replace, repair or renovate the property involved, or shall credit such proceeds against the cost of the work covered by the contract, or shall reimburse the Department, at the Department's direction.

L. <u>DISASTERS</u>

If, during the terms of this contract, the Commonwealth's premises are so damaged by flood, fire or other Acts of God as to render them unfit for use; then the Agency shall be under no liability or obligation to the contractor hereunder during the period of time there is no need for the services provided by the contractor except to render compensation which the contractor was entitled to under this agreement prior to such damage.

M. <u>SUSPENSION OR DEBARMENT</u>

In the event of suspension or debarment, 4 Pa Code Chapter 60.1 through 60.7, as it may be amended, shall apply.

N. <u>COVENANT AGAINST CONTINGENT FEES</u>

The contractor warrants that no person or selling agency has been employed or retained to solicit or secure this contract upon an agreement or understanding for a commission, percentage, brokerage or contingent fee (excepting bona fide employees or bona fide established commercial or selling agencies maintained by the contractor for the purpose of securing business). For breach or violation of this warranty, the Department shall have the right to annul this contract without liability or, in its discretion, to deduct from

the consideration otherwise due under the contract, or otherwise recover, the full amount of such commission, percentage, and brokerage or contingent fee.

O. CONTRACTOR'S CONFLICT OF INTEREST

The contractor hereby assures that it presently has not interest and will not acquired any interest, direct or indirect, which would conflict in any manner or degree with the performance of its services hereunder. The contractor further assures that in the performance of this contract, it will not knowingly employ any person having such interest. Contractor hereby certifies that no member of the Board of the contractor or any of its officers or directors has such an adverse interest.

P. INTEREST OF THE COMMONWEALTH AND OTHERS

No officer, member or employee of the Commonwealth and no member of its General Assembly, who exercises any functions or responsibilities under this contract, shall participate in any decision relating to this contract which affects his personal interest or the interest of any corporation, partnership or association in which he is, directly or indirectly, interested; nor shall any such officer, member or employee of the Commonwealth or member of its General Assembly have interest, direct or indirect, in this contract or the proceeds thereof.

Q. CONTRACTOR RESPONSIBILITY TO EMPLOY WELFARE CLIENTS

(Applicable to contracts $25,000 or more)

1. The contractor, within 10 days of receiving the notice to proceed, must contact the Department of Public Welfare's Contractor Partnership Program (CPP) to present, for review and approval, the contractor's plan for recruiting and hiring recipients currently receiving cash assistance. If the contract was not procured via Request for Proposal (RFP); such plan must be submitted on Form PA-778. The plan must identify a specified number (not percentage) of hires to be made under this contract. If no employment opportunities arise as a result of this contract, the contractor must identify other employment opportunities available within the organization that are not a result of this contract. The entire completed plan (Form PA-778) must be submitted to the Bureau of Employment and Training Programs (BETP)**:** Attention CPP Division. (Note: Do not keep the pink copy of Form PA-778). The approved plan will become a part of the contract.

2. The contractor's CPP approved recruiting and hiring plan shall be maintained throughout the term of the contract and through any renewal or extension of the contract. Any proposed change must be submitted to the CPP Division which will make a recommendation to the Contracting Officer regarding course of action. If a contract is assigned to another contractor, the new contractor must maintain the CPP recruiting and hiring plan of the original contract.

3. The contractor, within 10 days of receiving the notice to proceed, must register in the Commonwealth Workforce Development System (CWDS). In order to register the selected contractor must provide business, location and contact details by creating an Employer Business Folder for review and approval, within CWDS at HTTPS://WWW.CWDS.State.PA.US . Upon CPP review and approval of Form PA-778 and the Employer Business Folder in CWDS, the Contractor will receive written notice (via the pink Contractor's copy of Form PA-778) that the plan has been approved.

4. Hiring under the approved plan will be monitored and verified by Quarterly Employment Reports (Form PA-1540); submitted by the contractor to the Central Office of Employment and Training – CPP Division. A copy of the submitted Form PA-1540 must also be submitted (by the contractor) to the DHS Contract Monitor (i.e. Contract Officer). The reports must be submitted on the DHS Form PA-1540. The form may not be revised, altered, or re-created.

5. If the contractor is non-compliant, CPP Division will contact the Contract Monitor to request corrective action. The Department may cancel this contract upon thirty (30) days written notice in the event of the contractor's failure to implement or abide by the approved plan.

R. TUBERCULOSIS CONTROL

As recommended by the Centers for Disease Control and the Occupational Safety and Health Administration, effective August 9, 1996, in all State Mental Health and Mental Retardation Facilities, all

full-time and part-time employees (temporary and permanent), including contract service providers, having direct patient contact or providing service in patient care areas, are to be tested serially with PPD by Mantoux skin tests. PPD testing will be provided free of charge from the state MH/MR facility. If the contract service provider has written proof of a PPD by Mantoux method within the last six months, the MH/MR facility will accept this documentation in lieu of administration of a repeat test. In addition, documented results of a PPD by Mantoux method will be accepted by the MH/MR facility. In the event that a contractor is unwilling to submit to the test due to previous positive reading, allergy to PPD material or refusal, the risk assessment questionnaire must be completed. If a contractor refuses to be tested in accordance with this new policy, the facility will not be able to contract with this provider and will need to procure the services from another source.

S. ACT 13 APPLICATION TO CONTRACTOR

Contractor shall be required to submit with their bid information obtained within the preceding one-year period for any personnel who will have or may have direct contact with residents from the facility or unsupervised access to their personal living quarters in accordance with the following:

1. Pursuant to 18 Pa.C.S. Ch. 91(relating to criminal history record information) a report of criminal history information from the Pennsylvania State Police or a statement from the State Police that their central repository contains no such information relating to that person. The criminal history record information shall be limited to that which is disseminated pursuant to 18 Pa.C.S. 9121(b)(2) (relating to general regulations).

2. Where the applicant is not, and for the two years immediately preceding the date of application has not been a resident of this Commonwealth, the Department shall require the applicant to submit with the application a report of Federal criminal history record information pursuant to the Federal Bureau of Investigation's under Department of State, Justice, and Commerce, the Judiciary, and Related Agencies Appropriation Act, 1973 (Public Law 92-544, 86 Stat. 1109). For the purpose of this paragraph, the applicant shall submit a full set of fingerprints to the State Police, which shall forward them to the Federal Bureau of Investigation for a national criminal history check. The information obtained from the criminal record check shall be used by the Department to determine the applicant's eligibility. The Department shall insure confidentially of the information.

3. The Pennsylvania State Police may charge the applicant a fee of not more than $10 to conduct the criminal record check required under subsection 1. The State Police may charge a fee of not more than the established charge by the Federal Bureau of Investigation for the criminal history record check required under subsection 2.

The Contractor shall apply for clearance using the State Police Background Check (SP4164) at their own expense. The forms are available from any State Police Substation. When the State Police Criminal History Background Report is received, it must be forwarded to the Department. State Police Criminal History Background Reports not received within sixty (60) days may result in cancellation of the contract.

T. LOBBYING CERTIFICATION AND DISCLOUSRE

(applicable to contracts $100,000 or more)

Commonwealth agencies will not contract with outside firms or individuals to perform lobbying services, regardless of the source of funds. With respect to an award of a federal contract, grant, or cooperative agreement exceeding $100,000 or an award of a federal loan or a commitment providing for the United States to insure or guarantee a loan exceeding $150,000 all recipients must certify that they will not use federal funds for lobbying and must disclose the use of non-federal funds for lobbying by filing required documentation. The contractor will be required to complete and return a "Lobbying Certification Form" and a "Disclosure of Lobbying Activities form" with their signed contract, which forms will be made attachments to the contract.

U. AUDIT CLAUSE

(applicable to contracts $100,000 or more)

This contract is subject to audit in accordance with the Audit Clause attached hereto and incorporated herein.

EXHIBIT E(1)

OTHER FEDERAL REQUIREMENTS

1. The contract shall include notice of grantor agency requirements and regulations pertaining to reporting and patient rights under any contract involving research, developmental, experimental or demonstration work with respect to any discovery or invention which arises or is developed in the course of or under such contract, and of grantor agency requirements and regulations pertaining to copyrights and rights in data.

2. Contracts, subcontracts, and subgrants of amounts in excess of $100,000 shall contain a provision, which requires compliance with all applicable standards, orders or requirements issued under section 306 of the Clean Air Act (42 USC 1857 (h)), section 508 of the Clean Water Act (33 USC 1368), Executive Order 1178, and Environmental Protection Agency regulations (40 CFR part 15).

3. Contracts shall recognize mandatory standards and policies relating to energy efficiency, which are contained in the State energy conservation plan issued in compliance with the Energy Policy and Conservation Act (Pub. L. 94-165).

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

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

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

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

Specific Federal Regulatory Cites for Managed Care Agreements

Citation	Requirement
1903(m)(4)(B)	The PH-MCO will make reports of any transactions between the PH-MCO and parties in interest that are provided to the State or other agencies pursuant to Section 1903(m)(4)(A) of the Act available to PH-MCO enrollees upon reasonable request.

Citation	Requirement
42 CFR 438.6(f)(2)(ii)	The PH-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 PH-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 PH-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 PH-MCO must demonstrate that there are sufficient I/T/U providers in the network to ensure timely access to services available under the Agreement for Indian enrollees who are eligible to receive services from such providers.
ARRA 5006(d) SMD 10-001	The PH-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 enrollees who are eligible to receive services from such providers either at a rate negotiated between the PH-MCO and the I/T/U provider, or if there is no negotiated rate, at a rate no less than the level and amount of payment that would be made if the provider were not an I/T/U provider.

Citation	Requirement
42 CFR 438.6(f)(2)(i) 42 CFR 434.6(a)(12)(i) 42 CFR 447.26(b)	The PH-MCO is prohibited from making payment to a provider for provider-preventable conditions that meet the following criteria: (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.
42 CFR 438.6(f)(2)(ii) 42 CFR 434.6(a)(12)(ii)	The PH-MCO must require all providers to report provider-preventable conditions associated with claims for payments or enrollee treatments for which payment would otherwise be made.
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	Any cost sharing imposed by the PH-MCO on enrollees is in accordance with Medicaid fee for service requirements at 42 CFR 447.50 through 42 CFR 447.57
1903(i) final sentence 1903(i)(2)(A)	The PH-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).

Citation	Requirement
1903(i) final sentence 1903(i)(2)(B)	The PH-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).
1903(i) final sentence 1903(i)(2)(C)	The PH-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.
1903(i) final sentence 1903(i)(16)	The PH-MCO shall not make payment with respect to any amount expended for which funds may not be used under the Assisted Suicide Funding Restriction Act of 1997.
1903(i) final sentence 1903(i)(17)	The PH-MCO shall not make payment with respect to any amount expended for roads, bridges, stadiums, or any other item or service not covered under the Medicaid State Plan.

Citation	Requirement
1903(i) final sentence 1903(i)(18)	The PH-MCO shall not make payment with respect to any amount expended for home health care services provided by any agency or organization, unless the agency or organization provides the State with a surety bond as specified in Section 1861(o)(7) of the Act.
1903(t) 42 CFR 495.332 (d)(2) 42 CFR 438.6(c)(5)(iii) 42 CFR 495.332 (d)(2) 42 CFR 438.6(c)(5)(iii) 42 CFR 495.304 42 CFR 495.310(c) 42 CFR 447.253(e) 42 CFR 495.370(a) SMD# 09-006, Attachment A 1903(t)(6)(A)(ii)	If the PH-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).
1903(t)(6)(A)(ii) 495.310(k) 495.332(c)(9)	If the PH-MCO is required by the State to disburse EHR incentive payments to eligible professionals, the agreement between the PH-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 PH-MCO must disclose the following information to the state for any person or corporation with ownership or control interest in the PH-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 PH-MCO or a PH-MCO subcontractor is related to another person with ownership or control interest in the PH-MCO as a spouse, parent, child, or sibling. • 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 PH-MCO.

EXHIBIT F

FAMILY PLANNING SERVICES PROCEDURES

PROCEDURES WHICH MAY BE INCLUDED WITH A FAMILY PLANNING CLINIC COMPREHENSIVE VISIT, A FAMILY PLANNING CLINIC PROBLEM VISIT OR A FAMILY PLANNING CLINIC ROUTINE REVISIT

- Insertion, implantable contraceptive capsules
- Implantation of contraceptives, including device (e.g. Norplant) (once every five years) (females only)
- Removal, Implantable contraceptive capsules
- Removal with reinsertion, Implantable contraceptive capsules (e.g., Norplant) (once per five years) (females only)
- Destruction of vaginal lesion(s); simple, any method (females only)
- Biopsy of vaginal mucosa; simple (separate procedure) (females only)
- Biopsy of vaginal mucosa; extensive, requiring suture (including cysts) (females only)
- Colposcopy (vaginoscopy); separate procedure (females only)[A]
- Colposcopy (vaginoscopy); with biopsy(s) of the cervix and/or endocervical curettage[A]
- Colposcopy (vaginoscopy); with loop electrosurgical excision(s) of the cervix (LEEP) (females only)[B]
- Intensive colposcopic examination with biopsy and or excision of lesion(s) (females only)[B]
- Biopsy, single or multiple or local excision of lesion, with or without fulguration (separate procedure) (females only)
- Cauterization of cervix; electro or thermal (females only)
- Cauterization of cervix; cryocaury, initial or repeat (females only)
- Cauterization of cervix; laser ablation (females only)

- Endometrial and/or endocervical sampling (biopsy), without cervical dilation, any method (separate procedure) (females only)
- Alpha-fetoprotein; serum (females only)
- Nuclear molecular diagnostics; nucleic acid probe, each
- Nuclear molecular diagnosis; nucleic acid probe, each
- Nuclear molecular diagnostics; nucleic acid probe, with amplification; e.g., polymerase chain reaction (PCR), each
- Fluorescent antibody; screen, each antibody
- Immunoassay for infectious agent antibody; quantitative, not elsewhere specified
- Antibody; HIV-1
- Antibody; HIV-2
- Treponema Pallidum, confirmatory test (e.g., FTA-abs)
- Culture, chlamydia
- Cytopathology, any other source; preparation, screening and interpretation
- Progestasert I.U.D. (females only)
- Depo-Provera injection (once per 60 days) (females only)
- ParaGuard I.U.D. (females only)
- Hemoglobin electrophoresis (e.g., A2, S, C)
- Microbial Identification, Nucleic Acid Probes, each probe used
- Microbial Identification, Nucleic Acid probes, each probe used; with amplification (PCR)

[A] Medical record must show a Class II or higher pathology.

[B] Medical record must show a documentation of a history of previous uterine cancer surgery or in-utero DES (diethylstilbestrol) exposure.

PROCEDURES WHICH MAY BE INCLUDED WITH A FAMILY PLANNING CLINIC PROBLEM VISIT

- Gonadotropin, chorionic, (hCG); quantitative
- Gonadotropin, chorionic, (hCG); qualitative
- Syphilis test; qualitative (e.g., VDRL, RPR, ART)
- Culture, bacterial, definitive; any other source
- Culture, bacterial, any source; anaerobic (isolation)
- Culture, bacterial, any source; definitive identification, each anaerobic organism, including gas chromatography
- Culture, bacterial, urine; quantitative, colony 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

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EXHIBIT H

PRIOR AUTHORIZATION GUIDELINES FOR PARTICIPATING MANAGED CARE ORGANIZATIONS IN THE HEALTHCHOICES PROGRAM

A. GENERAL REQUIREMENT

The HealthChoices Physical Health Managed Care Organizations (PH-MCOs) must submit to the Department all written policies and procedures for the Prior Authorization of services. The PH-MCO may require Prior Authorization for any services that require Prior Authorization in the Medical Assistance Fee-for-Service (FFS) Program. The PH-MCO must notify the Department of the FFS authorized services they will continue to prior authorize and the basis for determining if the service is Medically Necessary. The PH-MCO must receive advance written approval from the Department to require the Prior Authorization of any services not currently required to be Prior Authorized under the FFS Program. For each service to be Prior Authorized, the PH-MCO must submit for the Department's review and approval the written policies and procedures in accordance with the guidelines described below. The policies and procedures must:

- Be submitted in writing, for all new and revised criteria, prior to implementation;
- Be approved by the Department in writing prior to implementation;
- Adhere to specifications of the HealthChoices RFP, HealthChoices Agreement, federal regulations, and applicable policy in Medical Assistance General Regulations, Chapter 1101 and DHS regulations;
- Ensure that physical health care is Medically Necessary and provided in an appropriate, effective, timely, and cost efficient manner;
- Adhere to the applicable requirements of Centers for Medicare and Medicaid Services (CMS) Guidelines for Internal Quality Assurance Programs of Health Maintenance Organizations (HMOs), Health Insuring Organizations (HIOs), and Prepaid Health Plans (PHPs), contracting with Medicaid/Quality Assurance Reform Initiative (QARI);
- Include an expedited review process to address those situations when an item or service must be provided on an urgent basis.

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

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

The DHS Prior Authorization Review Panel has the sole responsibility to review and approve all prior authorization proposals from the PH-MCOs.

B. GUIDELINES FOR REVIEW

1. Basic Requirements:

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

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

2. Medically Necessary Requirements:

   a. The PH-MCO must describe the process to validate medical necessity for:

      - covered care and services;
      - procedures and level of care;
      - medical or therapeutic items.

   b. The PH-MCO must identify the source of the criteria used to review the request for Prior Authorization of services. The criteria must be consistent with the HealthChoices contract definition for a service or benefit that is Medically Necessary. All criteria must be submitted to the Department for evaluation and approval under URCAP prior to implementation.

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

      - Purchased and licensed, the PH-MCO must identify the vendor;
      - Developed/recommended/endorsed by a national or state health care provider association or society, the PH-MCO must identify the association or society;
      - Based on national best practice guidelines, the PH-MCO must identify the source of those guidelines;
      - Based on the medical training, qualifications, and experience of the PH-MCO's Medical Director or other qualified and trained practitioners, the PH-

MCO must identify the individuals who will determine if the service or benefit is Medically Necessary.

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

e. The PH-MCO must identify the qualification of staff that will determine if the service is Medically Necessary. Health Care Providers, qualified and trained in accordance with the CMS Guidelines, the RFP, the HealthChoices Agreement, and applicable legal settlements must make the determination of Medically Necessary services.

   For children under the age of twenty-one (21), requests for service will not be denied for lack of Medical Necessity unless a physician or other health care professional with appropriate clinical expertise in treating the Member's condition or disease determines:

   - That the prescriber did not make a good faith effort to submit a complete request, or

   - That the service or item is not Medically Necessary, <u>after</u> making a reasonable effort to consult with the prescriber. The reasonable effort to consult must be documented in writing.

3. <u>Administrative Requirements</u>

   a. The PH-MCO's written policies and procedures must identify the time frames for review and decisions and the PH-MCO must demonstrate that the time frames are consistent with the following required maximum time frames:

      - <u>Immediate</u>: Inpatient Place of Service Review for emergency and urgent admissions.

      - <u>24 hours</u>: All drugs; and items or services which must be provided on an urgent basis.

      - <u>48 hours:</u> (following receipt of required documentation): Home Health Services.

      - <u>21 days:</u> All other services.

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

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

4. Notification, Grievance, and DHS Fair Hearing Requirements

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

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

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

EXHIBIT J

EPSDT GUIDELINES

The PH-MCO must adhere to specific Department regulations at 55 PA Code Chapters 3700 and 3800 as they relate to EPSDT examinations for individuals under the age of 21 and entering substitute care or a child residential facility placement. These examinations must be performed within the timeframes established by the regulations. The scope of PH-MCO EPSDT requirements that address screening, diagnosis and treatment, tracking, follow-up and outreach, and interagency teams for children are provided below.

The PH-MCO must have written policies and procedures for enrolling Members into an EPSDT program and for providing all Medically Necessary Title XIX EPSDT services to all eligible individuals under the age of twenty-one (21) regardless of whether the service is included on the Medicaid State Plan. The PH-MCO must assist individuals in gaining access to necessary medical, social, education, and other services in accordance with Medical Assistance Bulletin #1239-94-01 "Medical Assistance Case Management Services for Recipients Under the Age of 21.

1. Screening

The PH-MCO must ensure that periodic EPSDT screens are conducted by a process, including data collection format, approved by the Department, on all Members under age 21 to identify health and developmental problems. These screens must be in accordance with the most current periodicity schedule developed by the Department and recommended pediatric immunization schedules, both of which are based on guidelines issued by the American Academy of Pediatrics (AAP) and the Centers for Disease Control and Prevention (CDC).

2. Diagnoses and Treatment

If a suspected problem is detected by a screening examination, the child must be evaluated as necessary for further diagnosis. This diagnosis is used to determine treatment needs. Following an EPSDT screen, if the screening Provider suspects developmental delay and the child is not receiving services at the time of screening, s/he is required to refer the child (not over five years of age) through CONNECT, 1-800-692-7288, for referral for local Early Intervention Program services. The PH-MCO is responsible for developing a system that tracks treatment needs as they are identified and ensures that appropriate follow-up is pursued and reflected in the medical record (see Section 3, Tracking, for all requirements).

OBRA '89 entitles individuals under the age of 21 to receive all Medically Necessary health care services that are contained in Section 1905(a) of the Social Security Act and required to treat a condition diagnosed during any encounter with a Health Care Provider practicing

within the scope of state law. Any Medically Necessary health care, eligible under the federal Medicaid program, required to treat conditions detected during a visit must be covered by the PH-MCO, except Behavioral Health Services which will be covered through the BH-MCO. Even though the PH-MCO is not responsible for behavioral health treatment, it is still responsible for identifying Members who are in need of behavioral health treatment services, and for linking the Member with the appropriate BH-MCO.

The PH-MCO must have a system in place to actively identify the need for and furnish "expanded services". Such policies will be clearly communicated to Providers and Recipient through the Provider Manual and the Member Handbook. If a Health Care Provider prescribes services or equipment for an individual under the age of 21, which is not normally covered by the MA Program, or for which the PH-MCO requires Prior Authorization, the PH-MCO must follow the Prior Authorization requirements outlined in Section V.B and Exhibit H of the contract.

With respect to SSI and SSI-related Members under the age of 21, at the first appointment following enrollment, the PCP must make an initial assessment of the health needs of the child over an appropriate period (not to exceed one year), including the child's need for primary and specialty care. The results of that assessment shall be discussed with the family or custodial agency (and, if appropriate, the child) and shall be listed in the child's medical records. The family shall be informed in writing of the plan, and the right to use complaint procedures if they disagree. As part of the initial assessment, the PCP shall make a recommendation regarding whether case management services should be provided to the child, based on medical necessity, and with the families or custodial agency's consent, this recommendation shall be binding on the PH-MCO.

3. Tracking

The PH-MCO must establish a tracking system that provides information on compliance with EPSDT service provision requirements in the following areas:

- Initial visit for newborns. The initial EPSDT screen shall be the newborn physical exam in the hospital.
- EPSDT screen and reporting of all screening results.
- Diagnosis and/or treatment, or other referrals for children.
- Other tracking activities include: Number of comprehensive screens (reported by age); hearing and vision examinations; dental screens; age appropriate screens; complete age appropriate immunizations; blood lead screens; prenatal care for teen mothers; provision of eyeglasses to those in need of them; dental sealants; newborn home visits; referral of very low birth weight babies to early intervention; referral of Members under the age of 21 with elevated blood lead levels to early intervention; routine evaluation for iron deficiencies ; and timely identification and treatment of asthma.

4. Follow-ups and Outreach

The PH-MCO must have an established process for reminders, follow-ups and outreach to Members that includes:

- Written notification of upcoming or missed appointments within a set time period, taking into consideration language and literacy capabilities of Members.

- Telephone protocols to remind Members of upcoming visits and follow-up on missed appointments within a set time period.

- If requested, any necessary assistance with transportation to ensure that recipients obtain necessary EPSDT screening services. This assistance must be offered prior to each due date of a child's periodic examination.

- Protocols for conducting outreach with non-compliant Members, including home visits, as appropriate.

- A process for outreach and follow-up to Members under the age of twenty-one (21) with Special Needs, such as homeless children.

- A process for outreach and follow-up with County Children and Youth Agencies and Juvenile Probation Offices to assure that they are notified of all Members under the age of 21 who are under their supervision and who are due to receive EPSDT screens and follow-up treatment.

- The PH-MCO may develop alternate processes for follow up and outreach subject to prior written approval from the Department.

The PH-MCO shall submit to the Department reports that identify its performance in the above four required services (Screening, Diagnosis and Treatment, Tracking and Follow-up and Outreach).

Arranging for Medically Necessary follow-up care for health care services is an integral part of the Provider's continuing care responsibility after a screen or any other health care contact. In cases involving a Member under the age of 21 with complex medical needs or serious or multiple disabilities or illnesses, case management services must be offered, consistent with MA Bulletin #1239-94-01 regarding "Medical Assistance Case Management Services for Recipients Under the Age of 21".

To assist the PH-MCO in provision of the above four required services (Screening, Diagnosis and Treatment, Tracking and Follow-up and Outreach) to children in substitute care, the PH-MCO will be required to develop master lists of all enrolled children who are coded as such on the monthly membership files. The PH-MCO must assign specific staff to monitor the services provided to these children and to ensure that they receive comprehensive EPSDT screens and follow-up services. The assigned staff must contact the relevant agencies with custody of these Members or with jurisdiction over them (e.g., County Children and Youth Agency, Juvenile Probation Office) when a particular child has

yet to receive an EPSDT screen or is not current with their EPSDT screen and/or immunizations and to ensure that an appointment for such service is scheduled.

Further, in addition to the EPSDT related Pennsylvania Performance Measures, the PH-MCO must submit to the Department, reports providing all data regarding children in substitute care (e.g., the number of children enrolled in substitute care who have received comprehensive EPSDT screens, the number who have received blood level assessments, etc.).

5. Interagency Teams for EPSDT Services for Children

For the ongoing coordination of EPSDT services for Members under the age of 21 identified with Special Needs, the PH-MCO must appoint a PH-MCO representative who will ensure coordination with other health, education and human services systems in the development of a comprehensive individual/family services plan.

The goal is to develop and implement a comprehensive service plan through a collaborative interagency team approach, which ensures that children have access to appropriate, coordinated, comprehensive health care. To achieve this goal, The PH-MCO must ensure the following:

- Children have access to adequate pediatric care.
- The service plan is developed in coordination with the interagency team, including the child (when appropriate), the adolescent and family members and a PH-MCO representative.
- Development of adequate specialty Provider Networks.
- Integration of covered services with ineligible services.
- Prevention against duplication of services.
- Adherence to state and federal laws, regulations and court requirements relating to individuals with Special Needs.
- Cooperation of PH-MCO Provider Networks.
- Applicable training for PCPs and Providers including the identification of PH-MCO contact persons.

EXHIBIT K

EMERGENCY SERVICES

The PH-MCO must agree to accept the Department's definition of Emergency Services. Case management protocols will not apply in cases where they would interfere with treatment of emergencies. In the case of a pregnant woman who is having contractions, if the PH-MCO attempts to utilize its case management protocols to direct its Member from an Out-of-Network provider to a Network Provider, it must collect and maintain data to demonstrate that there was adequate time to effect a safe transfer to another hospital before delivery or that the transfer would not pose a threat to the health and safety of the patient or the unborn child. Where a transfer is enacted, the PH-MCO must be able to demonstrate that its case management protocols did not interfere with the transferring hospital's obligation to:

- Restrict transfer until the patient is stabilized;
- Effect an appropriate transfer or provide medical treatment within its capacity to minimize the risk of transfer to the individual's health;
- Require a supervised transfer;
- Offer the Member informed refusal to consent to transfer along with documentation of the associated risks and benefits and;
- Not divert a Member being transported by emergency vehicle from its Emergency Service on the basis of his/her insurance.

Emergency providers may initiate the necessary intervention to stabilize the condition of the patient without seeking or receiving prospective authorization by the PH-MCO.

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

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

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

The PH-MCO may not:

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

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

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

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

The PH-MCO is responsible for all Emergency Services including those categorized as mental health or drug and alcohol. Exception: Emergency room evaluations for voluntary and involuntary commitments pursuant to the 1976 Mental Health Procedures Act will be the responsibility of the BH-MCO.

EXHIBIT L

MEDICAL ASSISTANCE TRANSPORTATION PROGRAM

The Medical Assistance Transportation Program (MATP) is responsible for the following:

- Non-emergency transportation to a medical service that is covered by the MA Program. This includes transportation for urgent care appointments.
- Transportation to another county, as medically necessary, to get medical care as well as advice on locating a train, the bus, and route information.
- Reimbursement for mileage, parking, and tolls with valid receipts, if the consumer used their own car or someone else's to get to the medical care provider.

When requested, the PH-MCO must arrange urgent non-emergency transportation for urgent appointments for their Members through the MATP. MATP agencies have been instructed to contact the PH-MCO for verification that a Medical Assistance consumer's services request is for transportation to a Medical Assistance compensable service. The Department strongly encourages the PH-MCO to jointly undertake activities with MATP agencies such as sharing Provider Network information, developing informational brochures and establishing procedures which enhance transportation services for Members.

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EXHIBIT M(1)

QUALITY MANAGEMENT AND UTILIZATION MANAGEMENT PROGRAM REQUIREMENTS

The Department will monitor the Quality Management (QM) and Utilization Management (UM) programs of all PH-MCOs and retains the right of advance written approval of all QM and UM activities. The PH-MCO's QM and UM programs must be designed to assure and improve the accessibility, availability, and quality of care being provided to its members. The PH-MCO's QM and UM programs must, at a minimum:

A. Contain a written program description, work plan, evaluation and policies/procedures that meet requirements outlined in the agreement;

B. Allow for the development and implementation of an annual work plan of activities that focuses on areas of importance as identified by the PH-MCO in collaboration with the Department;

C. Be based on statistically valid clinical and financial analysis of Encounter Data, Member demographic information, HEDIS, CAHPS, Pennsylvania Performance Measures and other data that allows for the identification of prevalent medical conditions, barriers to care and racial/ethnic disparities to be targeted for quality improvement and disease management initiatives;

D. Allow for the continuous evaluation of its activities and adjustments to the program based on these evaluations;

E. Demonstrate sustained improvement for clinical performance over time; and

F. Allow for the timely, complete, and accurate reporting of Encounter Data and other data required to demonstrate clinical and service performance, including HEDIS and CAHPS as outlined in Exhibit M(4), Healthcare Effectiveness Data and Information Set (HEDIS).

G. Include processes for the investigation and resolution of individual performance or quality of care issues whether identified by the PH-MCO or the Department that:

   1) Allow for the tracking and trending of issues on an aggregate basis pertaining to problematic patterns of care;

   2) Allow for submission of improvement plans, as determined by and within time frames established by the Department. Failure by the PH-MCO to comply with the requirements and improvement actions requested by the Department may result in the application of penalties and/or sanctions as outlined in Section VIII.H, Sanctions, of the Agreement.

H. Obtain accreditation by a nationally recognized organization, such as National Committee of Quality Assurance (NCQA).

Standard I: The scope of the QM and UM programs must be comprehensive in nature; allow for improvement and be consistent with the Department's goals related to access, availability and quality of care. At a minimum, the PH-MCO's QM and UM programs, must:

A. Adhere to current Medicaid CMS guidelines.

B. Be developed and implemented by professionals with adequate and appropriate experience in QM/UM and techniques of peer review.

C. Ensure that that all QM and UM activities and initiatives undertaken by the PH-MCO are–based upon clinical and financial analysis of Encounter Data, Member demographic information, HEDIS, CAHPS, Pennsylvania Performance Measures and/or other identified areas.

D. Contain policies and procedures which provide for the ongoing review of the entire scope of care provided by the PH-MCO assuring that all demographic groups, races, ethnicities, care settings and types of services are addressed.

E. Contain a written program description that addresses all standards, requirements and objectives established by the Department and that describes the goals, objectives, and structure of the PH-MCO's QM and UM programs. The written program description must, at a minimum:

1) Include standards and mechanisms for ensuring the accessibility of primary care services, specialty care services, urgent care services, and Member services in accordance with timeframes outlined in Exhibit AAA(1), Provider Network Composition/Service Access of the Agreement.

2) Include mechanisms for planned assessment and analysis of the quality of care provided and the utilization of services against formalized standards, including but not limited to:

   a) Primary, secondary, and tertiary care;
   b) Preventive care and wellness programs;
   c) Acute and/or chronic conditions;
   d) Dental care
   e) Care coordination; and
   f) Continuity of care.

3) Allow for the timely, accurate, complete collection and clinical and financial analysis of Encounter Data and other data including, but not limited to, HEDIS, CAHPS, and Pennsylvania Performance Measures.

4) Allow for systematic analysis and re-measurement of barriers to care, the quality of care provided to Members, and utilization of services over time.

F. Provide a comprehensive written evaluation, completed on at least an annual basis, that details all QM and UM program activities including, but not limited to:

a) Studies and activities undertaken; including the rationale, methodology and results
b) Subsequent improvement actions; and
c) Aggregate clinical and financial analysis of Encounter, HEDIS, CAHPS, Pennsylvania Performance Measures, and other data on the quality of care rendered to Members and utilization of services.

G. Include a work plan and timetable for the coming year which clearly identifies target dates for implementation and completion of all phases of all QM activities, including, but not limited to:

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 PH-MCO performance in improving access to care, the quality of care provided to Members and utilization of services.

I. Include mechanisms and processes which ensure related and relevant operational components, activities, and initiatives from the QM and UM programs are integrated into activities and initiatives undertaken by other departments within the PH-MCO including, but not limited to, the following:

1) Special Needs;
2) Provider Relations;
3) Member Services; and
4) Management Information Systems

J. Include procedures for informing both physician and non-physician Providers about the written QM and UM programs, and for securing cooperation with the QM and UM programs in all physician and non-physician Provider agreements.

K. Include procedures for feedback and interpretation of findings from analysis of quality and utilization data to Providers, health professionals, PH-MCO staff, and MA Consumers/family members.

L. Include mechanisms and processes which allow for the development and implementation of PH-MCO wide and Provider specific improvement actions in response to identified barriers to care, quality of care concerns, and over-utilization, under-utilization and/or mis-utilization of services.

Standard II: The organizational structures of the PH-MCO must ensure that:

A. The Governing Body:

1) Has formally designated an accountable entity or entities, within the PH-MCO to provide oversight of QM and UM program activities or has formally decided to provide such oversight as a committee, e.g. Quality Management Committee.

2) Regularly receives written reports on the QM and UM program activities that describe actions taken, progress in meeting objectives and improvements made. The governing body formally reviews, on at least an annual basis, a written evaluation of the QM and UM program activities that includes studies undertaken, results of studies, and subsequent improvement actions taken. The written evaluation must include aggregate clinical and financial analysis of quality and utilization data, including HEDIS, CAHPS, and Pennsylvania Performance Measures.

3) Documents actions taken by the governing body in response to findings from QM and UM program activities.

B. The Quality Management Committee (QMC):

1) Must contain policies and procedures which describe the role, structure and function of the QMC that:

a) Demonstrate that the QMC has oversight responsibility and input, including review and approval, on all QM and UM program activities;

b) Ensure membership on the QMC and active participation by individuals representative of the composition of the PH-MCO's Providers; and

c) Provide for documentation of the QMC's activities, findings, recommendations, and actions.

2) Meets at least monthly, and otherwise as needed.

C. The Senior Medical Director must be directly accountable to and act as liaison to the Chief Medical Officer for DHS.

D. The Medical Director:

1) Serves as liaison and is accountable to the governing body and Quality Management Committee for all QM and UM activities and initiatives;

2) Is available to the PH-MCO's medical staff for consultation on referrals, denials, Complaints and problems;

3) Is directly involved in the PH-MCO's recruiting and credentialing activities;

4) Is familiar with local standards of medical practice and nationally accepted standards of practice;

5) Has knowledge of due process procedures for resolving issues between participating Providers and the PH-MCO administration, including those related to medical decision making and utilization review;

6) Is available to review, advise and take action on questionable hospital admissions, Medically Necessary days and all other medical care and medical cost issues;

7) Is directly involved in the PH-MCO's process for prior authorizing or denying services and is available to interact with Providers on denied authorizations;

8) Has knowledge of current peer review standards and techniques;

9) Has knowledge of risk management standards;

10) Is directly accountable for all Quality Management and Utilization Management activities and

11) Oversees and is accountable for:

    a) Referrals to the Department and appropriate agencies for cases involving quality of care that have adverse effects or outcomes; and

    b) The processes for potential Fraud and Abuse investigation, review, sanctioning and referral to the appropriate oversight agencies.

E. The PH-MCO must have sufficient material resources, and staff with the appropriate education, experience and training, to effectively implement the written QM and UM programs and related activities.

Standard III: The QM and UM programs must include methodologies that allow for the objective and systematic monitoring, measurement, and evaluation of the quality and appropriateness of care and services provided to Members through quality of care

studies and related activities with a focus on identifying and pursuing opportunities for continuous and sustained improvement.

A. The QM and UM programs must include professionally developed practice guidelines/standards of care 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.

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 needs of the populations served by the PH-MCO. The clinical areas addressed must include, but are not limited to:

1) Adult preventive care;
2) Pediatric and adolescent preventive care with a focus on EPSDT services;
3) Obstetrical care including a requirement that Members be referred to obstetricians or certified nurse midwives at the first visit during which pregnancy is determined;
4) Selected diagnoses and procedures relevant to the enrolled population;
5) Selected diagnoses and procedures relevant to racial and ethnic subpopulations within the PH-MCO's membership; and
6) Preventive dental care.

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 Members upon request.

E. The PH-MCO must develop methodologies for assessing performance of PCPs/PCP sites, high risk/high volume specialists, dental Providers, and Providers of ancillary services not less than every two years (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 plan;

2) Allow for the tracking and trending of individual and PH-MCO wide Provider performance over time;

3) Include active mechanisms and processes that allow for the identification, investigation and resolution of quality of care concerns, including events such as Health Care-Associated Infections and medical errors; and

4) Include mechanisms for detecting instances of over-utilization, under-utilization, and mis-utilization;

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 concerns including Health Care-Associated Infections, medical errors, and unnecessary and/or ineffective care patterns;

2) Processes for tracking and trending problematic patterns of care;

3) Use of progressive sanctions as indicated;

4) Person(s) or body responsible for making the final determinations regarding quality problems; and

5) Types of actions to be taken, such as:

a) Education;
b) Follow-up monitoring and re-evaluation;
c) Changes in processes, structures, forms;
d) Informal counseling;
e) Procedures for terminating the affiliation with the physician or other health professional or Provider;
f) Assessment of the effectiveness of the actions taken; and
g) Recovery of inappropriate expenditures (e.g., related to Health Care-Associated Infections, medical errors, and unnecessary and/or ineffective care).

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 concerns, Member quality of care complaints, over-utilization, under-utilization, and/or mis-utilization, access/availability issues, and quality of care referrals from other sources;

H. The QM and UM programs must contain procedures for Member satisfaction surveys that are conducted on at least an annual basis including the collection of annual Member satisfaction data through application of the CAHPS instrument as

outlined in Exhibit M(4), Healthcare Effectiveness Data and Information Set (HEDIS).

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, and specialists, dental Providers, hospitals, and Providers of ancillary services.

J. Each PH-MCO will be required to comply with requirements for Performance Improvement Projects (PIPs) as outlined in Exhibit M(2) External Quality Review.

Standard IV: The QM and UM programs must objectively and systematically monitor and evaluate the appropriateness and cost effectiveness of care and services provided to Members through utilization review activities with a focus on identifying and correcting instances and patterns of over-utilization, under-utilization and mis-utilization.

A. Semi-annually, or more frequently as appropriate, the QM and UM programs must provide for production and distribution to Providers, (in either hard copy or web-based electronic formats) profiles comparing the average medical care utilization rates of the Members of each PCP to the average utilization rates of all PH-MCO Members. The PH-MCO must develop statistically valid methodologies for data collection regarding Provider profiling. Profiles shall include, but not be limited to:

1) Utilization information on Member Encounters with PCPs;
2) Specialty Claims;
3) Prescriptions;
4) Inpatient stays;
5) Emergency room use;
6) Clinical indicators for preventive care services (i.e., mammograms, immunizations, pap smear, etc.); and
7) Clinical indicators for EPSDT requirements.

B. The PH-MCO must have mechanisms and processes for profiling physicians using risk adjusted diagnostic data for profiles.

C. The QM and UM programs must implement statistically valid methodologies for analysis and follow-up of semi-annual practitioner utilization profiles for patterns and instances of over-utilization, under-utilization, and mis-utilization across the continuum of care, as well as, trending of Provider utilization patterns over time. Follow up includes but is not limited to Provider education, Provider improvement plans, and Provider sanctions as necessary.

D. The QM and UM programs must at least annually, provide for verification of Encounter reporting rates and accuracy and completeness of Encounter information submitted by PCPs.

Standard V: The PH-MCO must develop mechanisms for integration of case/disease and health management programs that rely on wellness promotion, prevention of complications and treatment of chronic conditions for Members identified. Case/Disease and health management programs must:

A. Include mechanisms and processes that ensure the active collaboration and coordination of care and services for identified members.

B. Include mechanisms and processes that allow for the identification of conditions to be targeted for case/disease and health management programs and that allow for the assessment and evaluation of the effectiveness of these programs in improving outcomes for and meeting the needs of individuals with targeted conditions.

C. Include care guidelines and/or protocols for appropriate and effective management of individuals with specified conditions. These guidelines must be written in measurable and accepted professional formats and be based on scientific evidence.

D. Include performance indicators that allow for the objective measurement and analysis of individual and PH-MCO wide performance in order to demonstrate progress made in improving access and quality of care.

E. Include mechanisms and processes that lead to healthy lifestyles such as weight loss program memberships, gym memberships and asthma camps.

F. The PH-MCO agrees to comply with Department requirements and procedures related to the Enhanced Medical Home (EMH) model. EMH model is a system of care that provides access to a primary care provider, as well as targeted care management support for members at high risk of using acute medical services. There are four Pillars of the EMH model with which the PH-MCO would be expected to participate:

- Embedded care managers in high volume practices (HVPs)
- Working with HVP(s) to achieve NCQA Medical Home recognition
- Transition of Care (TOC) nurses to work with high volume health systems
- Participation with regional learning network collaboratives

Standard VI: The QM and UM programs must have mechanisms to ensure that Members receive seamless, continuous, and appropriate care throughout the continuum of care, by means of coordination of care, benefits, and quality improvement activities between:

A. PCPs and specialty care practitioners and other Providers**;**

B. Other HealthChoices PH-MCOs;

D. The PH-MCO and HealthChoices BH-MCOs;

E. The PH-MCOs and the Department's Fee For Service Program; and

F. The PH-MCO and other third party insurers

Standard VII: The PH-MCO must demonstrate that it retains accountability for all QM and UM program functions, including those that are delegated to other entities. The PH-MCO must:

A. Have a written description of the delegated activities, the delegate's accountability for these activities, and the frequency of reporting to the PH-MCO.

B. Have written procedures for monitoring and evaluating the implementation of the delegated functions and for verifying the actual quality of care being provided.

C. Document evidence of continuous and ongoing evaluation of delegated activities, including approval of quality improvement plans and regular specified reports.

D. Make available to the Department, and its authorized representatives, any and all records, documents, and data detailing its oversight of delegated QM and UM program functions.

E. Must ensure that delegated entities make available to the Department, and its authorized representatives, any and all records, documents and data detailing the delegated QM and UM program functions undertaken by the entity of behalf of the PH-MCO.

F. Compensation and payments to individuals or entities that conduct Utilization Management activities may not be structured so as to provide incentives for the individual or entity to deny, limit, or discontinue Medically Necessary services to any Member

Standard VIII: The QM/UM program must have standards for credentialing/ recredentialing Providers to determine whether physicians and other Health Care Providers, who are licensed by the Commonwealth and are under contract to the PH-MCO, are qualified to perform their services.

A. The PH-MCO must establish and maintain minimum credentialing and recredentialing criteria for all Provider types. Recredentialing activities must be conducted by the PH-MCO at least every three (3) years. Criteria must include, but not be limited to, the following:

1) Appropriate license or certification as required by Pennsylvania state law;

2) Verification that Providers have not been suspended, terminated or entered into a settlement for voluntary withdrawal from the Medicaid or Medicare Programs;

3) Verification that Providers and/or subcontractors have a current Provider Agreement and an active 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 Member Complaint and/or Member satisfaction information, sentinel events and quality of care concerns.

B. For purposes of credentialing and recredentialing, the PH-MCO must perform a check on all PCPs and other physicians by contacting the National Practitioner Data Bank (NPDB). If the PH-MCO does not meet the statutory requirements for accessing the NPDB, then the PH-MCO must obtain information from the Federation of State Medical Boards

C. Appropriate PCP qualifications:

1) Seventy-five to 100% of the Network consists of PCPs who have completed an approved primary care residency in family medicine, osteopathic general medicine, internal medicine or pediatrics;

2) No more than 25% of the Network consists of PCPs without appropriate residencies but who have, within the past seven years, five years of post-training clinical practice experience in family medicine, osteopathic general medicine, internal medicine or pediatrics. Post-training experience is defined as having practiced at least as a 0.5 full-time equivalent in the practice areas described; and

3) No more than 10% of the Network consists of PCPs who were previously trained as specialist physicians and changed their areas of practice to primary care, and who have completed Department-approved primary care retraining programs.

4) A PCP must have the ability to perform or directly supervise the ambulatory primary care services of Members;

5) Membership of the medical staff with admitting privileges of at least one general hospital or an acceptable arrangement with a PCP with admitting privileges;

6) Demonstrate evidence of continuing professional medical education;

7) Attend at least one PH-MCO sponsored Provider education training session as outlined in Section V.R.2, Provider Education, of the Agreement.

D. Assurance that any CRNP, Certified Registered Midwife or physician's assistant, functioning as part of a PCP team, is performing under the scope of their respective licensure; and

E. As part of the Provider release form, the potential Provider must agree to release all MA records pertaining to sanctions and/or settlement to the PH-MCO and the Department.

F. The Department will recoup from the PH-MCO any and all payments made to a Provider who does not meet the enrollment and credentialing criteria for participation or is used by the PH-MCO in a manner that is not consistent with the Provider's licensure. In addition, the PH-MCO must notify its PCPs and all subcontractors of the prohibitions and sanctions for the submission of false Claims and statements.

G. The PH-MCO shall evaluate a Provider's professional qualifications through objective measures of competence and quality. Providers should be given the opportunity to have input on the PH-MCO's credentialing practices.

H. Any economic profiles used by the PH-MCOs to credential Providers should be adjusted to adequately account for factors that influence utilization independent of the Provider's clinical management, including Member age, Member sex, Provider case-mix and Member severity. The PH-MCO must report any utilization profile that it utilizes in its credentialing process and the methodology that it uses to adjust the profile to account for non-clinical management factors at the time and in the manner requested by the Department.

I. In the event that a PH-MCO renders an adverse credentialing decision, the PH-MCO must provide the affected Provider with a written notice of the decision. The notice should include a clear and complete explanation of the rationale and factual basis for the determination. The notice shall include any utilization profiles used as a basis for the decision and explain the methodology for adjusting profiles for non-clinical management factors. All credentialing decisions made by the PH-MCO are final and may not be appealed to the Department.

J. The PH-MCO must meet the following standards related to timeliness of processing new provider applications for credentialing.

1) The PH-MCO must begin its credentialing process upon receipt of a provider's credentialing application if the application contains all required information.

2) The PH-MCO may not delay processing the application if the provider does not have an MAID number that is issued by the DHS. However, the PH-MCO cannot complete its process until the provider has received its MAID number from DHS.

3) Provider applications submitted to the PH-MCO for credentialing must be completed within sixty (60) days of receipt of the application packet if the information is complete.

Standard IX: The PH-MCO's written UM program must contain policies and procedures that describe the scope of the program, mechanisms, information sources used to make determinations of medical necessity and in conjunction with the requirements in Exhibit H Prior Authorization Guidelines for Participating Managed Care Organizations in the HealthChoices Program.

A. The UM program must contain policies and procedures for Prospective, Concurrent, and Retrospective review determinations of medical necessity.

B. The UM program must allow for determinations of medical necessity that are consistent with the HealthChoices Program definition of Medically Necessary:

Determinations of medical necessity for covered care and services whether made on a Prior Authorization, Concurrent Review or Retrospective Review basis, shall be documented in writing. The PH-MCO shall base its determination on medical information provided by the Member, the Member's family/care taker and the PCP, as well as any other Providers, programs and agencies that have evaluated the Member. Medical necessity determinations must be made by qualified and trained Health Care Providers. A Health Care Provider who makes such determinations of Medical Necessity is not considered to be providing a health care service under this Agreement. Satisfaction of any one of the following standards will result in authorization of the service:

1) The service or benefit will, or is reasonably expected to, prevent the onset of an illness, condition or disability;

2) The service or benefit will, or is reasonably expected to, reduce or ameliorate the physical, mental or developmental effects of an illness, condition, injury or disability;

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

C. If the PH-MCO wishes to require Prior Authorization of any services, they must establish and maintain written policies and procedures for the Prior Authorization review process. Prior Authorization policies and procedures must:

1) Meet the HealthChoices Program's definition of Medically Necessary;

2) Contain timeframes for decision making or cross reference policies on time frames for decision making that meet requirements outlined in Section V.B, Prior Authorization of Services, of the Agreement.

3) Contain language or cross reference policies and procedures of notifying Members of adverse decisions and how to file a Complaint/Grievance/DHS Fair Hearing;

4) Comply with state/federal regulations;

5) Comply with HealthChoices RFP and other contractual requirements;

6) Specify populations covered by the policy;

7) Contain an effective date; and

8) Be received under signature of individuals authorized by the plan.

D. The PH-MCO must provide all Licensed Proprietary Products which include, but are not limited to: Interqual and Milliman. All Utilization Review Criteria and/or policies and procedures that contain Utilization Review Criteria used to determine medical necessity must:

1) Not contain any definition of medical necessity that differs from the HealthChoices definition of Medically Necessary;

2) Allow for determinations of medical necessity that are consistent with the HealthChoices Program definition of Medically Necessary;

3) Allow for the assessment of the individual's current condition and response to treatment and/or co-morbidities, psychosocial, environmental and/or other needs that influences care;

4) Provide direction to clinical reviewers on how to use clinical information gathered in making a determination to approve, deny, continue, reduce or terminate a service;

5) Be developed using a scientific based process;

6) Be reviewed at least annually and updated as necessary; and

7) Provide for evaluation of the consistency with which reviewers implement the criteria on at least an annual basis.

E. The PH-MCO must ensure that Prior Authorization and Concurrent review decisions:

1) Are supervised by a physician or Health Care practitioner with appropriate clinical expertise in treating the Member's condition or disease;

2) That result in a denial may only be made by a licensed physician;

3) Are made in accordance with established RFP time-frames for routine, urgent, or emergency care; and

4) Are made by clinical reviewers using the HealthChoices definition of medical necessity.

F. The PH-MCO agrees to provide twenty-four (24) hour staff availability to authorize weekend services, including but not limited to: home health care, pharmacy, DME, and medical supplies. The PH-MCO must have written policies and procedures that address how Members and Providers can make contact with the PH-MCO to receive instruction or Prior Authorization, as necessary

G. Additional Prior Authorization requirements can be found in Exhibit H, Prior Authorization Guidelines for Participating Managed Care Organizations in the HealthChoices Program.

H. The PH-MCO must ensure that utilization records document efforts made to obtain all pertinent clinical information and efforts to consult with the prescribing Provider before issuing a denial based upon medical necessity.

I. The PH-MCO must ensure that sources of utilization criteria are provided to Members and Providers upon request.

J. The UM program must contain procedures for providing written notification to Members of denials of medical necessity and terminations, reductions and changes in level of care or placement, which clearly document and communicate the reasons for each denial. These procedures must:

1) Meet requirements outlined in Exhibit GG, Complaints, Grievances, and DHS Fair Hearing Process.

2) Provide for written notification to Members of denials, terminations, reductions and changes in medical services at least ten (10) days before the effective date.

3) Include notification to Members of their right to file a Complaint, Grievance or DHS Fair Hearing as outlined in Exhibit GG, Complaints, Grievances, and DHS Fair Hearing Process.

K. The PH-MCO must agree to comply with the Department's utilization review monitoring processes, including, but not limited to:

1) Submission of a log of all denials issued using formats to be specified by the Department.
2) Submission of denial notices for review as requested by the Department
3) Submission of utilization review records and documentation as requested by the Department
4) Ensure that all staff who have any level of responsibility for making determinations to approve or deny services, for any reason have completed a utilization review training program.
5) Development of an internal quality assurance process designed to ensure that all denials issued by the plan and utilization review record documentation meet Department requirements. This process must be approved by the Department prior to implementation.

Standard X: The PH-MCO must have a mechanism in place for Provider Appeals/Provider Disputes related to the following:

A. Administrative denials including denials of Claims/payment issues, and payment of Claims at an alternate level of care than what was provided, i.e. acute versus skilled days. This includes the appeal by Health Care Providers of a PH-MCO's decision to deny payment for services already rendered by the Provider to a Member.

B. QM/UM sanctions

C. Adverse credentialing/recredentialing decisions

D. Provider Terminations

Standard XI: The PH-MCO must ensure that findings, conclusions, recommendations and actions taken as a result of QM and UM program activities are documented and

reported to appropriate individuals within the PH-MCO for use in other management activities.

A. The QM and UM program must have procedures which describe how findings, conclusions, recommendations, actions taken and results of actions taken are documented and reported to individuals within the PH-MCO for use in conjunction with other related activities such as:

1) PH-MCO Provider Network changes;
2) Benefit changes;
3) Medical management systems (e.g., pre-certification); and
4) Practices feedback to Providers.

Standard XII: The PH-MCO must have written policies and procedures for conducting prospective and retrospective DUR that meet requirements outlined in Exhibit BBB(2), Drug Utilization Review Guidelines.

Standard XIII: The PH-MCO must have written standards for medical record keeping. The PH-MCO must ensure that the medical records contain written documentation of the medical necessity of a rendered, ordered or prescribed service.

A. The PH-MCO must have written policies and procedures for the maintenance of medical records so that those records are documented accurately and in a timely manner, are readily accessible and permit prompt and systematic retrieval of information. Written policies and procedures must contain standards for medical records that promote maintenance of medical records in a legible, current, detailed, organized and comprehensive manner that permits effective patient care and quality review.

B. Medical record standards must meet or exceed medical record keeping requirements contained in 55 Pa. Code Section 1101.51(d)(e) of the MA Manual and medical record keeping standards adopted by DOH.

C. Additional standards for patient visit data must, at a minimum, include the following:

1) History and physical that is appropriate to the patient's current condition;
2) Treatment plan, progress and changes in treatment plan;
3) Diagnostic tests and results
4) Therapies and other prescribed regimens;
5) Disposition and follow-up;
6) Referrals and results thereof;
7) Hospitalizations;
8) Reports of operative procedures and excised tissues; and
9) <u>All other aspects of patient care.</u>

D. The PH-MCO must have written policies and procedures to assess the content of medical records for legibility, organization, completion and conformance to its standards.

E. The PH-MCO must ensure access of the Member to his/her medical record at no charge and upon request. The Member's medical records are the property of the Provider who generates the record.

F. The Department and/or its authorized agents (i.e., any individual or corporation or entity employed, contracted or subcontracted with by the Department) shall be afforded prompt access to all Members' medical records whether electronic or paper. All medical record copies are to be forwarded to the requesting entity within 15 calendar days of such request and at no expense to the requesting entity. The Department is not required to obtain written approval from a Member before requesting the Member's medical record from the PCP or any other agency.

G. Medical records must be preserved and maintained for a minimum of five years from expiration of the PH-MCO's contract. Medical records must be made available in paper form upon request.

H. When a Member changes PCPs, the PH-MCO must facilitate the transfer of his/her medical records or copies of medical records to the new PCP within seven business days from receipt of the request. In emergency situations, the PH-MCO must facilitate the transfer of medical records as soon as possible from receipt of the request.

I. When a Member changes PH-MCOs, the PH-MCO must facilitate the transfer of his/her medical records or copies of medical records to the new PH-MCO within seven business days from the effective date of enrollment in the gaining PH-MCO. In emergency situations, the PH-MCO must facilitate the transfer of medical records as soon as possible from receipt of the request.

Standard XIV: The QM and UM program must demonstrate a commitment to ensuring that Members are treated in a manner that acknowledges their defined rights and responsibilities.

A. The PH-MCO must have a written policy that recognizes the following rights of Members:

1) To be treated with respect, and recognition of their dignity and need for privacy;

2) To be provided with information about the PH-MCO, its services, the practitioners providing care, and Members rights and responsibilities;

3) To be able to choose Providers, within the limits of the PH-MCO Network, including the right to refuse treatment from specific practitioners;

4) To participate in decision making regarding their health care, including the right to refuse treatment, and to express preferences about future treatment decisions;

5) To have a Health Care Provider, acting within the lawful scope of practice, discuss Medically Necessary care and advise or advocate appropriate care with or on behalf of the Member including; information regarding the nature of treatment options; risks of treatment; alternative therapies; and consultation or tests that may be self-administered; without any restriction or prohibition from the PH-MCO;

6) To file a Grievance about the PH-MCO or care provided;

7) To file a DHS Fair Hearing appeal with the Department;

8) To formulate advance directives including:

   a) Written policies and procedures that meet advance directive requirements in accordance with 42 CFR 489, Subpart I

   b) Written policies and procedures concerning advance directives with respect to all adult Members receiving medical care by or through the PH-MCO

9) To have access to his/her medical records in accordance with applicable Federal and State laws and the right to request that they be amended or corrected as specified as in 45 CFR Section 164.526.

B. The PH-MCO must have a written policy that addresses Member's responsibility for cooperating with those providing health care services. This written policy must address Member's responsibility for:

1) Providing, to the extent possible, information needed by professional staff in caring for the Member; and

2) Following instructions and guidelines given by those providing health care services.

   Members shall provide consent to managed care plans, Health Care Providers and their respective designees for the purpose of providing patient care management, outcomes improvement and research. For these purposes, Members will remain anonymous to the greatest extent possible.

C. The PH-MCO's policies on Member rights and responsibilities must be provided to all participating Providers.

D. Upon enrollment, Members must be provided with a written statement that includes information on the following:

1) Rights and responsibilities of Members;

2) Benefits and services included as a condition of membership, and how to obtain them, including a description of:

a) Any special benefit provisions (for example, co-payment, higher deductibles, rejection of Claim) that may apply to services obtained outside the system; and
b) The procedures for obtaining Out-of-Area Services;
c) Charges to Members if applicable;
d) Benefits and services excluded.
e) Provisions for after-hours, urgent and emergency coverage;
f) The PH-MCO's policy on referrals for specialty care;
g) PH-MCO Procedures for notifying, in writing, those Members affected by denial, termination or change in any benefit or service including denials, terminations or changes in level of care or placement;
h) Procedures for appealing decisions adversely affecting the Member's coverage, benefits or relationship to the PH-MCO;
i) Information about OMAP's Hotline functions;
j) Procedures for changing practitioners;
k) Procedures for disenrolling from the PH-MCO;
l) Procedures for filing Complaints and/or Grievances; DHS Fair Hearings; and
m) Procedures for recommending changes in policies and services.

E. The PH-MCO must have policies and procedures for resolving Member Complaints and Grievances that meet all requirements outlined in Exhibit GG, Complaints, Grievances, and DHS Fair Hearing Processes. These procedures must include mechanisms that allow for the review of all Complaints and Grievances to determine if quality of care issues exists and for appropriate referral of identified issues.

F. Opportunity must be provided for Members to offer suggestions for changes in policies and procedures.

G. The PH-MCO must take steps to promote accessibility of services offered to Members. These steps must include identification of the points of access to primary care, specialty care and hospital services. At a minimum, Members are given information about:

1) How to obtain services during regular hours of operation;

2) How to obtain after-hours, urgent and emergency care; and

3) How to obtain the names, qualifications, and titles of the Health Care Provider providing and/or responsible for their care.

H. Member information (for example, Member brochures, announcements, and handbooks) must be written in language that is readable and easily understood.

I. The PH-MCO must make vital documents disseminated to English speaking members available in alternate languages, upon request of the member. Documents may be deemed vital if related to the access of LEP persons to programs and services.

Standard XV: The PH-MCO must maintain systems, which document implementation of the written QM and UM program descriptions.

A. The PH-MCO must document that it is monitoring the quality of care across all services, all treatment modalities, and all sub-populations according to its written QM and UM programs.

B. The PH-MCO must adhere to all systems requirements as outlined in Section V.O.7, Management Information Systems, and Section VIII.B, Systems Reporting, of the Agreement and in Management Information System and Systems Performance Review Standards provided by the Department on the HealthChoices Intranet.

C. The PH-MCO must adhere to all Encounter Data requirements as outlined in Section VIII.B.1, Encounter Data Reporting, of the Agreement.

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EXHIBIT M(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 Members. "Quality", as it pertains to EQR, means the degree to which a PH-MCO maintains or improves the health outcomes of its Members through its structural and operational characteristics and through the provision of services. The results of the EQR are made available, upon request, to specified groups and to interested stakeholders. This is one of many tools that facilitate achieving continuous quality improvement in the delivery of care, health care outcomes, and timeliness of care, access to services, quality and utilization management systems, and program oversight. The Department requires that the PH-MCOs:

A. Actively participate in planning and developing the measures to be utilized with the Department and the EQRO. The Medical Assistance Advisory Committee will be given an opportunity to provide input into the measures to be utilized.

B. Accurately, completely and within the required timeframe identify eligible Members to the EQRO.

C. Correctly identify and report the numerator and denominator for each measure.

D. Actively encourage and require Providers, including subcontractors, to provide complete and accurate Provider medical records within the timeframe specified by the EQRO.

E. Demonstrate how the results of the EQR are incorporated into the Plan's overall Quality Improvement Plan and demonstrate progressive improvements during the term of the contract.

F. Improve Encounter Data in an effort to decrease the need for extensive Provider medical record reviews.

G. Provide information to the EQRO as requested to fulfill the requirements of the mandatory and optional activities required in 42 CFR Parts 433 and 438.

H. Ensure that data, clinical records and workspace located at the PH-MCO's work site are available to the independent review team and to the Department, upon request.

EXHIBIT M(4)

HEALTHCARE EFFECTIVENESS DATA AND INFORMATION SET (HEDIS®)

HEDIS is a set of standardized performance measures designed to reliably compare health plan performance. HEDIS performance measures are divided into five domains of care:

- Effectiveness of care,
- Access/availability of care,
- Experience of care (Adult and Child CAHPS),
- Utilization and Relative resource use, and
- Health plan descriptive information,

The Department requires that the PH-MCOs:

A. Must produce rates for all Medicaid reporting measures, with the exclusion of the behavioral health measures, unless otherwise specified by the Department.

B. Must follow NCQA specifications as outlined in the HEDIS Technical Specifications clearly identifying the numerator and denominator for each measure.

C. Must have all HEDIS results validated by an NCQA-licensed vendor. The Department currently contracts with an NCQA-licensed entity to validate the MCOs' HEDIS results used in public reporting. The MCO may utilize these validation results for other purposes such as pursuit of accreditation. The Department may at some future date relinquish the direct contracting of NCQA validation activities.

D. Must assist with the HEDIS validation process by the Department's NCQA licensed contractor.

E. Must demonstrate how HEDIS results are incorporated into the MCO's overall Quality Improvement Plan.

F. Must submit validated HEDIS results annually on June 15th unless otherwise specified by the Department.

Measures publicly reported in the HealthChoices Consumer Guide are based on the Department's NCQA-licensed organization's validated findings.

EXHIBIT M(4)

Consumer Assessment of Healthcare Providers and Systems (CAHPS®)

CAHPS are a set of standardized surveys that assess patient satisfaction with the experience of care. CAHPS surveys (Adult and Child) are subsets of HEDIS reporting required by the Department. For HEDIS, MCOs must contract with an NCQA-certified vendor to administer the survey according to the HEDIS survey protocol that is designed to produce standardized results. The survey is based on a randomly selected sample of Members from the MCO and summarizes satisfaction with the experience of care through ratings and composites.

In addition to the Adult survey, HEDIS incorporates a CAHPS survey of parental experiences with their child's care. The separate survey is necessary because children's health care frequently requires different Provider Networks and addresses different consumer concerns (e.g. child growth and development).

The HEDIS protocol for administering CAHPS surveys consists of a mail protocol followed by telephone administration to those not responding by mail. MCOs must contract with a certified vendor to administer both the Adult and Child CAHPS surveys. The MCO must generate a sample frame for each survey sample, and arrange for an NCQA-certified auditor to verify the integrity of the sample frame before the certified vendor draws the sample and administers the survey. The MCOs are also required to have the certified vendor submit Member level data files to NCQA for calculation of HEDIS CAHPS survey results. The Department requires that the MCOs:

A. Must conduct both an Adult and Child CAHPS survey using the current version of CAHPS.

B. Must include all Medicaid core questions in both surveys.

C. Must add the following supplemental dental care questions, one through three, from the Supplemental Items for Adult/Child Questionnaires to both the Adult and Child CAHPS surveys and questions four and five to the Child 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?

1. 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)?
2. D4. What are the major difficulties your child has in seeing a dentist as often as you need?
   - I have trouble getting transportation to my child's dentist
   - I forget to go
   - I do not like dentists
   - It is difficult to schedule an appointment
   - My child's dentist does not have convenient office hours

- I have to wait too long in the waiting room
- My child is afraid or nervous to go
- I don't have time
- I don't have someone to watch my other children
- I can't take time off from work
- I don't know how to find a dentist
- I cannot find an office with handicap accessibility
- 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 child's insurance
- Medicaid does not cover dentists
- None of the above. I haven't had any difficulty in seeing a dentist
- Other (write in)

3. D5. Which of the following would help your child 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
   - Better communication about benefits from my child's health plan
   - Education about good dental care
   - None of the above. My child sees the dentist as often as I like.
   - Other (write in)

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?

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.

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EXHIBIT N

NOTICE OF DENIAL

A written notice of denial must be issued to the Member for the following:

a. The denial or limited authorization of a requested service, including the type or level of service.

b. The reduction, suspension or termination of a previously authorized service.

c. The denial of a requested service because it is not a covered service for the Member.

d. The denial of a requested service but approval of an alternative service

Please refer to Exhibits N(1) through N(6) for denial notice templates and Exhibit N(7), Request for Additional Information Letter template.

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EXHIBIT N(1)

STANDARD DENIAL NOTICE – COMPLETE DENIAL

[DATE] [This MUST be the date the notice is mailed]

RE: [*Member's name and DOB*]

Dear **[Member Name]:**

[PH-MCO Name] has reviewed the request for **[*identify SPECIFIC service/item*]** submitted by **[*prescriber's name*]** on behalf of **[*patient name*]** on **[*date*]**. After physician review, the request for service/item is:

Denied completely because**: *[Explain in detail every reason for denial. In addition to explanation for decision, include specific references to approved criteria, rules or protocols on which decision is based. If denied because of insufficient information, identify all additional information needed to render decision.]***

This decision will take effect on [*date*].

To continue getting services:
If you have been receiving the service or item that is being reduced, changed, or denied and you file a complaint, grievance or request for a Fair Hearing (see instructions below) that is postmarked or hand-delivered **within 10 days of the date on this notice**, the service or item will continue until a decision is made.

IF YOU DO NOT AGREE WITH THIS DECISION, YOU MAY DO ONE OR ALL OF THE FOLLOWING:

File a Complaint or Grievance

You may file a complaint or grievance with **[PH-MCO Name] within 45 days from the date you get this notice**. Your complaint or grievance will be decided no later than ( ) days *[PH-MCO: Insert 30 unless PH-MCO will be using a shorter timeframe.]* from when we receive it.

To file a complaint or grievance:

- Call **[PH-MCO Name]** at **[Phone #/Toll-free TTY #]**;
- Fax **[PH-MCO Fax #]**; or
- Send your complaint or grievance to **[PH-MCO Name]** at the following address:

PH-MCO Address for filing complaint or grievance

To ask for an early decision:

If your doctor or dentist believes that waiting ( ) days *[PH-MCO: Insert 30 unless PH-MCO will be using a shorter timeframe.]* to get a decision could harm your health, you may ask that your complaint or grievance be decided more quickly. To do this:

- Call **[PH-MCO Name]** at **[Phone #/Toll-free TTY #];**

AND

- Your doctor or dentist must fax a signed letter to **[PH-MCO fax #]** explaining why taking 30 days to decide your complaint or grievance could harm your health.

[PH-MCO Name] will notify you of the decision within 48 hours from when we receive your doctor's or dentist's letter, or within 3 business days from when we receive your request for an early decision, whichever is sooner.

Request a Fair Hearing

You may ask for a Fair Hearing from the Department of Human Services. Your request for a Fair Hearing must be in writing and must be postmarked **within 30 days from the date on this notice**. Your request should include the following information:

- Your (the Member's) name, social security number, and date of birth;
- A telephone number where you can be reached during the day;
- Whether you want to have a hearing in person or by telephone;
- A copy of this notice.

Your request for a Fair Hearing must be sent to the following address:

Department of Human Services
OMAP – HealthChoices Program
Complaint, Grievance and Fair Hearings
P.O. Box 2675
Harrisburg, PA 17105-2675

The Department will issue a decision between 60 and 90 days from when it receives your request (see your Member handbook for more details).

To ask for an early decision

If your doctor or dentist believes that the usual time frame for deciding your request for a Fair Hearing could harm your health, you may ask that the Fair Hearing take place more quickly. To do this:

- Call the Department at 1-800-798-2339, or fax your request to the Department at 1-717-772-6328
- Your doctor or dentist must fax a signed letter to 717-772-6328 explaining why taking the usual amount of time to decide your request for a Fair Hearing could

harm your health. If your doctor or dentist does not send a written letter, your doctor or dentist must testify at the Fair Hearing to explain why taking the usual amount of time to decide your request for a Fair Hearing could harm your health.

The Department will schedule a telephone hearing and notify you of its decision within three business days from when it receives your request.

You have the right to be present either in person or by telephone at the complaint review, grievance review, or Fair Hearing and to bring a family member, friend, lawyer or other person to help you.

If you file a complaint, grievance, or request for a Fair Hearing, you may request all documents relevant to this decision by sending a written request for the information to the following address:

PH-MCO Address for records information

Request Criteria

You may request a copy of the medical necessity criteria or other rules on which the decision was based by sending a written request to:

PH-MCO Name and Address

Get a second opinion

You may get a second opinion from a provider in the **[PH-MCO Name]** network. Call your PCP or **[PH-MCO Name]** at **[Phone #/Toll-free TTY #]** to get a referral for a second opinion. Asking for a second opinion will not extend the time for filing a complaint, grievance, or request for a Fair Hearing, and it will not continue any service or item that you have been receiving.

Get Help with Grievances, Complaints, or Fair Hearings

If you need help filing a grievance, complaint, or request a Fair Hearing, you can call:

- [PH MCO Name] at [Phone #/Toll-free TTY#]

To ask for free legal help with your grievance, complaint, or Fair Hearing, or with filing your grievance, complaint or request for Fair Hearing, you can call:

- Pennsylvania Health Law Project at 1-800-274-3258 (www.phlp.org) <OR>
- Pennsylvania Legal Aid Network at 1-800-322-7572 (www.palegalaid.net)

cc: Prescribing Provider

PH-MCO, the following statement must appear in English, Russian, Cambodian, Vietnamese, Spanish, Chinese, and any other language as required by the contract:]

The information in this notice is available in other languages and formats by calling [PH-MCO Name] at [Phone #/Toll-free TTY #].

EXHIBIT N(2)

STANDARD DENIAL NOTICE – PARTIAL APPROVAL OF REQUESTED SERVICE/ITEM

[DATE] [This MUST be the date the notice is mailed]

RE: [*Member's name and DOB*]

Dear **[Member Name]:**

[PH-MCO Name] has reviewed the request for **[*identify SPECIFIC service/item*]** submitted by **[*prescriber's name*]** on behalf of **[*patient name*]** on **[*date*]**. After physician review, the request for service/item is:

> Approved other than as requested as follows: **[Describe the level, frequency, and duration of service approved and the level, frequency, and duration of service denied.]**

The service or item is not approved as requested because: **[Explain in detail every reason for denial. In addition to explanation for decision, include specific references to approved criteria, rules or protocols on which decision is based. If denied because of insufficient information, identify all additional information needed to render decision.]**

This decision will take effect on [*date*].

To continue getting services:
If you have been receiving the service or item that is being reduced, changed, or denied and you file a complaint, grievance or request for a Fair Hearing (see instructions below) that is postmarked or hand-delivered **within 10 days of the date on this notice**, the service or item will continue until a decision is made.

IF YOU DO NOT AGREE WITH THIS DECISION, YOU MAY DO ONE OR ALL OF THE FOLLOWING:

File a Complaint or Grievance

You may file a complaint or grievance with **[PH-MCO Name] within 45 days from the date you get this notice**. Your complaint or grievance will be decided no later than ( ) days *[PH-MCO: Insert 30 unless PH-MCO will be using a shorter timeframe.]* from when we receive it.

To file a complaint or grievance:

- Call **[PH-MCO Name]** at **[Phone #/Toll-free TTY #]**;
- Fax **[PH-MCO Fax #]**; or
- Send your complaint or grievance to **[PH-MCO Name]** at the following address:

PH-MCO Address for filing complaint or grievance

To ask for an early decision:

If your doctor or dentist believes that waiting ( ) days *[PH-MCO: Insert 30 unless PH-MCO will be using a shorter timeframe.]* to get a decision could harm your health, you may ask that your complaint or grievance be decided more quickly. To do this:

- Call **[PH-MCO Name]** at **[Phone #/Toll-free TTY #];**

AND

- Your doctor or dentist must fax a signed letter to **[PH-MCO fax #]** explaining why taking 30 days to decide your complaint or grievance could harm your health.

[PH-MCO Name] will notify you of the decision within 48 hours from when we receive your doctor's or dentist's letter, or within 3 business days from when we receive your request for an early decision, whichever is sooner.

Request a Fair Hearing

You may ask for a Fair Hearing from the Department of Human Services. Your request for a Fair Hearing must be in writing and must be postmarked **within 30 days from the date on this notice**. Your request should include the following information:

- Your (the Member's) name, social security number, and date of birth;
- A telephone number where you can be reached during the day;
- Whether you want to have a hearing in person or by telephone;
- A copy of this notice.

Your request for a Fair Hearing must be sent to the following address:

Department of Human Services
OMAP – HealthChoices Program
Complaint, Grievance and Fair Hearings
P.O. Box 2675
Harrisburg, PA 17105-2675

The Department will issue a decision between 60 and 90 days from when it receives your request (see your Member handbook for more details).

To ask for an early decision

If your doctor or dentist believes that the usual time frame for deciding your request for a Fair Hearing could harm your health, you may ask that the Fair Hearing take place more quickly. To do this:

- Call the Department at 1-800-798-2339, or fax your request to the Department at 1-717-772-6328
- Your doctor or dentist must fax a signed letter to 717-772-6328 explaining why taking the usual amount of time to decide your request for a Fair Hearing could harm your health. If your doctor or dentist does not send a written letter, your doctor or dentist must testify at the Fair Hearing to explain why taking the usual amount of time to decide your request for a Fair Hearing could harm your health.

The Department will schedule a telephone hearing and notify you of its decision within three business days from when it receives your request.

You have the right to be present either in person or by telephone at the complaint review, grievance review, or Fair Hearing and to bring a family member, friend, lawyer or other person to help you.

If you file a complaint, grievance, or request for a Fair Hearing, you may request all documents relevant to this decision by sending a written request for the information to the following address:

PH-MCO Address for records information

Request Criteria

You may request a copy of the medical necessity criteria or other rules on which the decision was based by sending a written request to:

PH-MCO Name and Address

Get a second opinion

You may get a second opinion from a provider in the **[PH-MCO Name]** network. Call your PCP or **[PH-MCO Name]** at **[Phone #/Toll-free TTY #]** to get a referral for a second opinion. Asking for a second opinion will not extend the time for filing a complaint, grievance, or request for a Fair Hearing, and it will not continue any service or item that you have been receiving.

Get Help with Grievances, Complaints, or Fair Hearings

If you need help filing a grievance, complaint, or request a Fair Hearing, you can call:

- [PH MCO Name] at [Phone #/Toll-free TTY#]

To ask for free legal help with your grievance, complaint, or Fair Hearing, or with filing your grievance, complaint or request for Fair Hearing, you can call:

- Pennsylvania Health Law Project at 1-800-274-3258 (www.phlp.org) <OR>
- Pennsylvania Legal Aid Network at 1-800-322-7572 (www.palegalaid.net)

cc: Prescribing Provider

PH-MCO, the following statement must appear in English, Russian, Cambodian, Vietnamese, Spanish, Chinese, and any other language as required by the contract:]

The information in this notice is available in other languages and formats by calling [PH-MCO Name] at [Phone #/Toll-free TTY #].

EXHIBIT N(3)

STANDARD DENIAL NOTICE – APPROVAL OF DIFFERENT SERVICE/ITEM

[DATE] [This MUST be the date the notice is mailed]

RE: [*Member's name and DOB*]

Dear **[Member Name]:**

[PH-MCO Name] has reviewed the request for **[*identify SPECIFIC service/item*]** submitted by **[*prescriber's name*]** on behalf of **[*patient name*]** on **[*date*]**. After physician review, the request for service/item is:

> Denied as requested, but the following service/item is approved: **[Describe the specific service/item approved, including the level, frequency, and duration of service.]**

A different service or item is approved because: **[Explain in detail every reason for denial. In addition to explanation for decision, include specific references to approved criteria, rules or protocols on which decision is based. If denied because of insufficient information, identify all additional information needed to render decision.]**

This decision will take effect on [*date*].

To continue getting services:
If you have been receiving the service or item that is being reduced, changed, or denied and you file a complaint, grievance or request for a Fair Hearing (see instructions below) that is postmarked or hand-delivered **within 10 days of the date on this notice**, the service or item will continue until a decision is made.

IF YOU DO NOT AGREE WITH THIS DECISION, YOU MAY DO ONE OR ALL OF THE FOLLOWING:

File a Complaint or Grievance

You may file a complaint or grievance with **[PH-MCO Name] within 45 days from the date you get this notice**. Your complaint or grievance will be decided no later than ( ) days *[PH-MCO: Insert 30 unless PH-MCO will be using a shorter timeframe.]* from when we receive it.

To file a complaint or grievance:

- Call **[PH-MCO Name]** at **[Phone #/Toll-free TTY #]**;

- Fax **[PH-MCO Fax #]**; or
- Send your complaint or grievance to **[PH-MCO Name]** at the following address:

PH-MCO Address for filing complaint or grievance

To ask for an early decision:

If your doctor or dentist believes that waiting ( ) days *[PH-MCO: Insert 30 unless PH-MCO will be using a shorter timeframe.]* to get a decision could harm your health, you may ask that your complaint or grievance be decided more quickly. To do this:

- Call **[PH-MCO Name]** at **[Phone #/Toll-free TTY #];**

AND

- Your doctor or dentist must fax a signed letter to **[PH-MCO fax #]** explaining why taking 30 days to decide your complaint or grievance could harm your health.

[PH-MCO Name] will notify you of the decision within 48 hours from when we receive your doctor's or dentist's letter, or within 3 business days from when we receive your request for an early decision, whichever is sooner.

Request a Fair Hearing

You may ask for a Fair Hearing from the Department of Human Services. Your request for a Fair Hearing must be in writing and must be postmarked **within 30 days from the date on this notice**. Your request should include the following information:

- Your (the Member's) name, social security number, and date of birth;
- A telephone number where you can be reached during the day;
- Whether you want to have a hearing in person or by telephone;
- A copy of this notice.

Your request for a Fair Hearing must be sent to the following address:

Department of Human Services
OMAP – HealthChoices Program
Complaint, Grievance and Fair Hearings
P.O. Box 2675
Harrisburg, PA 17105-2675

The Department will issue a decision between 60 and 90 days from when it receives your request (see your Member handbook for more details).

To ask for an early decision

If your doctor or dentist believes that the usual time frame for deciding your request for a Fair Hearing could harm your health, you may ask that the Fair Hearing take place more quickly. To do this:

- Call the Department at 1-800-798-2339, or fax your request to the Department at 1-717-772-6328
- Your doctor or dentist must fax a signed letter to 717-772-6328 explaining why taking the usual amount of time to decide your request for a Fair Hearing could harm your health. If your doctor or dentist does not send a written letter, your doctor or dentist must testify at the Fair Hearing to explain why taking the usual amount of time to decide your request for a Fair Hearing could harm your health.

The Department will schedule a telephone hearing and notify you of its decision within three business days from when it receives your request.

You have the right to be present either in person or by telephone at the complaint review, grievance review, or Fair Hearing and to bring a family member, friend, lawyer or other person to help you.

If you file a complaint, grievance, or request for a Fair Hearing, you may request all documents relevant to this decision by sending a written request for the information to the following address:

PH-MCO Address for records information

Request Criteria

You may request a copy of the medical necessity criteria or other rules on which the decision was based by sending a written request to:

PH-MCO Name and Address

Get a second opinion

You may get a second opinion from a provider in the **[PH-MCO Name]** network. Call your PCP or **[PH-MCO Name]** at **[Phone #/Toll-free TTY #]** to get a referral for a second opinion. Asking for a second opinion will not extend the time for filing a complaint, grievance, or request for a Fair Hearing, and it will not continue any service or item that you have been receiving.

Get Help with Grievances, Complaints, or Fair Hearings

If you need help filing a grievance, complaint, or request a Fair Hearing, you can call:

- [PH MCO Name] at [Phone #/Toll-free TTY#]

To ask for free legal help with your grievance, complaint, or Fair Hearing, or with filing your grievance, complaint or request for Fair Hearing, you can call:

- Pennsylvania Health Law Project at 1-800-274-3258 (www.phlp.org) <OR>

- Pennsylvania Legal Aid Network at 1-800-322-7572 (www.palegalaid.net)

cc: Prescribing Provider

PH-MCO, the following statement must appear in English, Russian, Cambodian, Vietnamese, Spanish, Chinese, and any other language as required by the contract:]

The information in this notice is available in other languages and formats by calling [PH-MCO Name] at [Phone #/Toll-free TTY #].

EXHIBIT N(4)

STANDARD BENEFIT LIMIT EXCEPTION (BLE)
DENIAL NOTICE – COMPLETE DENIAL

[DATE] [This MUST be the date the notice is mailed]

RE: [*Member's name and DOB*]

Dear **[Member Name]:**

[PH-MCO Name] has reviewed the benefit limit exception request for **[*identify SPECIFIC service/item*]** submitted by **[*prescriber's name*]** on behalf of **[*patient name*]** on **[*date*]**. After physician review, the request for benefit limit exception is:

Denied completely because***: [Explain in detail every reason for denial. In addition to explanation for decision, include specific references to approved criteria, rules or protocols on which decision is based. If denied because of insufficient information, identify all additional information needed to render decision.]***

This decision will take effect on [*date*].

To continue getting services
If you have been receiving the service or item that is being reduced, changed, or denied and you file a complaint or request for a Fair Hearing (see instructions below) that is postmarked or hand-delivered **within 10 days of the date on this notice**, the service or item will continue until a decision is made.

IF YOU DO NOT AGREE WITH THIS DECISION, YOU MAY DO ONE OR ALL OF THE FOLLOWING:

File a Complaint or Grievance

You may file a complaint or grievance with **[PH-MCO Name] within 45 days from the date you get this notice**. Your complaint or grievance will be decided no later than ( ) days *[PH-MCO: Insert 30 unless PH-MCO will be using a shorter timeframe.]* from when we receive it.

To file a complaint or grievance:

- Call **[PH-MCO Name]** at **[Phone #/Toll-free TTY #]**;
- Fax **[PH-MCO Fax #]**; or
- Send your complaint or grievance to **[PH-MCO Name]** at the following address:

PH-MCO Address for filing complaint or grievance

To ask for an early decision

If your doctor or dentist believes that waiting ( ) days *[PH-MCO: Insert 30 unless PH-MCO will be using a shorter timeframe.]* to get a decision could harm your health, you may ask that your complaint or grievance be decided more quickly. To do this:

- Call **[PH-MCO Name]** at **[Phone #/Toll-free TTY #];**

AND

- Your doctor or dentist must fax a signed letter to **[PH-MCO fax #]** explaining why taking 30 days to decide your complaint or grievance could harm your health.

[PH-MCO Name] will notify you of the decision within 48 hours from when we receive your doctor's or dentist's letter, or within 3 business days from when we receive your request for an early decision, whichever is sooner.

Request a Fair Hearing

INSTRUCTIONS FOR RECIPIENT FAIR HEARING REQUEST

If you have not yet received the service, you may ask for a Fair Hearing from the Department of Human Services. If you have already received the service, then you may ask for a fair hearing if your provider told you, before you got the service, that you would have to pay for the service if an exception was not granted. If your provider did not tell you that you might have to pay for the service, then the provider may not bill you for the service and you should not file an appeal**.**

Your request for a Fair Hearing must be in writing and must be postmarked **within 30 days from the date on this notice**. Your request should include the following information:

- Your (the Member's) name, social security number, and date of birth;
- A telephone number where you can be reached during the day;
- Whether you want to have a hearing in person or by telephone;
- A copy of this notice.

Your request for a Fair Hearing must be sent to the following address:

Department of Human Services
OMAP – HealthChoices Program
Complaint, Grievance and Fair Hearings
P.O. Box 2675
Harrisburg, PA 17105-2675

The Department will issue a decision between 60 and 90 days from when it receives your request (see your Member handbook for more details).

You have the right to be present either in person or by telephone at the complaint review, grievance review, or Fair Hearing and to bring a family member, friend, lawyer or other person to help you.

If you file a complaint, grievance, or request for a Fair Hearing, you may request all documents relevant to this decision by sending a written request for the information to the following address:

PH-MCO Address for records information

To ask for an early decision

If your doctor or dentist believes that the usual time frame for deciding your request for a Fair Hearing could harm your health, you may ask that the Fair Hearing take place more quickly. To do this:

- Call the Department at 1-800-798-2339, or fax your request to the Department at 1-717-772-6328
- Your doctor or dentist must fax a signed letter to 717-772-6328 explaining why taking the usual amount of time to decide your request for a Fair Hearing could harm your health. If your doctor or dentist does not send a written letter, your doctor or dentist must testify at the Fair Hearing to explain why taking the usual amount of time to decide your request for a Fair Hearing could harm your health.

The Department will schedule a telephone hearing and notify you of its decision within three business days from when it receives your request.

The provider may use the provider dispute process in the provider agreement with [PH MCO Name].

Request Criteria

You may request a copy of the benefit limit exception criteria or other rules on which the decision was based by sending a written request to:

PH-MCO Name and Address

Get a second opinion

You may get a second opinion from a provider in the **[PH-MCO Name]** network. Call your PCP or **[PH-MCO Name]** at **[Phone #/Toll-free TTY #]** to get a referral for a second opinion. Asking for a second opinion will not extend the time for filing a complaint, grievance, or request for a Fair Hearing, and it will not continue any service or item that you have been receiving.

Get Help with Grievances, Complaints, or Fair Hearings

If you need help filing a grievance, complaint, or request a Fair Hearing, you can call:

- [PH MCO Name] at [Phone #/Toll-free TTY#]

To ask for free legal help with your grievance, complaint, or Fair Hearing, or with filing your grievance, complaint or request for Fair Hearing, you can call:

- Pennsylvania Health Law Project at 1-800-274-3258 (www.phlp.org) <OR>

- Pennsylvania Legal Aid Network at 1-800-322-7572 (www.palegalaid.net)

INSTRUCTIONS FOR PROVIDER APPEAL

Providers may use the provider dispute resolution process as described in their provider contract with [PH MCO Name].

cc: Prescribing Provider

PH-MCO, the following statement must appear in English, Russian, Cambodian, Vietnamese, Spanish, Chinese, and any other language as required by the contract:]

The information in this notice is available in other languages and formats by calling [PH-MCO Name] at [Phone #/Toll-free TTY #].

EXHIBIT N(5)

STANDARD BENEFIT LIMIT EXCEPTION (BLE)
DENIAL NOTICE – PARTIAL APPROVAL OF REQUESTED SERVICE/ITEM

[DATE] [This MUST be the date the notice is mailed]

RE: [*Member's name and DOB*]

Dear **[Member Name]:**

[PH-MCO Name] has reviewed the benefit limit exception request for **[*identify SPECIFIC service/item*]** submitted by **[*prescriber's name*]** on behalf of **[*patient name*]** on **[*date*]**. After physician review, the request for benefit limit exception is:

> Approved other than as requested as follows: **[Describe the level, frequency, and duration of service approved and the level, frequency, and duration of service denied.]**

The service or item is not approved as requested because: ***[Explain in detail every reason for denial. In addition to explanation for decision, include specific references to approved criteria, rules or protocols on which decision is based. If denied because of insufficient information, identify all additional information needed to render decision.]***

This decision will take effect on [*date*].

To continue getting services
If you have been receiving the service or item that is being reduced, changed, or denied and you file a complaint or request for a Fair Hearing (see instructions below) that is postmarked or hand-delivered **within 10 days of the date on this notice**, the service or item will continue until a decision is made.

IF YOU DO NOT AGREE WITH THIS DECISION, YOU MAY DO ONE OR ALL OF THE FOLLOWING:

File a Complaint or Grievance

You may file a complaint or grievance with **[PH-MCO Name] within 45 days from the date you get this notice**. Your complaint or grievance will be decided no later than ( ) days *[PH-MCO: Insert 30 unless PH-MCO will be using a shorter timeframe.]* from when we receive it.

To file a complaint or grievance:

- Call **[PH-MCO Name]** at **[Phone #/Toll-free TTY #]**;
- Fax **[PH-MCO Fax #]**; or
- Send your complaint or grievance to **[PH-MCO Name]** at the following address:

PH-MCO Address for filing complaint or grievance

To ask for an early decision

If your doctor or dentist believes that waiting ( ) days *[PH-MCO: Insert 30 unless PH-MCO will be using a shorter timeframe.]* to get a decision could harm your health, you may ask that your complaint or grievance be decided more quickly. To do this:

- Call **[PH-MCO Name]** at **[Phone #/Toll-free TTY #];**

AND

- Your doctor or dentist must fax a signed letter to **[PH-MCO fax #]** explaining why taking 30 days to decide your complaint or grievance could harm your health.

[PH-MCO Name] will notify you of the decision within 48 hours from when we receive your doctor's or dentist's letter, or within 3 business days from when we receive your request for an early decision, whichever is sooner.

Request a Fair Hearing

INSTRUCTIONS FOR RECIPIENT FAIR HEARING REQUEST

If you have not yet received the service, you may ask for a Fair Hearing from the Department of Human Services. If you have already received the service, then you may ask for a fair hearing if your provider told you, before you got the service, that you would have to pay for the service if an exception was not granted. If your provider did not tell you that you might have to pay for the service, then the provider may not bill you for the service and you should not file an appeal**.**

Your request for a Fair Hearing must be in writing and must be postmarked **within 30 days from the date on this notice**. Your request should include the following information:

- Your (the Member's) name, social security number, and date of birth;
- A telephone number where you can be reached during the day;
- Whether you want to have a hearing in person or by telephone;
- A copy of this notice.

Your request for a Fair Hearing must be sent to the following address:

Department of Human Services
OMAP – HealthChoices Program
Complaint, Grievance and Fair Hearings
P.O. Box 2675
Harrisburg, PA 17105-2675

The Department will issue a decision between 60 and 90 days from when it receives your request (see your Member handbook for more details).

You have the right to be present either in person or by telephone at the complaint review, grievance review, or Fair Hearing and to bring a family member, friend, lawyer or other person to help you.

If you file a complaint, grievance, or request for a Fair Hearing, you may request all documents relevant to this decision by sending a written request for the information to the following address:

PH-MCO Address for records information

To ask for an early decision

If your doctor or dentist believes that the usual time frame for deciding your request for a Fair Hearing could harm your health, you may ask that the Fair Hearing take place more quickly. To do this:

- Call the Department at 1-800-798-2339, or fax your request to the Department at 1-717-772-6328
- Your doctor or dentist must fax a signed letter to 717-772-6328 explaining why taking the usual amount of time to decide your request for a Fair Hearing could harm your health. If your doctor or dentist does not send a written letter, your doctor or dentist must testify at the Fair Hearing to explain why taking the usual amount of time to decide your request for a Fair Hearing could harm your health.

The Department will schedule a telephone hearing and notify you of its decision within three business days from when it receives your request.

The provider may use the provider dispute process in the provider agreement with [PH MCO Name].

Request Criteria

You may request a copy of the benefit limit exception criteria or other rules on which the decision was based by sending a written request to:

PH-MCO Name and Address

Get a second opinion

You may get a second opinion from a provider in the **[PH-MCO Name]** network. Call your PCP or **[PH-MCO Name]** at **[Phone #/Toll-free TTY #]** to get a referral for a second opinion. Asking for a second opinion will not extend the time for filing a complaint, grievance, or request for a Fair Hearing, and it will not continue any service or item that you have been receiving.

Get Help with Grievances, Complaints, or Fair Hearings

If you need help filing a grievance, complaint, or request a Fair Hearing, you can call:

- [PH MCO Name] at [Phone #/Toll-free TTY#]

To ask for free legal help with your grievance, complaint, or Fair Hearing, or with filing your grievance, complaint or request for Fair Hearing, you can call:

- Pennsylvania Health Law Project at 1-800-274-3258 (www.phlp.org) <OR>
- Pennsylvania Legal Aid Network at 1-800-322-7572 (www.palegalaid.net)

INSTRUCTIONS FOR PROVIDER APPEAL

Providers may use the provider dispute resolution process as described in their provider contract with [PH MCO Name].

cc: Prescribing Provider

PH-MCO, the following statement must appear in English, Russian, Cambodian, Vietnamese, Spanish, Chinese, and any other language as required by the contract:]

The information in this notice is available in other languages and formats by calling [PH-MCO Name] at [Phone #/Toll-free TTY #].

EXHIBIT N(6)

STANDARD BENEFIT LIMIT EXCEPTION (BLE)
DENIAL NOTICE – APPROVAL OF DIFFERENT SERVICE/ITEM

[DATE] [This MUST be the date the notice is mailed]

RE: [*Member's name and DOB*]

Dear **[Member Name]:**

[PH-MCO Name] has reviewed the benefit limit exception request for **[*identify SPECIFIC service/item*]** submitted by **[*prescriber's name*]** on behalf of **[*patient name*]** on **[*date*]**. After physician review, the request for benefit limit exception is:

> Denied as requested, but the following service/item is approved: **[Describe the specific service/item approved, including the level, frequency, and duration of service.]**

A different service or item is approved because: ***[Explain in detail every reason for denial. In addition to explanation for decision, include specific references to approved criteria, rules or protocols on which decision is based. If denied because of insufficient information, identify all additional information needed to render decision.]***

This decision will take effect on [*date*].

To continue getting services
If you have been receiving the service or item that is being reduced, changed, or denied and you file a complaint or request for a Fair Hearing (see instructions below) that is postmarked or hand-delivered **within 10 days of the date on this notice**, the service or item will continue until a decision is made.

IF YOU DO NOT AGREE WITH THIS DECISION, YOU MAY DO ONE OR ALL OF THE FOLLOWING:

File a Complaint or Grievance

You may file a complaint or grievance with **[PH-MCO Name] within 45 days from the date you get this notice**. Your complaint or grievance will be decided no later than ( ) days *[PH-MCO: Insert 30 unless PH-MCO will be using a shorter timeframe.]* from when we receive it.

To file a complaint or grievance:

- Call **[PH-MCO Name]** at **[Phone #/Toll-free TTY #]**;
- Fax **[PH-MCO Fax #]**; or
- Send your complaint or grievance to **[PH-MCO Name]** at the following address:

PH-MCO Address for filing complaint or grievance

To ask for an early decision

If your doctor or dentist believes that waiting ( ) days *[PH-MCO: Insert 30 unless PH-MCO will be using a shorter timeframe.]* to get a decision could harm your health, you may ask that your complaint or grievance be decided more quickly. To do this:

- Call **[PH-MCO Name]** at **[Phone #/Toll-free TTY #];**

AND

- Your doctor or dentist must fax a signed letter to **[PH-MCO fax #]** explaining why taking 30 days to decide your complaint or grievance could harm your health.

[PH-MCO Name] will notify you of the decision within 48 hours from when we receive your doctor's or dentist's letter, or within 3 business days from when we receive your request for an early decision, whichever is sooner.

Request a Fair Hearing

INSTRUCTIONS FOR RECIPIENT FAIR HEARING REQUEST

If you have not yet received the service, you may ask for a Fair Hearing from the Department of Human Services. If you have already received the service, then you may ask for a fair hearing if your provider told you, before you got the service, that you would have to pay for the service if an exception was not granted. If your provider did not tell you that you might have to pay for the service, then the provider may not bill you for the service and you should not file an appeal**.**

Your request for a Fair Hearing must be in writing and must be postmarked **within 30 days from the date on this notice**. Your request should include the following information:

- Your (the Member's) name, social security number, and date of birth;
- A telephone number where you can be reached during the day;
- Whether you want to have a hearing in person or by telephone;
- A copy of this notice.

Your request for a Fair Hearing must be sent to the following address:

Department of Human Services
OMAP – HealthChoices Program
Complaint, Grievance and Fair Hearings

P.O. Box 2675
Harrisburg, PA 17105-2675

The Department will issue a decision between 60 and 90 days from when it receives your request (see your Member handbook for more details).

You have the right to be present either in person or by telephone at the complaint review, grievance review, or Fair Hearing and to bring a family member, friend, lawyer or other person to help you.

If you file a complaint, grievance, or request for a Fair Hearing, you may request all documents relevant to this decision by sending a written request for the information to the following address:

PH-MCO Address for records information

To ask for an early decision

If your doctor or dentist believes that the usual time frame for deciding your request for a Fair Hearing could harm your health, you may ask that the Fair Hearing take place more quickly. To do this:

- Call the Department at 1-800-798-2339, or fax your request to the Department at 1-717-772-6328
- Your doctor or dentist must fax a signed letter to 717-772-6328 explaining why taking the usual amount of time to decide your request for a Fair Hearing could harm your health. If your doctor or dentist does not send a written letter, your doctor or dentist must testify at the Fair Hearing to explain why taking the usual amount of time to decide your request for a Fair Hearing could harm your health.

The Department will schedule a telephone hearing and notify you of its decision within three business days from when it receives your request.

The provider may use the provider dispute process in the provider agreement with [PH MCO Name].

Request Criteria

You may request a copy of the benefit limit exception criteria or other rules on which the decision was based by sending a written request to:

PH-MCO Name and Address

Get a second opinion

You may get a second opinion from a provider in the **[PH-MCO Name]** network. Call your PCP or **[PH-MCO Name]** at **[Phone #/Toll-free TTY #]** to get a referral for a second opinion. Asking for a second opinion will not extend the time for filing a

complaint, grievance, or request for a Fair Hearing, and it will not continue any service or item that you have been receiving.

Get Help with Grievances, Complaints, or Fair Hearings

If you need help filing a grievance, complaint, or request a Fair Hearing, you can call:

- [PH MCO Name] at [Phone #/Toll-free TTY#]

To ask for free legal help with your grievance, complaint, or Fair Hearing, or with filing your grievance, complaint or request for Fair Hearing, you can call:

- Pennsylvania Health Law Project at 1-800-274-3258 (www.phlp.org) <OR>
- Pennsylvania Legal Aid Network at 1-800-322-7572 (www.palegalaid.net)

INSTRUCTIONS FOR PROVIDER APPEAL

Providers may use the provider dispute resolution process as described in their provider contract with [PH MCO Name].

cc: Prescribing Provider

PH-MCO, the following statement must appear in English, Russian, Cambodian, Vietnamese, Spanish, Chinese, and any other language as required by the contract:]

The information in this notice is available in other languages and formats by calling [PH-MCO Name] at [Phone #/Toll-free TTY #].

EXHIBIT N(7)

REQUEST FOR ADDITIONAL INFORMATION LETTER

[Date Letter Mailed (Date of Request for additional information)]

Member Name
Address
City, State Zip

Member ID: **********

Subject: Request for Additional Information from Your Provider

Dear [Member Name]:

[PH-MCO Name] received a request for **[describe specific services/items]** from **[provider name]** on **[date received]**.

In order to decide if this service is Medically Necessary for you, **[PH-MCO Name]** has requested the following additional information from your provider by **[date]:**

[List specific information requested]

[PH-MCO Name] will make a decision on the requested services within 2 business days after receiving the additional information from your provider. **[PH-MCO Name]** will notify you in writing within 2 business days after making its decision.

If we do not receive the additional information within 14 days, the decision to approve or deny the service will be made, based on the available information. **[PH-MCO Name]** will notify you in writing within 2 business days after we should have received the additional information.

If you have any questions, please contact Member Services at **[PH-MCO Phone #/Toll-free TTY #]**.

Sincerely,

[PH-MCO Name]

cc: prescribing provider

[PH-MCO, the following statement must appear in English, Russian, Cambodian, Vietnamese, Spanish, Chinese, and any other language as required by the contract].

The information in this notice is available in other languages and formats by calling [PH-MCO Member service's #/Toll-free TTY #].

EXHIBIT O

Description of Facilities and Related Services

Intermediate Care Facility For Individuals with Intellectual Disabilities And Other Related Conditions (ICF/ID/ORCs)

The PH-MCO is responsible to provide the full range of Physical Health Services to Members residing in private ICF/ID/ORC, except that the PH-MCO is not responsible to provide services to a Recipient to the extent services are covered under the facility's per diem payment. The PH-MCO is also not responsible to provide any services determined to fall under the scope of Behavioral Health Services or are the responsibility of the BH-MCO.

Residential Treatment Facility (RTF)

The PH-MCO is responsible to provide the full range of Physical Health Services to Members residing in RTFs. The PH-MCO is not responsible to provide any services that are currently covered under the facility's per diem payment. The PH-MCO is also not responsible to provide any services determined to fall under the scope of Behavioral Health Services or are the responsibility of the BH-MCOs.

Extended Acute Psychiatric Facility

The PH-MCO is responsible to provide the full range of physical health services to Members residing in extended acute psychiatric facilities. The PH-MCO is not responsible to provide any services that are currently covered under the facilities per diem payment. The PH-MCO is also not responsible to provide any services that are determined to fall under the scope of Behavioral Health Services or are the responsibility of the BH-MCOs.

Non-Hospital Residential Detoxification, Rehabilitation, and Half-Way House Facilities for Drug/Alcohol Dependence/ Addiction

The PH-MCO is responsible to provide the full range of physical health services to Members admitted to non-hospital residential detoxification, rehabilitation and halfway house facilities for drug/alcohol dependence/addiction. The PH-MCO is not responsible to provide any services that are currently covered under the facilities per diem payment. The PH-MCO is also not responsible to provide any services that are determined to fall under the scope of Behavioral Health Services or are the responsibility of the BH-MCOs.

Area Agencies on Aging (AAA)/OPTIONS Assessment and Pre-admission Screening Requirements

An OPTIONS Assessment must be completed to assess an individual's need for Nursing Facility services. The PH-MCO must contact the county AAA to initiate the OPTIONS assessment. This must occur prior to a Member's admission to a Nursing Facility. The PH-MCO must abide by the decision of the OPTIONS assessment related to the need for Nursing Facility services. The PH-MCO is not responsible for providing or paying for the OPTIONS assessment.

The PH-MCO must also comply with pre-admission screening requirements contained in 42 U.S.C. Section 1396r(e)(7) and 42 CFR 483.100-483.138 regarding individuals with Mental Retardation/Other Related Conditions or mental illness.

Pennsylvania Department of Aging (PDA) Waiver

The PDA waiver targets individuals age 60 and older who require Nursing Facility services, but who can safely be served in a community setting. However, the costs for this care may not exceed 80% of the average cost of a Nursing Facility. Individuals wishing to enter the waiver program must meet the current financial waiver requirements (300% of the SSI federal benefit rate) and choose to receive services in their own home or other community settings.

The PDA waiver program is operated by the AAA in selected counties in the HealthChoices Zone. It is the responsibility of the AAA to notify the PH-MCO should one of their Members become eligible for the PDA waiver program. The PH-MCO will remain financially responsible for the Member and continue to provide medical services, including waiver program medical services, for 30 consecutive days from the date the Member becomes eligible for the PDA waiver services. However, the PH-MCO will not be responsible for non-medical PDA waiver services during this 30 consecutive day period. The Member will then be disenrolled from the PH-MCO.

The PH-MCO must coordinate all requested medical services with the AAA to ensure continuity, as well as quality of care and to avoid duplication of services.

Members Admitted to Juvenile Detention Centers (JDCs)

Any child receiving MA benefits will continue to receive those benefits during placement in a JDC. Children enrolled in a PH-MCO prior to placement at a JDC either inside or outside the HealthChoices Zone will continue to be covered by the PH-MCO from the date of placement for a maximum of 35 consecutive days. The child will be disenrolled from the PH-MCO after the 35th consecutive day of placement. During the 35 consecutive days, MA eligible services provided to the child on-site at the JDC will be covered under the Medical Assistance Fee-for-Service Program. Any services that are covered by the PH-MCO and provided outside of the JDC site are the responsibility of the PH-MCO. Should a child either be voluntarily disenrolled from a PH-MCO or become ineligible for enrollment due to a change in status, coverage of the child will remain consistent with enrollment

policies. If during the period of placement the child transfers from one PH-MCO to another, the child will receive benefits through the new PH-MCO from the new PH-MCO effective date through the 35th consecutive day of placement.

A child already residing in a JDC will not be permitted to newly enroll in a PH-MCO until after release from the JDC. All other applicable coverage rules will apply.
EPSDT screening results or other health care needs detected during the period of the JDC placement should be reported to the effective PH-MCO. Should a covered service be identified that cannot be provided at the JDC site, the JDC must contact the PH-MCO in order to arrange for the covered service to be provided.

Dual Eligibles (Medicare/Medicaid) under the age of twenty - one

Recipients, under the age of twenty-one who receive both Medicare as their primary health care coverage and Medicaid (MA) as a supplemental coverage, will be required to enroll in the HealthChoices Program and choose both a PH-MCO and PCP within the PH-MCO. See Section V.F., Member Enrollment and Disenrollment, of the Agreement for enrollment information into HealthChoices Zone.

Due to their Medicare eligibility, many of these recipients may require special assistance with the coordination of their Medicare/Medicaid benefits. Therefore, these dually eligible Recipients are classified as having Special Needs and should fall under the guidelines outlined in Section V.P., Special Needs Unit (SNU), of the Agreement.

Recipients who are dually eligible are not required to go to their PH-MCO for services that are covered by Medicare. If appropriate, Recipients who are Dual Eligible are required to comply with the PH-MCO's referral and authorization requirements if they have exhausted their Medicare benefit for a Medicare covered service.

The PH-MCO is responsible to provide prescriptions written by Medicare Providers for a Member as long as the Member goes to a pharmacy within the PH-MCO's Provider Network. Prescription coverage for Recipients who are dually eligible is subject to the PH-MCO's authorization protocols, with the exception of drugs covered by Medicare. In addition, the provisions outlined in Section V.B., Prior Authorization of Services, of this Agreement, will apply.

The PH-MCO's financial responsibility for Dual Eligibles is outlined in Section VII. of the Agreement.

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EXHIBIT P

OUT-OF-PLAN SERVICES

Out of Plan Services include, but are not limited to:

A) Transitional Care Homes

The PH-MCO will only be responsible to provide medical services to children upon the child leaving the transitional care home to reside with family or other caretakers living within the HealthChoices Zone. The PH-MCO must ensure continuity of care, as well as coordination with necessary Providers and interagency teams once they are notified that the child has become enrolled in the PH-MCO.

B) Medical Foster Care Services

Medical foster care services are provided to children with special or chronic medical conditions or physical disabilities in the custody of the County Children and Youth Agency and placed in foster family care. Medical foster care services enable the child to be treated by a licensed practitioner on an outpatient rather than an inpatient or institutional basis. Medical foster care services include both supportive and supervisory activities as well as direct care of children. Such tasks include but are not limited to: medical management, nutritional care, hygiene and personal care and developmental education

Medical foster care services are provided by both county and private children and youth social service agencies. The foster parents who are under contract with the agency provide direct care. The licensed foster care agency is enrolled as a Provider Type 40, Specialty 400, Medically Fragile Foster Care, and claims reimbursement is through the Medical Assistance Fee-for-Service Program according to the maximum daily fees for the four levels of medical foster care as established by the Office of Medical Assistance Programs. Even though the PH-MCO is responsible to provide Medically Necessary services to children residing in medical foster care homes, the PH-MCO is not responsible for the medical foster care services identified in the four levels of care. These four levels of medical foster care are described as Level(s) I - IV with each level progressively requiring increased care.

- Level I
    - The Child has one or more medical conditions or physical disabilities that can be relieved, alleviated, or controlled by a regimen of medical supervision and consistent non-specialized care. No life threatening situations are anticipated.
    - Some specialized training may be required for the foster parent to care for the child, such as the preparation and control of special diets and the administration of non-oral medications.

    - Wheel chairs, ramps, and/or prostheses may be required but sophisticated technological equipment usually will not be necessary. Few special medical supplies are necessary.
- Level II
    - The child has one or more acute medical conditions or physical disabilities that can be relieved, alleviated, or controlled by specialized intervention and a regimen of medical supervision and consistent care. No immediate life threatening situations are anticipated.
    - Some special medical procedures training may be required for the foster parent for the management of tracheostomies, ileostomies, NG feeding tubes, catheters, etc.
    - Use of sophisticated technological equipment will be minimal. Some special medical supplies will be necessary.
    - The child will usually require special therapeutic interventions and special social, educational, and vocational planning.
- Level III
    - The child has a combination of acute temporary, chronic, or permanent medical conditions or physical disabilities which require intensive, home-based medical intervention on a constant basis to sustain life. Life threatening situations are anticipated.
    - Considerable special medical procedures training will be required for the foster parent.
    - Use of sophisticated technological equipment will be necessary. Special medical supplies will be necessary.
    - Because the child will usually be home-bound, all developmental areas will require special planning.
- Level IV
    - The child has a combination of acute, chronic, or permanent medical conditions or physical disabilities whose life can be sustained only by intensive, home-based medical intervention on a 24-hour basis. Life threatening situations are constantly present.
    - Extensive special medical procedures training will be required for the foster parent.
    - Use of a variety of sophisticated technological equipment will be necessary. Special medical supplies will be necessary.
    - Because the child will be home-bound, all developmental areas will require special planning.

When children in the custody of the County Children and Youth Agency are placed in medical foster care homes, the PH-MCO's Special Needs Unit must work with the medical foster care agency to ensure that necessary medical and ancillary services are provided in the amount and level that enable the child to be maintained in the foster care home and minimize hospitalization/institutionalization of the child.

C) Early Intervention Services

An infant or toddler may receive services under both the HealthChoices Program and the Early Intervention Program, but the services are separate and distinct.

The HealthChoices Program consists of Medically Necessary services prescribed by the Primary Care Practitioner. Early intervention services consist of a range of family-centered habilitation services and supports as defined by each family's individualized family service plan.

D) OLTL/OBRA Waiver: The Home and Community Based Waiver Program

This program provides services to people with developmental physical disabilities to allow them to live in the community and remain as independent as possible.

The Department's Office of Long-Term Living, (OLTL) currently operates a Home and Community-Based Waiver that provides services to Pennsylvania residents age 18 and older with a severe developmental physical disability requiring an Intermediate Care Facility / Other Related Conditions (ICF/ORC) level of care. The disability must result in substantial functional limitations in three or more of the following major life activities: mobility, communication, self-care, self-direction, capacity for independent living, and learning.

Other related conditions (ORCs) include physical, sensory, or neurological disabilities which manifested before age 22, are likely to continue indefinitely, and result in substantial functional limitations in three or more of the following areas of major life activity: capacity for independent living, mobility, self-direction, learning, understanding and use of language, and self-care.

Recipients receiving these home and community based services through the OLTL/ OBRA Waiver will be enrolled in the HealthChoices Program. The PH-MCO is responsible for providing all medically necessary state plan services to these individuals PRIOR TO services being covered under the OLTL/ OBRA Waiver. The PH-MCO must coordinate with the waiver service providers to promote a seamless continuum of care. The PH-MCO is not responsible to provide any medical services that are determined to fall under the scope of Behavioral Health Services or is the responsibility of the Behavioral Health MCOs. A description of these services is addressed in the MA Eligibility Handbook.

E) OLTL - Independence Waiver

The Independence Waiver is a Home and Community Based waiver program administered through the Office of Long-Term Living that provides services to persons with physical disabilities to allow them to live in the community and remain as independent as possible. The waiver covers Pennsylvania residents aged 18-59 who are physically disabled (but not with intellectual disabilities or have a major mental disorder as a primary diagnosis), who reside in a Nursing Facility (NF) or the community but who have been assessed to require services

at the level of nursing facility level of care. In addition, the disability must result in substantial functional limitations in three or more of the following major life activities: Self-care, understanding and use of language, learning, mobility, self-direction and/or capacity for independent living.

Recipients receiving these home and community based services through the OLTL Independence Waiver will be enrolled in the HealthChoices Program. The PH-MCO is responsible for providing all medically necessary state plan services to these individuals PRIOR TO services being covered under the OLTL/ Independence Waiver. The PHMCO must coordinate with the waiver service providers to promote a seamless continuum of care. The PH-MCO is not responsible to provide any medical services that are determined to fall under the scope of Behavioral Health Services or are the responsibility of the Behavioral Health MCOs.

F) The Home and Community Based Waiver Program for Attendant Care Services (OLTL/AC Waiver)

The Department's Office of Long-Term Living currently operates a Home and Community Based Services Waiver which provides attendant care to mentally alert adults 18 through 59 years of age with physical disabilities who require nursing facility level of care but who choose to remain in their own home or community living arrangement.

Recipients receiving these home and community-based services through the OLTL /AC Waiver will be enrolled in the HealthChoices Program. The PH-MCO is responsible for providing all medically necessary state plan services to these individuals PRIOR TO services being covered under the OLTL/ AC Waiver. The PH-MCO must coordinate with the waiver service providers to promote a seamless continuum of care. The PH-MCO is not responsible to provide any medical services that are determined to fall under the scope of Behavioral Health Services or are the responsibility of the Behavioral Health MCOs.

G) Office of Developmental Programs (ODP) Waivers: Person/Family Directed Support Waiver (P/FDS) and Consolidated Waiver

The Home and Community Based Waiver Program for Persons with Intellectual Disabilities: The Department's Office of Developmental Programs currently operates the Home and Community Based Services Waivers (P/FDS and Consolidated) which provides services to individuals with intellectual disabilities in their homes and communities who would otherwise need care in an Intermediate Care Facilities for Persons with Intellectual Disabilities (ICF/ID/Other Related Conditions ORC).

Recipients receiving community based services through these waivers will be enrolled in the HealthChoices Program. The PH-MCO is responsible for

providing all medically necessary state plan services to these individuals PRIOR TO services being covered under the ODP Waivers. The PH-MCO must coordinate with the waiver service providers to promote a seamless continuum of care. The PH-MCO is also not responsible to provide any medical services that fall under the scope of Behavioral Health Services, or are the responsibility of the Behavioral Health MCOs. A description of these services is addressed in the MA Eligibility Handbook .

H) OLTL COMMCARE Waiver - The Home and Community Based Waiver Program for Persons with a Primary Diagnosis of Traumatic Brain Injury

The Department's Office of Long-Term Living operates a Home and Community-Based Waiver that provides services in the community to persons age twenty-one (21) and older who experience a medically determinable diagnosis of traumatic brain injury and require a nursing facility level of care.

Recipients receiving community based services through this waiver will be enrolled in the HealthChoices Program. The PH-MCO is responsible for providing all medically necessary state plan services to these individuals PRIOR TO services being covered under the COMMCARE Waiver. The PH-MCO must coordinate with the waiver service providers to promote a seamless continuum of care. The PH-MCO is also not responsible to provide any medical services that fall under the scope of Behavioral Health Services, or are the responsibility of the Behavioral Health MCOs. A description of these services is addressed in the MA Eligibility Handbook .

I) ODP Autism Waiver: The Home and Community Based Waiver program for Persons with Autism Spectrum Disorder.

The Adult Autism Waiver is a Home and Community Based Waiver program. The Office of Developmental Programs administrates this waiver which provides home and community based services specifically designed to help adults, 21 and older, who possess an autism spectrum disorder. The overriding goal of the Waiver is to aid the recipients with participation in their communities in the manners which they desire.

Recipients receiving community based services through this waiver will be enrolled in the HealthChoices Program. The PH-MCO is responsible for providing all medically necessary state plan services to these individuals PRIOR TO services being covered under the Autism. The PH-MCO must coordinate with the waiver service providers to promote a seamless continuum of care. The PH-MCO is also not responsible to provide any medical services that fall under the scope of Behavioral Health Services, or are the responsibility of the Behavioral Health MCOs. A description of these services is addressed in the MA Eligibility Handbook.

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EXHIBIT Q

SAMPLE MODEL AGREEMENT

This sample model Agreement is illustrative only and is designed for use by the county children and youth agencies, but can be adapted by other community agencies. Letters of Agreement must contain the information found in Exhibit S, Written Agreements Between PH-MCO and Service Providers.

[COUNTY AGENCY]/OFFICE

HEALTH SERVICES COORDINATION AGREEMENT

This County Office Health Services Coordination Agreement is entered into and effective this _____ day of _____, _____, by and between [Plan], a corporation, and the [County Agency] for _____ County, and the _____ Office of _____ County, Pennsylvania (collectively [County Agency]).

WHEREAS, [Plan], a licensed health maintenance organization in the Commonwealth of Pennsylvania, has entered into an agreement with the Pennsylvania Department of Human Services ("DHS") to furnish Medical Assistance-covered services ("covered services") to Medical Assistance (MA) recipients under the [Plan] Medical Assistance product (MA product"), in accordance with the Commonwealth's Medical Assistance programs, and in accordance with the agreements between [Plan] and DHS ("MA Agreements"); and

WHEREAS, [Plan] and [County Agency] wish to ensure that Medical Assistance recipients who are children in substitute care ("MA covered persons"), and served by the parties, receive the necessary and appropriate covered services; and

WHEREAS, since covered services can be delivered more efficiently and more timely if [County Agency] and [Plan] coordinate the identification and treatment of MA covered persons, DHS requires that [Plan] enter into agreements with county agencies] and county offices to set forth the terms on which they will coordinate the delivery of covered services to MA covered persons; and

WHEREAS, the parties explicitly acknowledge, understand and agree that the common purpose of this cooperative relationship is to ensure that access to covered services and the quality of covered services provided will not be diminished or compromised because of an MA covered person's placement in substitute care.

NOW, THEREFORE, in consideration of the mutual covenants and premises, and for other good and valuable consideration, and intending to be legally bound, the parties agree as follows:

1.0 DEFINITIONS

For the purposes of this Agreement, the following terms shall have the meanings set forth below:

1.1 **Covered Services** means those health care services MA covered persons are entitled to receive under the state and federal law. It also means those services that a PH-MCO is required to provide under its agreement with the Department of Human Services to MA covered persons.

1.2 **DOH** means the Pennsylvania Department of Health.

1.3 **DHS** means the Pennsylvania Department of Human Services.

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

1.5 **EPSDT** means the Early and Periodic Screening, Diagnosis, and Treatment Program that provides medical services for individuals under the age of 21 administered under the Medical Assistance Program.

1.6 **MA Covered Person** means: (1) any Medical Assistance recipient that (a) is under the age of 18; or (b) over the age of 18 up to age 21 and under the jurisdiction of [County Agency] care and custody; <u>and</u> (2) for whom [Plan] and [County Agency] have agreed to coordinate the provision of covered services.

1.7 **Medical Assistance (MA)** means the Medical Assistance Program authorized by Title XIX of the federal Social Security Act, 42 U.S.C. §1396 *et seq*., and regulations promulgated thereunder, and Title 62, Chapter 1, Article 4 of the Pennsylvania Statutes and regulations promulgated thereunder.

1.8 **MA Agreements** means the contracts between [Plan] and DHS under any of Pennsylvania's Medical Assistance managed care programs, including DHS's HealthChoices Program, pursuant to which [Plan] arranges for the provision of certain services covered by Medical Assistance to MA covered persons.

1.9 **MA Product** means [Plan's] Medical Assistance HMO product.

1.10 **MA Recipient** means an individual eligible to receive services under Pennsylvania's MA Program, including the HealthChoices Managed Care Program, and is enrolled in the MA product.

1.11 **Medically Necessary** means that condition or procedure defined as medically necessary by DHS as delineated in DHS's HealthChoices Agreement between the [Plan] and DHS.

1.12 **PID** means the Pennsylvania Insurance Department.

Terms not defined hereinabove shall be given the meanings ascribed to them in the MA Agreements or the RFP.

2.0 MUTUAL [PLAN] AND [COUNTY AGENCY] OBLIGATIONS RELATIVE TO COORDINATION OF CARE

2.1 The parties, and their liaisons where applicable agree to communicate with the MA covered person's Primary Care Physicians (PCPs), coordinate services, exchange relevant enrollment and individual health-related information and services needs of MA covered persons, including the institution of a process to monitor such activity, and a process to monitor the quality management and utilization management responsibilities of each party.

2.2 The parties agree to develop policies, within 60 days of the effective date, on referral, collaboration, and coordination of diagnostic assessment and treatment, prescribing practices, continuity of care, and other treatment issues necessary for optimal health and disease prevention, including policies on coordination of specialized service plans for MA covered persons with special health needs.

2.3 The parties agree to interact with the PCPs for prompt treatment and coordination of care.

2.4 The parties agree to jointly monitor the quality of the covered services delivered.

2.5 The parties agree to work cooperatively to establish programmatic responsibility for each MA covered person.

2.6 The parties agree to serve on interagency teams, when requested by either of the parties hereto.

2.7 The parties agree to cooperate in the coordination of covered services with the applicable Behavioral Health Managed Care Organizations in the HealthChoices Zone (HC Zone), including Pharmacy Coordination, to the extent permitted by law**.**

2.8 Where the parties have identified an issue, the parties mutually agree to undertake intensive outreach efforts to MA covered persons identified as needing covered services.

2.9 To assure the effectiveness of this Agreement and the services provided hereunder, the parties will review the Agreement for accuracy at least [insert time frame] or, if necessary, more often. Additionally, the parties agree to set up a

forum to discuss opportunities to assess training needs, consultation, and sharing of information between the parties to facilitate the cost-effective use of resources. The parties also agree to meet [insert time frame], or as requested by either party, to resolve any outstanding issues existing between them.

2.10 The parties agree to assist, when appropriate, in the development of an adequate provider network to serve special needs populations.

2.11 The parties agree to develop and implement a work plan to address issues or actions so as to bring said issues and actions into compliance with the term(s) of this Agreement.

2.12 The parties agree to adhere to the Americans with Disabilities Act, as amended, and the Rehabilitation Act of 1973.

2.13 The parties agree to collaborate on identifying and reducing the frequency of fraud, abuse, over use, under use, and inappropriate or unnecessary medical care.

2.14 The parties will work cooperatively to develop processes to ensure that:

(i) The [County Agency] caseworker will contact a participating provider or attempt to contact the PCP, when the [County Agency] caseworker can identify the PCP, when admission or discharge physical examinations are required due to the initial placement or discharge of an MA covered person or if the MA covered person is relocated. When it is not possible to contact the PCP, the [County Agency] shall coordinate with the plan's Special Needs Unit to arrange to use other providers within the [Plan's] network. In cases of suspected abuse, [County Agency] shall contact the appropriate medical provider for the examination without having to obtain prior approval from the PCP or [Plan]. If the enrollment of the MA recipient cannot be determined at the time the exam is required, the exam may be performed in an emergency room or through a provider affiliated with [County Agency]. Within 24 hours, or as soon as it can be reasonably determined that the MA recipient is eligible for the MA Product and eligible to be an MA covered person, [County Agency] will notify [Plan's] Special Needs Unit and/or the PCP in order that necessary follow-up care can be coordinated.

(ii) Information related to suspected abuse cases obtained from a PCP or [Plan] provider, including diagnostic tests, is shared with [County Agency].

(iii) Physical assessments needed by the MA covered persons entering emergency shelters are being performed within the time frames established by law. The same procedure set forth in 2.14(i) above applies.

(iv) Medically necessary home health services are being provided to MA covered persons in medical foster care.

(v) [County Agency] will be notified by [Plan] of denial of services to MA covered persons, including explicit steps on how to file an appeal, which has the right to file, and how denials will be processed.

2.15 [Plan] and [County Agency] will work together to determine the post-discharge needs of any MA covered person placed in substitute care, and to develop a care plan that will maintain continuity of care through the MA covered person's transition from substitute care to home.

2.16 [Plan] and [County Agency] will work together to develop policies and procedures on the identification of individuals who have the authority to represent MA covered persons to request PCP selections and changes; receive MA covered person information including identification cards, MA covered person notices, or filing MA covered person complaints, grievances or appeals on behalf of the MA covered persons.

2.17 [Plan] and [County Agency] will work together to develop and implement joint education and training programs related to requirements of both. This training will be provided to [County Agency] caseworkers, staff, or private agencies and [Plan's] Special Needs Unit staff and participating providers throughout the implementation of HealthChoices and as specific needs are identified.

2.18 [Plan] and [County Agency] will cooperate in the identification of opportunities for improvement of processes or procedures identified in this Agreement and the need for additional processes or procedures. At a minimum, representatives from [Plan] and [County Agency] will meet to discuss identified opportunities and to establish a work plan to address those issues. This process will be coordinated through the designated contact persons.

2.19 [Plan] shall provide to [County Agency] at [County Agency's] address set forth hereinafter, any notification that [Plan] is required to provide to MA covered persons, in lieu of providing it to MA covered persons, and [County Agency] shall then be obligated to provide any such notification to MA covered persons, and MA covered persons' caretaker, provider, or guardian.

2.20 [County Agency] and [Plan] shall cooperate with each other and shall share medical information for children entering placement who are covered persons and if appropriate.

3.0. <u>[PLAN] OBLIGATIONS</u>

3.1 [Plan] will be responsible for the payment of physical health services as set forth in the RFP, including eye care, dental care, hearing exams, and immunizations. [Plan] shall not be obligated to pay for medical services currently covered by Fee-For-Service Medical Assistance and for which [County Agency] contracts directly with providers of medical care. [Plan] shall not be obligated to pay for medical services for children who are not MA covered persons. Medical services provided to children who are currently being evaluated for Medicaid eligibility

shall be paid for by DHS under Fee-For-Service Medical Assistance programs. [Plan] shall not be obligated to pay for inpatient hospital days that are not a medical necessity, as determined by [Plan], including the situation where [County Agency] is in the process of placing the child in a foster or similar home and is having difficulty doing so. [Plan] shall not be obligated to pay for psychological evaluations for any purpose whatsoever.

3.2 [Plan] shall be responsible to provide or arrange for the provision of medically necessary covered services to any MA covered person upon his or her discharge from substitute care to his/her family or other primary caretaker (i.e. legal guardian), provided that the MA covered person is discharged to a location in the HC Zone.

3.3 [Plan] has a Special Needs Unit that will deal, in a timely manner, with issues relating to MA covered persons with special needs.

3.4 [Plan] shall identify a contact person for coordination with [County Agency] and further shall define the roles and responsibilities of the contact person to address mass change situations such as enrollment and incorrect PCP designations, which affect all MA covered persons, and individual requirements such as emergency physical exams, PCP selections or change, or EPSDT screens that are due.

3.5 For MA covered persons with complex medical needs, the designated contact person at [Plan's] Special Needs Unit will coordinate requests for specialists to serve as PCP with the contact person at [County Agency]. The procedures will include a timeline for submission of requests, tracking of requests, and decisions on requests. The procedures will include the selection of an accessible PCP until a decision has been provided. If the request has been denied, any request for a change in PCP will be coordinated with the [County Agency] contact person.

3.6 [Plan] shall coordinate notification and scheduling of EPSDT screens that are due with the [County Agency] contact person or the appropriate foster parent if [County Agency] notifies [Plan's] Special Needs Unit of the foster parent. [Plan] shall provide [County Agency] with EPSDT data on MA covered persons on a mutually agreed upon reporting, time frame, and format.

3.7 [Plan] shall provide [County Agency] with its provider directories when they are produced on no less than an annual basis.

3.8 [Plan's] Special Needs Unit shall provide information in writing to [County Agency] describing [Plan's] operations, including the manner in which [County Agency] may contact [Plan] regarding benefit coverage rules and access to additional information or resources on behalf of an MA covered person placed in substitute care.

3.9 [Plan's] Special Needs Unit staff shall provide education to [County Agency] staff on the [Plan's] requests for accessing medically necessary services.

3.10 All denials by [Plan] of requests for services shall be provided to [County Agency] via telefax and regular mail.

4.0 [COUNTY AGENCY'S] OBLIGATIONS

4.1 Within four months after the implementation of this Agreement, and, at a minimum, quarterly as new providers are identified by [County Agency], [County Agency] shall provide to [Plan] the names of the health care providers [County Agency] uses for exams on an annual basis.

4.2 [County Agency] shall identify a contact person to [Plan], and further shall define the roles and responsibilities of the contact person, to address mass change situations such as enrollment, which affect all MA covered persons, and individual requirements such as emergency physical exams, PCP selection or change, or EPSDT screens which are due.

4.3 [County Agency] will attempt to determine a Medical Assistance recipient's eligibility including physical health plan enrollment by utilizing DHS's Eligibility Verification System (EVS). If EVS is not available in the [County Agency] office, [County Agency] will secure an EVS terminal or educate staff on how to contact DHS to verify eligibility.

4.4 [County Agency] shall arrange for the provision of any medically necessary physical health services by [Plan] contract providers unless the situation is an emergency. [County Agency] will arrange for the provision of any EPSDT screening exams, immunizations, tests or follow-up medical care with [Plan's] Special Needs Unit or PCP. [Plan] shall consider all DHS-required EPSDT services covered services as set forth in DHS's EPSDT guidelines.

4.5 [County Agency] shall advise [Plan] of all new placements or relocations of MA recipients within 15 days or as soon as it can be determined that the recipient is an MA covered person. [County Agency] will coordinate PCP selection or change with [Plan's] Special Needs Unit contact person upon notification of the MA covered person's need to timely access to a PCP.

4.6 [County Agency] will notify [Plan] within 15 days of new placements, changes in placement, or removals from placement of an MA covered person.

4.7 As appropriate, [Plan's] Special Needs Unit will contact [County Agency's] Managed Care Unit [or its equivalent] to request assistance in gathering medical information on the MA covered person. The medical information can include that collected as part of the [County Agency's] intake function or obtained from past medical records. The [County Agency's] Managed Care Unit and the Special Needs Unit [or its equivalent] will work together to obtain the necessary medical information and to share this information with [Plan's] participating provider as appropriate.

4.8 [County Agency] will assist in obtaining required consent-to-treat documents from the MA covered person's parent, legal guardian, or through the court system, if necessary.

4.9 [County Agency] will require any private contracted agencies to cooperate with [Plan]. [County Agency] will require each private contracted agency to identify a contact person to [Plan's] Special Needs Unit designated contact person. [County Agency] will coordinate training and education of private contracted agencies with [Plan].

5.0 SPECIAL NEEDS UNIT

5.1 [County Agency] shall notify [Plan's] Special Needs Unit of the planned transition for the MA covered person within 15 days of discharge from substitute care. Included in these arrangements will be the transfer of all relevant medical information/records to a [Plan] PCP to which the MA covered person will be assigned if different from the current PCP.

5.2 As part of the joint [County Agency] and [Plan] discharge planning, and based on the individual needs of the MA covered person, the [County Agency] case worker and the [Plan's] Special Needs Unit will identify those MA covered persons who could benefit from Special Needs Unit case management. [Plan] case managers will cooperate with the PCP and the [County Agency] caseworker in the development of an appropriate care plan. The [Plan] case manager will assist in the coordination of services required to meet the needs of the MA covered person including any non- MA covered services.

5.3 In the event that [Plan] does not receive notice of an MA covered person's discharge from substitute care until after the discharge has occurred, a care coordinator from [Plan's] Special Needs Unit will be assigned to the case upon [Plan's] receipt of such notification. This care coordination will then work with the MA covered person's PCP and a [County Agency] Managed Care Unit, or its equivalent liaison, to make appropriate arrangements for the MA covered person's care.

6.0 DATA COLLECTION/REPORTING/SHARING

6.1 The parties agree to develop procedures on the collection of information on the covered services delivered, which information shall be shared with DHS upon request.

6.2 The parties agree to develop provisions for the notification of reportable conditions experienced by any MA covered persons to the appropriate regulatory agency as required by law.

6.3 The parties agree to share necessary data to ensure delivery of appropriate covered services.

7.0 COORDINATION OF CARE

If an MA covered person is placed by [County Agency] outside the HC services area, the [County Agency] contact person will notify the DHS County Assistance Office. DHS shall disenroll the MA covered person from [Plan]. The MA covered person will then either be enrolled in another HealthChoices service area or covered by the Fee-For-Service Medical Assistance Program. The [County Agency] contact person will notify [Plan's] Special Needs Unit contact person of the placement outside of the HC service area. [Plan] and [County Agency] will coordinate the transfer of the medical information to the new HealthChoices health plan or selected PCP.

8.0 CONFIDENTIALITY

8.1 The parties recognize and acknowledge that performance of this Agreement may result in the disclosure to the other party of trade secrets, proprietary information, and confidential information (collectively referred to as "Confidential Information"). The non-disclosing party agrees that it and its employees, representatives, and agents shall treat confidential information as strictly confidential and shall: (i) protect the confidential information from unauthorized use or disclosure either directly or indirectly, and keep it confidential; (ii) use the confidential information only for purposes related to this Agreement; (iii) not disclose or otherwise permit any third person or party access to the confidential information without prior written authorization by the disclosing party; and (iv) limit disclosure to necessary individuals and ensure that individuals exposed to confidential information are advised of its confidential nature and their obligations hereunder.

8.2 This Section, (8.0 Confidentiality) shall survive termination of this Agreement. The parties agree that the breach or prospective breach of this provision will cause irreparable harm of which money damages may not be adequate. The parties agree that in addition to any other remedies, the non-breaching party shall be entitled to injunctive or other equitable relief to restrain the breach hereof.

9.0 MEDICAL RECORDS

9.1 The parties agree to obtain the appropriate releases necessary to share clinical information and provide health records to each other as requested, consistent with all applicable laws.

9.2 The parties agree to maintain the confidentiality of all covered persons' medical records in accordance with all applicable state and federal laws.

9.3 DHS and/or its authorized agents shall be afforded prompt access to all MA covered persons' medical records whether electronic or paper. All medical

record copies are to be forwarded to the requesting party within 15 calendar days of such request and at no expense to the requesting party. DHS is not required to obtain written approval from an MA covered person before requesting the MA covered person's medical record from the parties or any other agency.

10.0 EMERGENCY CARE

[County Agency] has the right to proceed in an emergency without obtaining prior authorization from [Plan]. An emergency will not require an authorization at any time. [County Agency] shall contact the PCP to authorize urgent care or any follow-up care related to the emergency.

11.0 TERM AND TERMINATION

11.1 This Agreement shall become effective on the later of the effective date set forth above or DHS's approval thereof, and shall continue in effect until ___Date_____, or until the earlier termination of the HealthChoices MA Agreement. This Agreement shall renew upon the mutual consent of the parties and the renewal of the HealthChoices MA Agreement for a term consistent with the HealthChoices MA Agreement.

11.2 Either party may terminate this Agreement for cause by giving the other party and DHS 90 days written notice of a breach of this Agreement. Any such termination shall be effective on the date stated in the notice of termination unless the other party cures the breach prior to the expiration of the 90-day notice period. In the event the breach is cured to the reasonable satisfaction of the other party, the Agreement shall not be so terminated, and DHS shall be notified of the same.

11.3 This Agreement may also be terminated by mutual agreement of both parties with notice to DHS, and by either party upon 120 days advance written notice to the other party and DHS.

12.0 IMPLEMENTATION AND REVIEW OF AGREEMENT

The parties will jointly develop an implementation plan for the coordination of covered services and will appoint representatives who will meet regularly to carry out such plan. To assure the effectiveness of this Agreement and the services to be provided hereunder, the parties will review the Agreement at least once each year, or more often if necessary.

13.0 DISPUTE RESOLUTION

Any controversy, dispute, or disagreement arising out of or relating to the Agreement, or breach thereof, that cannot be resolved at the meetings described in Section 2.9 above,

shall first be mediated, which shall be conducted in [enter appropriate county] County, Pennsylvania, in accordance with the American Health Lawyers' Association Alternative Dispute Resolution Service Rules of Procedure. In the event the parties cannot resolve their differences through mediation, the parties shall have the right to undertake proceedings in a court of proper jurisdiction. No regulatory order or requirement of DOH shall be subject to such mediation.

14.0 MISCELLANEOUS

14.1 **Compliance with Federal and State Laws.** Throughout the term of this Agreement, it shall be each party's responsibility to maintain compliance with all state and federal laws and regulations that affect its respective operations and the furnishing of covered services under this Agreement.

14.2 **Assignment.** This Agreement shall not in any manner be assigned, delegated, or transferred by either party without the prior written consent of the other party, provided, however, that [Plan] may assign this Agreement to another party that controls, is controlled by, or is under common control with [Plan].

14.3 **Notices.** Any notice required to be given pursuant to the terms and provisions hereof shall be in writing and if such notice relates to a modification to this Agreement or the MA product, it shall be sent by certified mail, return receipt requested, to the parties at the addresses set forth below, or personally delivered, delivered by facsimile, or regular or overnight mail. If mailed by regular mail, any such notice shall be deemed given on the fifth day following the date of mailing.

If to [Plan]
[Address]
[Fax #]

If to [County Agency]
_____ County _____ Agency
[Address]
Attention: _____

14.4 **Relationship of Parties.** The relationship between [Plan] and [County Agency] is that of independent contractors and neither shall be considered an agent or representative of the other for any purpose.

14.5 **Non-Exclusivity.** [County Agency] may enter into independent contracts with any payor or participate in other organizations that have purposes identical or similar to the purposes of [Plan].

14.6 **No Third Party Beneficiaries.** This Agreement shall be construed to give rights and place obligations solely upon the parties to this Agreement.

14.7 **Section Headings.** The headings and captions in this Agreement are for ease of reference only and shall not affect in any way the meaning or interpretation of this Agreement.

14.8 **Severability/Invalid Provisions.** The provisions of this Agreement are independent of and separate from each other. If any one provision is determined to be invalid or unenforceable, it shall not render any other provision invalid or unenforceable.

14.9 **Waiver/Compliance with Terms.** Waiver of any part of this Agreement shall not be considered a waiver of any other part of this Agreement. Failure to insist upon strict compliance with any terms of this Agreement (by way of waiver or breach) by either party hereto shall not be deemed to be a continuous waiver in the event of any future breach or waiver of any condition hereunder.

14.10 **Governing Law.** This Agreement shall be governed by and construed in accordance with the laws of the Commonwealth of Pennsylvania and all applicable federal laws.

14.11 **Inconsistencies.** In the event of any inconsistency between the provisions of this Agreement and the provisions of any MA Agreement or the RFP, or any exhibit thereto, the provisions of the HealthChoices MA Agreement or the RFP, respectively, shall govern.

14.12 **Entire Agreement and Amendments.** This Agreement, and all attachments and amendments hereto, constitute the entire understanding and agreement of the parties hereto and supersede any prior written or oral agreement pertaining to the subject matter hereof. This Agreement may be amended by the parties upon the written consent of both parties and DHS. In the event the parties are unable to agree to the content or the wording of an amendment, the proposed amendment and the facts related thereto shall be conveyed to DHS for guidance and direction on how to proceed.

IN WITNESS WHEREOF, the parties have caused their duly authorized representatives to affix their signatures to this Agreement as of the date written above.

_____County [County Agency]	[Plan]
By: _____	By: _____
Title: _____	Title: _____
Witness:	Witness:
By: _____	By: _____

Title: _____

Date: _____

Title: _____

Date: _____

[County/Agency] Primary Contact:

Name: _____

Address: _____

_____

Telephone: _____

Fax: _____

[Plan] Primary Contact

Name: _____

Address: _____

_____

Telephone: _____

Fax: _____

[County/Agency] Office

By: _____

Title: _____

Witness:

By: _____

Title: _____

Date: _____

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EXHIBIT R

COORDINATION WITH BH-MCOS

The HealthChoices PH-MCOs and the BH-MCOs are required to develop and implement written agreements regarding the interaction and coordination of services provided to Recipients enrolled in the HealthChoices Program. These agreements must be submitted and approved by the Department. The PH-MCOs and BH-MCOs in the HealthChoices Zone are encouraged to develop uniform coordination agreements to promote consistency in the delivery and administration of services. A sample coordination agreement (which does not include all required procedures) can be found in Exhibit Q, Sample Model Agreement. Complete agreements, including operational procedures, must be available for review by the Department upon request. The agreements must be submitted for final review and approval to the Department at least 30 days prior to the implementation of the HealthChoices Program. The written agreements must include, but not be limited to:

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

- Procedures, including Prior Authorization, which govern reimbursement by the BH-MCO to the PH-MCO for behavioral health service provided by the PH-MCO or vice versa and the resolution of any payment disputes for services rendered. Procedures must include provisions for differential diagnosis of persons with co-existing physical and behavioral health disorders, as well as provisions for cost-sharing when both Physical and Behavioral Health Services are provided to a Member by a service Provider;

- Procedures for the exchange of relevant enrollment and health-related information among the BH-MCO, the PH-MCO, and PCP and Behavioral and Physical Health Services Providers in accordance with federal and state confidentiality laws and regulations; (e.g., periodic treatment updates with identified primary and relevant specialty Providers);

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

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

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

- Procedures for serving on interagency teams, as necessary;

- Procedures for the development of adequate Provider Networks to serve Special Needs populations and coordination of specialized service plans between the BH-MCO service managers, Behavioral Health Service Provider(s) and the PH-MCO PCP for Members with special health needs (e.g., Behavioral Health Services for individuals under the age of 21 in medical foster care and older adults with coexisting physical and behavioral health disorders);

- The BH-MCO is required to provide behavioral health crisis intervention and other necessary In-Plan Services to Members with behavioral health Emergency Conditions. The PH-MCO and BH-MCO must establish clear procedures for coordinating the transport and treatment of persons with behavioral health emergencies who initially present themselves at general hospital emergency rooms to appropriate behavioral health facilities;

- Procedures for the coordination and payment of emergency and non-emergency medically necessary ambulance transportation of Members. All emergency and non-emergency medically necessary ambulance transportation for both physical and behavioral health covered services is the responsibility of the Member's PH-MCO even for a behavioral health diagnosis.

- Procedures for the coordination of laboratory services;

- Mechanisms and procedures to ensure coordination between the BH-MCO service managers, Member services staff and BH-MCO network Providers with the PH-MCO's Special Needs Unit. The effectiveness of these mechanisms shall be included as an area for review by the BH-MCO's Quality Assurance Program and the PH-MCO's Quality Management Program;

- Procedures for the PH-MCO to provide physical examinations required for the delivery of Behavioral Health Services, within designated time frames for each service;

- Procedures for the interaction and coordination of pharmacy.

To 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 (SCA's):

http://www.dsf.health.state.pa.us/health/cwp/view.asp?a=173&q=199790

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EXHIBIT S

WRITTEN COORDINATION AGREEMENTS BETWEEN PH-MCO AND SERVICE PROVIDERS

Any written coordination agreements entered into between the PH-MCO and service Providers must contain, at a minimum:

- Provisions for ongoing communications; exchange of relevant enrollment and individual health related information; service needs among the PH-MCO, PCP and the community Provider, including a process to monitor such activity; and the Quality Management and Utilization Management program responsibilities of each entity.

- Provisions which govern referral, collaboration and coordination of diagnostic assessment and treatment, prescribing practices and other treatment issues necessary for optimal health and disease prevention, including coordination of specialized service plans for Members with special health needs.

- Provisions for requiring interaction by the PCP for prompt treatment, coordination of care or referral of Members for other identified services that are not the responsibility of the community Provider.

- Provisions for jointly identifying the services to be delivered and monitoring by the PH-MCO to determine the quality of the service delivered.

- Provisions for the PH-MCO and the community Provider to work cooperatively to establish programmatic responsibility for each HealthChoices Member.

- Provisions for serving on interagency teams, when requested.

- Provisions for assisting, when appropriate, in the coordination of services with the BH-MCO, including Pharmacy Coordination, to the extent permitted by law.

- Provisions for mutual intensive outreach efforts to Members identified as needing service (processes to conduct outreach and the measurement of the outreach efforts must be documented in the procedures governing the execution of the written agreement).

- Provisions for a timely resolution of any disputes.

- Provisions for training and consultations between both parties to facilitate continuity of care and the cost-effective use of resources.

- Provisions for assisting, when appropriate, in the development of an adequate Provider Network to serve Special Needs populations.

- Provisions for obtaining the appropriate releases necessary to share clinical information and provide health records to each other as requested consistent with state and federal laws.

- Provisions for the designation of a PH-MCO representative who will function as the liaison between the PH-MCO and the community Provider, if appropriate.

- Provisions for the development and implementation of corrective action plans in the event the provisions of the agreement are not being met.

- Provisions for the adherence to the Americans with Disabilities Act (ADA) (42 U.S.C. Section 12101 et seq) and the Rehabilitation Act of 1973 (29 U.S.C. Section 701 et seq).

- Provisions for the maintenance and confidentiality of medical records and other information considered confidential, including provisions for resolving confidentiality problems.

- Provisions for the collection of information on the service(s) delivered to be shared with the Department, upon request.

- Provisions for collaboration on identifying and reducing the frequency of Fraud, Abuse, overuse, under use, inappropriate or unnecessary medical care.

- Provisions for the reporting of health related information to the appropriate regulatory agency, if necessary.

EXHIBIT U

BEHAVIORAL HEALTH SERVICES

No mental health or drug and alcohol services, except ambulance, pharmacy and emergency room services, will be covered by the PH-MCOs.

Behavioral Health Services Excluded from PH-MCO Covered Services

The following services are not the responsibility of the PH-MCO, under the HealthChoices Program.

The BH-MCO will provide timely access to diagnostic, assessment, referral, and treatment services for members for the following benefits:

- Inpatient psychiatric hospital services, except when provided in a state mental hospital;
- Inpatient drug and alcohol detoxification;
- Psychiatric partial hospitalization services;
- Inpatient drug and alcohol rehabilitation;
- Non-hospital residential detoxification, rehabilitation and half-way house services for drug/alcohol dependence/addiction;
- Emergency room evaluations for voluntary and involuntary commitments pursuant to the Mental Health Procedures Act of 1976, 50 P.S. 7101 et seq.;
- Psychiatric outpatient clinic services, licensed psychologist, and psychiatrist services;
- Behavioral health rehabilitation services (BHRS) for individuals under the age of 21 with psychiatric, substance abuse or mental retardation disorders;
- Residential treatment services for individuals under the age of 21 whether treatment is provided in facilities that are Joint Commission for the Accreditation for Healthcare Organizations [JCAHO] accredited and/or without JCAHO accreditation;
- Outpatient drug and alcohol services, including Methadone Maintenance Clinic;
- Methadone when used to treat narcotic/opioid dependency and dispensed by an in-plan drug and alcohol services provider;
- Laboratory studies ordered by behavioral health physicians and clozapine support services;

- Crisis intervention with in-home capability;
- Family-based mental health services for individuals under the age of 21;
- Targeted mental health case management (intensive case management and resource coordination)

In addition to the in-plan mental health, drug and alcohol and behavioral services covered, supplemental mental health and drug and alcohol services may be made available pursuant to coordination agreements between the BH-MCO and the county mental health, mental retardation, and drug and alcohol authorities. Supplemental services are not part of the capitated, in-plan benefit package. The BH-MCO may, however, choose to purchase such services in lieu of or in addition to an in-plan service.

The supplemental benefits may include:

- Partial hospitalization for drug and alcohol dependence/addiction;
- Psychiatric Rehabilitation: Site Based, Clubhouse or Mobile
- Targeted drug and alcohol case management and Intensive Outpatient Services;
- Supported living services;
- Assistance in obtaining and retaining housing, employment, and income support services to meet basic needs;
- Continuous community based treatment teams;
- Adult residential treatment (including long term structured residences and residential treatment facilities for adults);
- Consumer operated/directed self-help programs; e.g., drop-in centers, 12-step programs, double trouble groups;
- Drug and alcohol prevention/intervention services, including student assistance programs;
- Support groups for individuals under the age of 21; e.g., ALATEEN, peer groups;
- Social rehabilitation and companion programs, e.g., Compeer;
- Drug and alcohol transitional housing; and
- Drug and alcohol drop-in centers.

Exhibit V - Telephonic Psychiatric Consultation Team Services

The HealthChoices MCO has the responsibility to coordinate the care of children who require therapeutic interventions and medication to treat mental health conditions especially those children in foster care. In order to improve the quality of care for children that require psychotropic mediation, the MCO will contract with a telephonic Psychiatric Consultation Team (PCT) that will provide real time telephonic consultative services to PCPs and other prescribers of psychotropic medications for children (referred to as PCPs throughout this document). **The MCO will work with all other BH and PH-MCOs within the HC region to collaboratively choose one PCT team for each HC region.**

The PCT must consist of a team of staff including one (1) full-time equivalent child psychiatrist, one (1) full-time equivalent behavioral health therapist, and one (1) full-time equivalent care coordinator.

Qualifications and key responsibilities for team staff are listed below:

(i) **Child Psychiatrist**. The full-time equivalent position of child psychiatrist may consist of one or more individuals as follows- child psychiatrists must be Board certified or Board eligible and skilled in psychopharmacology. At least one child psychiatrist shall be on call providing continuous coverage from 9:00 a.m. to 5:00 p.m., Monday through Friday, and shall at all times while on call carry a pager and/or cell phone and be accessible to a caller within thirty (30) minutes. The on-call team member shall not be engaged in any activity from which he/she cannot be interrupted within thirty (30) minutes. A child psychiatrist team member shall make an on-site visit to high volume participating PCPs defined by the MCOs in the HC region at least once per year. One child psychiatrist will be designated as the PCT's lead medical director with responsibility to assure consistent quality of care, convene periodic team meetings, assure team productivity and timely regional coverage of PCPs, and participate in quarterly meetings with all BH and PH MCOs within the HC region.

(ii) **Behavioral Health Therapist**. The one (1) full-time equivalent position of behavioral health therapist may consist of one or more individuals as follows: licensed clinical social workers ("LCSW"), licensed mental health counselor, or licensed psychologists. The behavioral health therapist team member's activities must be limited to consultative or short-term transitional care. The therapist(s) must be knowledgeable of local behavioral health resources and work as a team with the care coordinator to match a specific youth/family with the most appropriate and available community resource.

(iii) **Care Coordinator**. The care coordinator supports the team members by coordinating and maintaining schedules, managing registration and billing of patients requiring face-to-face visits, arranging appointments with local behavioral health

providers and oversees collection of any encounter data. The care coordinator must be in constant contact with the BH and PH MCOs.

The PCT will perform consultative services and provider outreach services as described below.

Consultation Services. The PCT will be available at all times between 9:00 a.m. to 5:00 p.m., Monday through Friday (excluding Provider's holidays), to PCPs and other designated providers in the HC region to provide immediate consultations by telephone concerning children and adolescent behavioral health matters. In the event that PCT is unable to consult with the PCP at the time of the PCP's initial inquiry, the PCT shall respond to the PCP within thirty (30) minutes of PCP's initial inquiry call. The telephone consultation will result in one of the following outcomes dependent upon the needs of the PCP's patient and patient's family- resolution of the PCP's inquiry to the satisfaction of the PCP; referral to the PCT care coordinator to assist the family in accessing routine local behavioral health services with such referral stating the average anticipated wait time for visits; referral to PCT's child psychiatrist for an acute psychopharmacological or diagnostic consultation within two (2) weeks or as agreed with the patient's family; or referral to the PCT's social worker to provide diagnostic consultation and/or transitional face-to-face care or telephonic support to the patient and family until the family can access routine local behavioral health services.

The PCT shall maintain an appropriate clinical setting for its staff to care for patients needing face-to-face consultative or transitional services.

The PCT shall maintain records on all consultations and maintain a single designated telephone number with paging ability or PCT person answering the telephone for PCPs to access consultation services.

For all encounters requiring the care coordinator to assist the family with access to routine local behavioral health services, the PCT will follow up with the family to ascertain whether the appointment was made and continue to assist the family as appropriate if the appointment was not made. The care coordinator will contact the BH-MCO to make it aware of any barriers to timely care.

The PCT will send to PCPs a written or electronic record of all face-to-face visits including results of any follow up contacts within 48 hours of the visit. The PCT is encouraged to provide verbal feedback to the PCP from all face-to-face visits requiring follow up. The PCT will also send to PCPs a written or electronic record of all telephonic care coordination encounters including results or any follow up contact within 48 hours of encounter.

The PCT will generate quarterly reports detailing the activity of participating PCPs and identifying which PCPs are not utilizing the service. The PCT will outreach to engage PCPs who are not utilizing the service. This may include but is not limited to outreach

by telephone, e-mail, continuing education sessions, or visits to the office. The quarterly reports will detail the number of telephonic and face to face encounters, the number of unique recipients using the service, the number referred for additional services with community BH providers, the number of recipients who showed up for referred services, the number of unique members discussed with the BH-MCO, and the number of unique members discussed with the PH MCO.

Provider outreach services

The PCT will sequentially contact PCPs and other targeted prescribers of psychotropic medications in the HC Region to inform them of the PCT program and encourage them to participate. The PCT will provide PCPs in the HC Region with training and behavioral health continuing education at PCP offices on how to access and use the consultation program, orientation to community behavioral health services, and guidelines for prescribing and monitoring side effects of common psychotropic medications.

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EXHIBIT X

HEALTHCHOICES PH-MCO GUIDELINES FOR ADVERTISING, SPONSORSHIPS, AND OUTREACH

I. Overview

The PH-MCO must submit a plan for advertising, sponsorship, and outreach procedures to the Department for advance written approval in accordance with the guidelines outlined in this exhibit.

II. HealthChoices Outreach Procedures

HealthChoices (HC) Managed Care Organizations (MCOs) must adhere to the following guidelines and all the requirements specified in Section V.F.2, PH-MCO Outreach Materials, and V.F.3, PH-MCO Outreach Activities, of the Agreement when submitting outreach materials, policies and procedures to the Department.

A. Submission of PH-MCO Outreach Material

Purpose: To obtain Department approval of new or revised outreach materials, plans or procedures.

Objectives:

1. To assure that PH-MCO outreach materials are accurate.

2. To prevent the PH-MCO from distributing outreach materials that mislead, confuse or defraud either the Member or the Department.

Process:

1. The PH-MCO submits outreach materials to the Department for prior approval using the HealthChoices Educational Materials Approval Request form (form attached).

2. The Department's contract monitoring Core Team will review and forward to the PH-MCO a preliminary response within thirty (30) calendar days from date of receipt of the request form.

   Exception: Should the materials require comments or approval from offices outside the Department contract monitoring Core Team, the turnaround time would be as soon as possible.

3. The PH-MCO will submit a final copy of the outreach materials to the Department contract monitoring Core Team for a final written approval prior to circulating the materials.

4. The Department review agency will forward a final written approval to the PH-MCO within ten (10) business days.

5. Outreach material usage:

   a. Direct outreach materials will be used only by the HealthChoices Independent Enrollment Assistance Program personnel after final written approval is received by the PH-MCO from the Department.

   b. Indirect outreach materials, i.e. advertisements, may be utilized immediately after final written approval is received by the PH-MCO from the Department.

B. Criteria for Review of PH-MCO Outreach Material

Purpose: To assure that printed materials, advertising, promotional activities and new Member orientations coordinated through the HealthChoices Independent Enrollment Assistance Program are designed to enable the Medical Assistance consumer to make an informed choice.

Objectives:

1. To assure that the information complies with all federal and state requirements.

2. To determine if the information is grammatically correct and appropriate for Pennsylvania's Medical Assistance population.

3. To ensure that outreach materials are accurate and do not mislead, confuse, or defraud the Member or the Department with the assertion or statement that the Member must enroll in the PH-MCO in order to obtain Medical Assistance benefits, or in order to not lose Medical Assistance benefits.

4. To ensure that there are no assertions or statements that the PH-MCO is endorsed by CMS, the Federal or State government, or similar entity.

Process:

1. Receive a written overall outreach plan annually if the PH-MCO anticipates participation in outreach activities. Requests for specific indirect advertising must be submitted thirty (30) calendar days in advance for written Department approval.

2. Determine if approval is necessary from other offices.

3. Review the information with the following criteria:

   a. Is the PH-MCO identified?
   b. Does the information comply with all federal and state regulations?
   c. Is the information presented in grammatically correct, precise, appropriate and unambiguous language, easily understood by the target audience (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? and
   g. Does the information create a negative image of the traditional Fee-for-Service system?

4. The Department will forward a final written response to the PH-MCO within ten (10) business days.

C. HC PH-MCO Participating In or Hosting an Event

The PH-MCO may submit requests to sponsor or participate in health fairs or community events; the request should demonstrate that the PH-MCO will participate in such fairs or events through activities, including approved outreach activities that are primarily health-care related. The PH-MCO must receive advance written approval from the Department prior to the event date. All requests must be submitted to the Department at least thirty 30 calendar days in advance of the event, on the forms which are included as part of this attachment.

Purpose: To clarify for PH-MCOs that Pennsylvania laws and regulations prohibit certain kinds of offers or payments to consumers as inducements or incentives for consumers to use the PH-MCO's services.

Objectives:

1. To provide amenities that create an environment that is comfortable and convenient for Recipients but is not offered as an artificial outreach inducement or incentive.

2. To eliminate fraudulent, abusive and deceptive practices that may occur as incentives or inducements to obtain specific covered services from the PH-MCO.

Process:

1. The PH-MCO must submit a request, using the applicable HealthChoices PH-MCO Outreach Approval Request Form or the HealthChoices Education Materials Request Form, to the appropriate Department review agency to host an event thirty (30) calendar days in advance of the event (see attached). Should the event require approval from other offices, the approval process may extend beyond thirty (30) calendar days.

2. The Department review agency considers the request confidential information.

D. PH-MCO Outreach Request Form

1. HealthChoices PH-MCO Outreach Approval Request Form

E. Health Education Materials Request Form

1. HealthChoices Educational Materials Approval Request Form

HEALTHCHOICES EDUCATIONAL MATERIALS APPROVAL FORM

PH-MCO Name: _____ Tracking #: _____

Contact Person: _____ Date: _____

Request Received By DHS: _____

Subject:
_____

Who:
_____

What:
_____

When:
_____

Where:
_____

Any Fees:
_____

Confirmation Letter Attached: Yes ☐ No ☐

Discussion:

DHS USE ONLY:

Approved: ☐ Denied: ☐

Reviewer: _____ Final Approval Date: _____

HEALTHCHOICES PH-MCO OUTREACH APPROVAL FORM

PH-MCO Name: _____ Tracking #: _____

Contact Person: _____ Date: _____

Request Received By DHS: _____

Subject:

_____

Who:

_____

What:

_____

When:

_____

Where:

_____

Any Fees:

_____

Confirmation Letter Attached: Yes ☐ No ☐

Discussion:

DHS USE ONLY:

Approved: ☐ Denied: ☐

Reviewer: _____ Final Approval Date: _____

EXHIBIT Z
AUTOMATIC ASSIGNMENT

Any Consumer who does not select a physical health-managed care organization (PH-MCO) and is mandated into the HealthChoices Program will be subject to the auto-assignment process as described below. The auto-assignment process does not negate the Consumer's option to change his/her PH-MCO. An eligible Consumer who has not made a PH-MCO selection and who has a case record that also includes another active member in the case with an active PH-MCO record will be assigned to that same PH-MCO. These Consumers will not count toward the percentages designated for auto-assignment. Consumers in a family unit will be assigned together to a PH-MCO. All remaining eligible Consumers, who have not voluntarily selected a PH-MCO, will be considered in the pool of Consumers who will be equally auto-assigned to PH-MCOs. The formula will direct an equal distribution of the auto-assignment pool in all HealthChoices Zones monthly based on the number of PH-MCOs in the Zone. For example, if there are five PH-MCOs in the Zone, each PH-MCO would receive 20%.

A. **Consumer Re-Assignment Following Resumption of Eligibility:** Consumers who lose eligibility and regain it within six (6) months will automatically be re-enrolled in their previously selected PH-MCO, as long as the Consumer's eligibility status or geographical residence is still valid for participation in that same PH-MCO.

   If the Consumer loses eligibility and regains it after six (6) months, s/he may be enrolled in the same PH-MCO as the payment name, the case payment name or any other Member in the case that has an active PH-MCO record. If there is no active PH-MCO record in the case, s/he will automatically become enrolled in a PH-MCO through the automatic assignment process.

   Prior to the future begin date for the auto-assigned PH-MCO, the Consumer may select a different PH-MCO and override the auto-assigned PH-MCO by contacting the EAP Contractor. When the Consumer contacts the EAP Contractor to make this change, it will be the EAP Contractor's responsibility to enroll the Consumer in the PH-MCO of his/her choice. The EAP Contractor will process the enrollment into the new PH-MCO through the weekly enrollment process.

B. **Continuing Enrollment When Moving Between Zones:** Eligible Consumers who move from one HealthChoices Zone to another will remain in the PH-MCO in which they were enrolled prior to their move, if the PH-MCO is also operational in the Zone to which they move.

The Department reserves the right to reassess the distribution process and to modify it in accordance with sound programmatic management principles. The Department shall institute such modifications at any time following appropriate notification to the PH-MCOs via executive correspondence.

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EXHIBIT BB

PH-MCO RECIPIENT COVERAGE DOCUMENT

This Recipient Coverage Document (RCD) includes descriptions of policies supported by the Department of Human Services (Department) data systems and processes. In cases in which policies expressed in this document conflict with another provision of the Managed Care Organization's (PH-MCO) Agreement, the Agreement will take precedence.

PH-MCO coverage as detailed in this document does not imply coverage under a BH-MCO. Refer to the BH-MCO RCD for behavioral health coverage guidelines.

The Department will provide sufficient information to the PH-MCO in order for it to reconcile PH-MCO membership data and amounts paid to and recovered from the PH-MCO. The Department will only pay capitation to one plan per recipient per month.

Coverage Rules

A PH-MCO is responsible for a Member if coverage is determined by applying the general rules found in any of paragraphs A, B, or C below, subject to exceptions and clarifications found in paragraphs D, E, F, and G.

Refer to the HealthChoices Intranet site "HealthChoices" for additional information on Recipient coverage, clarifications, examples, and membership Enrollment/disenrollment procedures.

A. Responsibility to Provide MA Benefits. - Unless otherwise specified, the PH-MCO is responsible to provide Medical Assistance (MA) benefits to Members in accordance with eligibility information included on the Monthly Membership File and/or the Daily Membership File, which is provided by the Department to each PH-MCO.

B. Membership Files/Coverage Dates/Eligibility. - Daily and Monthly Membership Files containing information and changes that apply to their Members are provided to each PH-MCO. The PH-MCO is responsible to provide services for each PH-MCO Member identified on the Daily or Monthly Membership File from the first day of the calendar month or the PH-MCO coverage start date, whichever is later, through the last day of the calendar month, or the PH-MCO end-date, if any. The Department will pay the PH-MCO from the first day of coverage in a month through the last day of the calendar month. PH-MCO coverage dates beyond the last day of the month in which the Daily or Monthly Membership File is created are preliminary information that is subject to change.

Members who become ineligible for MA will retain their PH-MCO selection for six months. These Members will become the responsibility of the same PH-MCO if

they regain MA eligibility during that six-month period, as long as their category of assistance and geographic location are valid for that PH-MCO. Upon regaining eligibility, their PH-MCO effective date will be their eligibility begin date or the date Client Information System (CIS) is updated with their coverage, whichever is later.

C. **Benefit Packages. -** The Department has established benefit packages based on category of assistance, program status code, age, and, for some packages, the existence of Medicare coverage, or a Deprivation Qualification Code. In cases where the Member benefits are determined by the benefit package, the most comprehensive package is to be honored. For example, if a Member has the most comprehensive package on the first of the month but changes to a lesser level package during the month, he/she should receive the higher level of benefits for the entire month. If a Member has a lesser level benefit package at the beginning of the month but changes to higher level during the month, he/she should receive the higher-level benefits effective the first day of coverage under the higher level through the end of that month regardless of whether the category/program status code combination resulting in the higher level of benefits is valid for PH-MCO Enrollment. Refer to the Daily and Monthly Membership Files to determine increased benefits during a month.

D. **Exceptions and Clarifications. -** The Department will recover Capitation payments made for Members for whom it has been determined that the PH-MCO was not responsible to provide services.

The PH-MCO will not be responsible and will not be paid when the Department notifies the PH-MCO of Members for whom they are not responsible.

1. Errors in PH-MCO coverage identified from any source must be reported to the Department within forty-five (45) days of receipt of the Daily Membership File in order for changes to be considered.

   If a Recipient is enrolled in an PH-MCO in error, that PH-MCO is responsible to cover the Recipient until the Department is notified and the correction is applied to the CIS eligibility record.

   If at the time of notification to the Department, the Recipient was disenrolled in error from an PH-MCO and the Recipient is enrolled in a different PH-MCO, the Recipient will be reenrolled in the previous PH-MCO effective the first of the next month. However, if at the time of notification the Recipient is covered by FFS, the Recipient will be reenrolled into the same PH-MCO effective the day following notification to the Department.

2. If CIS shows an exemption code or a facility/placement code that precludes PH-MCO coverage, the Recipient will not be enrolled in a PH-MCO.

3. If CIS shows Fee-For-Service (FFS) coverage that coincides with PH-MCO coverage, the Member may use either coverage and there will be no monetary adjustment between the Department and the PH-MCO. (This is subordinate to #7 below.)

4. If a PH-MCO has actual knowledge that a Member is deceased, and if such Member shows on either the Monthly Membership or the Daily Membership file as active, the PH-MCO is required to notify the County Assistance Office (CAO) and the Department. The Department will recover Capitation payments made for up to eighteen (18) months after the service month in which the date of death occurred.

5. The Department will recover Capitation payments for Members who were later determined to be ineligible for PH-MCO coverage or who were placed in settings that result in the termination of PH-MCO coverage by the Department. The Department will recoup payments back to the month following the month in which the termination of coverage occurred, for up to twelve (12) months afterwards (i.e. today's date is 9/18/11 and central office staff end date managed care coverage 9/30/10 – payments are recouped for 10/10 through 9/11. See Section F for examples of placements that result in termination of coverage).

6. A newborn is the responsibility of the PH-MCO that covered the mother on the newborn's date of birth. Where CIS does not reflect this, the PH-MCO must notify the Department to correct coverage. The Department will generate Capitation payments as appropriate. Limitations in Sections E-2 and E-3 applicable to the mother will apply to the newborn.

   Exception #1: If mother is in a PH-MCO and C&Y assumes custody of the newborn at birth and places the child in a county within the same HC zone as the mother, the child's coverage will mirror the mother's PH-MCO coverage.

   Exception #2: If mother is in a PH-MCO and C&Y assumes custody of the newborn at birth and places the child in a county outside of the same HC zone where the mother resides, the child will be FFS until auto assignment or selected PH-MCO is effective in the new HC County.

7. Movement out of a PH-MCO's service area does not necessarily eliminate the PH-MCO's responsibility to provide MA benefits. It is the PH-MCO's

responsibility to inform the CAO of the address change upon receipt of information that a Member is residing outside the PH-MCO service area.

8. Pursuant to the rules outlined in the RCD, a lack of MA eligibility indicated on CIS for a certain date does not necessarily eliminate the PH-MCO's responsibility to provide MA benefits. (Refer to Section E, Coverage During Inpatient Hospital Stays, for rules regarding the PH-MCO's responsibility for hospital stays when a Recipient loses MA eligibility during the stay.)

9. Dual Eligibles who are enrolled in Medicare Part D, and who turn 21 years of age will be identified by the Department on the first Friday of each month, and will be disenrolled from the PH-MCO, effective the end of the month in which the Department identifies that the Member turned 21 years of age. In addition, newly identified Dual Eligibles age 21 and over will be disenrolled the end of the month following the month in which Medicare Part D is posted to their eligibility record. The PH-MCO remains responsible for these Members through the disenrollment date.

10. The Department reserves the right to intercede in requests for expedited enrollments when Medically Necessary. The Department's determination for the expedited enrollment will be final. The Capitation rate will be retroactively adjusted for each PH-MCO based on the effective date of the expedited enrollment.

11. A Member who is attending a college or university in a state other than Pennsylvania remains the responsibility of the PH-MCO. However, at the sole discretion of the Department, the Member may be disenrolled from the PH-MCO and enrolled in FFS. The Department will take into consideration such factors as distance from Pennsylvania, the intensity and duration of medically required services, whether the PH-MCO has a business presence nearby, etc.

E. **Change in PH-MCO Coverage During Inpatient Hospital Stays. -** When an MA Recipient has managed care coverage during part of a hospital stay, payment responsibility is as documented in Section E, Coverage During Inpatient Hospital Stays.

Note: One or more of the rules documented in the following sections may apply during a hospital stay.

RULE: E-1.	
Condition	**A Recipient who is covered by FFS when admitted to a hospital assumes PH-MCO coverage while still in the hospital.**
PH-MCO	As of the begin date of PH-MCO coverage, the PH-MCO is responsible for physician,

Coverage Responsibility	DME and all other covered services not included in the hospital bill.
MA FFS Coverage Responsibility	The FFS program is responsible for the hospital bill through the date of discharge. Note: If the Recipient is discharged from the initial hospital to another hospital (acute or rehabilitation) after the PH-MCO begin date, FFS is only responsible for the stay in the initial hospital through the date of discharge. The PH-MCO is responsible for the stay in the subsequent hospital upon admission.

RULE: E-2.	
Condition	**A Recipient who is covered by a PH-MCO when admitted to a hospital loses PH-MCO coverage and assumes FFS coverage while still in the hospital.**
PH-MCO Coverage Responsibility	The PH-MCO is responsible for the hospital stay with the following exceptions. EXCEPTION #1: If the Recipient is still in the hospital on the FFS coverage begin date, and the Recipient's FFS coverage begin date is the first day of the month, the PH-MCO is financially responsible for the stay through the last day of that month. Example: If a Recipient covered by the PH-MCO is admitted to a hospital on June 21 and the FFS coverage begin date is July 1, the FFS program assumes payment responsibility for the stay on August 1. The PH-MCO remains financially responsible for the stay through July 31. EXCEPTION #2: If the Recipient is still in the hospital on the FFS coverage begin date, and the Recipient's FFS coverage begin date is any day other than the first day of the month, the PH-MCO is financially responsible for the stay through the last day of the following month. Example: If a Recipient covered by a PH-MCO is admitted to a hospital on June 21 and the FFS program coverage begin date is July 15, the FFS program assumes payment responsibility for the stay on September 1. The PH-MCO program remains financially responsible for the stay through August 31.
MA FFS Coverage Responsibility	Starting with the FFS begin date, FFS is responsible for physician, DME and other bills not included in the hospital bill. EXCEPTION #1: The FFS program is financially responsible for the stay beginning on the first day of the next month. EXCEPTION #2: The FFS program is financially responsible for the stay beginning on the first day of the month following the next month.

RULE: E-3.	
Condition	**A Recipient covered by a PH-MCO when admitted to a hospital transfers to another PH-MCO while still in the hospital.**
PH-MCO Coverage Responsibility	The losing PH-MCO is responsible for the hospital stay with the following exceptions. Starting with the gaining PH-MCO's begin date, the gaining PH-MCO is responsible for the physician, DME and all other covered services not included in the hospital bill. EXCEPTION #1: If the Recipient is still in the hospital on the gaining PH-MCO

	coverage begin date, and the Recipient's gaining PH-MCO coverage begin date is the first day of the month, the losing PH-MCO is financially responsible for the stay through the last day of the month. The gaining PH-MCO is financially responsible for the stay beginning on the first day of the next month. Example: If a Recipient is admitted to a hospital on June 21 and the gaining PH-MCO coverage begin date is July 1, the gaining PH-MCO assumes payment responsibility for the stay on August 1. The losing PH-MCO remains financially responsible for the stay through July 31. EXCEPTION #2: If the Recipient is still in the hospital on the gaining PH-MCO coverage begin date, and the Recipient's gaining PH-MCO coverage begin date is any day other than the first day of the month, the losing PH-MCO is financially responsible for the stay through the last day of the following month. The gaining PH-MCO is financially responsible for the stay beginning on the first day of the month following the next month. Example: If a Recipient is admitted to a hospital on June 21 and the gaining PH-MCO coverage begin date is July 15, the gaining PH-MCO assumes payment responsibility for the stay on September 1. The losing PH-MCO remains financially responsible for the stay through August 31.
MA FFS Coverage Responsibility	There is no FFS coverage in this example.

RULE: E-4a.	
Condition	**A Recipient covered by a PH-MCO when admitted to a hospital loses and <u>regains MA eligibility while in the hospital (Recipient is not discharged)</u>, resulting in a break in PH-MCO coverage. The Department's Division of Managed Care Systems Support (DMCSS) becomes aware of the break in PH-MCO coverage by the end of the month following the month in which it is lost.**
PH-MCO Coverage Responsibility	DMCSS will reopen the Recipient's PH-MCO coverage retroactive to the day it was end-dated on CIS and adjust the Capitation payment accordingly. The PH-MCO continues to be financially responsible for the stay including the physician, DME, and all other covered services. Example: • A Recipient who is admitted to the hospital on March 10 loses MA eligibility effective March 22 and regains it on April 9 retroactive to March 22. The PH-MCO coverage on CIS shows the Recipient was end-dated March 31 and reopened in the PH-MCO with a new PH-MCO begin date of April 9. On April 25, DMCSS becomes aware of the situation. • Because DMCSS is aware of the loss of MA eligibility within the month following the month in which it was lost, DMCSS reopens the PH-MCO coverage retroactive to April 1, the day after the PH-MCO end-date is posted on CIS (March 31). The PH-MCO continues to be financially responsible for the stay including the physician, DME, and all other covered services.

MA FFS Coverage Responsibility	There would be no FFS coverage in this example.

RULE: E-4b.	
Condition	**A Recipient covered by a PH-MCO when admitted to a hospital loses and regains MA eligibility while in the hospital (Recipient is not discharged), resulting in a break in PH-MCO coverage. DMCSS does not become aware of the break in PH-MCO coverage by the end of the month following the month in which it is lost.**
PH-MCO Coverage Responsibility	Example: Same as in RULE: E-4a except, because DMCSS is not aware of the break in PH-MCO coverage by the end of the month following the month in which it was lost, the PH-MCO coverage is not reopened retroactive to the day it was end-dated on CIS (March 31). The PH-MCO is only responsible to cover the Recipient through the end of March.
MA FFS Coverage Responsibility	FFS is responsible effective April 1.

RULE: E-4c.	
Condition	**A Recipient covered by a PH-MCO when admitted to a hospital loses MA eligibility while in the hospital (Recipient is not discharged). The Recipient regains MA eligibility retroactively after the month following the month in which the MA eligibility was ended, regardless of when DMCSS became aware of the action.**
PH-MCO Coverage Responsibility	Example: • A Recipient who is admitted to the hospital on March 10 loses MA eligibility effective March 22. The Recipient regains MA eligibility on May 15 retroactive to March 22. The PH-MCO coverage on CIS shows the Recipient was end-dated March 31 and reopened in the PH-MCO with a new begin date of May 15. • Because the MA eligibility was not reopened within the month following the month in which it was lost, the PH-MCO coverage is not reopened retroactive to the day it was end-dated on CIS (March 31). The PH-MCO is only responsible to cover the Recipient through the end of March.
MA FFS Coverage Responsibility	FFS is responsible effective April 1.

RULE: E-4d.	
Condition	**A Recipient covered by a PH-MCO when admitted to a hospital loses MA eligibility while in the hospital. The Recipient is discharged from the hospital after the month in which the MA eligibility was lost but before the MA eligibility is regained by the Recipient and reopened retroactively, regardless of when DMCSS became aware of the situation.**

PH-MCO Coverage Responsibility	Example: • A Recipient who is admitted to the hospital on March 10 loses MA eligibility effective March 22. The Recipient is discharged from the hospital April 3. The Recipient regains MA eligibility on April 22 retroactive to March 22. The PH-MCO coverage on CIS shows the Recipient was end-dated March 31 and reopened in the PH-MCO with a new begin date of April 22. • Because the Recipient was discharged from the hospital before the MA eligibility was reopened, which resulted in a 3-day period of FFS coverage on CIS, DMCSS does not reopen the PH-MCO coverage retroactive to April 1. The PH-MCO is only responsible for the stay through the end of March.
MA FFS Coverage Responsibility	FFS is responsible effective April 1.

RULE: E-4e.	
Condition	**A hospitalized Recipient never regains MA eligibility.**
PH-MCO Coverage Responsibility	If the Recipient is never determined retroactively eligible for MA, the PH-MCO is only responsible to cover the Recipient through the end of the month in which MA eligibility ended.
MA FFS Coverage Responsibility	FFS is not responsible for coverage since the Recipient has not regained MA eligibility.

F. **Other Causes for Coverage Termination and Involuntary Disenrollment. -** If a condition described in the following sections occurs, the PH-MCO must notify the Department. In accordance with Department's disenrollment guidelines, DMCSS will take action to disenroll the Member. The Department will recoup payments back to the month following the month in which the termination of coverage occurred, for up to twelve (12) months afterwards (i.e. today's date is 9/18/11 and central office staff end date managed care coverage 9/30/10 – payments are recouped for 10/10 through 9/11).

If a Recipient is placed in a setting listed in these sections, and is under FFS prior to the PH-MCO's begin date, PH-MCO coverage will be voided and adjustments will be processed for any Capitation payments made.

The PH-MCO must notify the Department within sixty (60) days following the satisfaction of the Department's disenrollment guidelines in order for DMCSS to end-date the member's enrollment. Failure on the part of the PH-MCO to notify DMCSS within the sixty (60) days **will** result in the end-date being delayed, thereby extending the PH-MCO's responsibility for covering the Recipient. The PH-MCO should not hold and then later submit the notifications.

RULE: F-1.	
Condition	**A. A Member is admitted to a Nursing Facility (MA provider type/specialty codes 03/31 – County Nursing Facility, 03/30 – Nursing Facility, 03/382 – Hospital Based Nursing Facility, and 03/040 – Certified Rehab Agency) including a Medicare certified Nursing Facility.** **B. A Member who is covered by a PH-MCO when admitted to a Nursing Facility transfers to another PH-MCO or to FFS during the thirty (30) day period.** **C. A Member is admitted to an out of state Nursing Facility (regardless of who places the Member in the facility).** **D. A Member transfers from a Nursing Facility to the Pennsylvania Department of Aging (PDA) Waiver Program, or from the PDA Waiver Program to a Nursing Facility.** **E. A member is admitted to a Veteran's Home (MA provider type/specialty 03/042).**
PH-MCO Coverage Responsibility	**A.** The PH-MCO is responsible for payment for up to thirty (30) days of nursing home care (<u>including hospital reserve or bed hold days</u>) and for notifying the Department in accordance with the Department's disenrollment guidelines if a Member is admitted to a Nursing Facility. • A Member is disenrolled thirty (30) days following the admission date to the Nursing Facility provided that the Member has not been discharged from the Nursing Facility to a community placement. Example: A Member is admitted to a Nursing Facility on July 1. The Member is disenrolled from Managed Care effective July 30. PH-MCO is responsible for Member's services through July 30. The thirty (30) day period includes any hospitalizations or transfers between Nursing Facilities during the thirty (30) days. If a Member is hospitalized during the thirty (30) day period and has not been discharged from the hospital by the end of the thirty (30) days, the PH-MCO is responsible for the hospital stay as described in Section E, Coverage During Inpatient Hospital Stays chart, of the RCD. **B.** The PH-MCO at the time of the admission is responsible for thirty (30) days of nursing home care and for notifying the Department in accordance with the Department's disenrollment guidelines. If a Member becomes hospitalized during the thirty (30) day period and remains hospitalized at the end of the thirty (30) days, the PH-MCO at the time of admission to the Nursing Facility is responsible for the hospital stay as described in Section E, Coverage During Inpatient Hospital Stays , of the RCD. **C.** The PH-MCO is not responsible for Members who are placed in a Nursing Facility outside of Pennsylvania. A Member who is placed in an out of state Nursing Facility is disenrolled from the PH-MCO the day before the admission date. **D.** If a Member transfers from a Nursing Facility to the PDA Waiver Program, or from the PDA Waiver Program to a Nursing Facility, before the 30th consecutive day of PH-MCO responsibility, the thirty (30) day count of PH-MCO responsibility will include the total combined days consecutively enrolled in both the PDA Waiver or in the Nursing Facility, which includes hospital or bed hold days. **E**. The PH-MCO is not responsible for Members who are admitted to a Veteran's Home. A Member who is admitted to a Veteran's Home is disenrolled from the PH-MCO the day before the admission date.

MA FFS Coverage Responsibility	FFS is financially responsible for nursing home care effective on the 31st day following admission to the Nursing Facility. **A.** FFS is responsible as described in Section E, Coverage During Inpatient Hospital Stays, of the RCD. **B.** FFS is responsible as described in Section E, Coverage During Inpatient Hospital Stays, of the RCD. **C.** FFS is not responsible for coverage in an out of state Nursing Facility.

RULE: F-2.	
Condition	**A Member is enrolled in the PDA Waiver.**
PH-MCO Coverage Responsibility	The PH-MCO is responsible for the first thirty (30) days. If a Member transfers from a Nursing Facility to the PDA Waiver Program, or from the PDA Waiver Program to a Nursing Facility, before the 30th consecutive day of PH-MCO responsibility, the thirty (30) day count of PH-MCO responsibility will include the total combined days consecutively enrolled in both the PDA Waiver or in the Nursing Facility, which includes hospital or bed hold days. A Member enrolled in the PDA Waiver is disenrolled from the PH-MCO after thirty (30) days of service.
MA FFS Coverage Responsibility	FFS coverage is effective on the thirty-first (31st) day.

RULE: F-3.	
Condition	**A Member is admitted to a State Facility (MA Provider Type/Specialty Codes 01/23 - Public Psychiatric Hospital and 03/37 - State LTC Unit located at State Mental Hospitals).**
PH-MCO Coverage Responsibility	The PH-MCO is not responsible for Members in a state facility. A Member admitted to a state facility is disenrolled from the PH-MCO the day before the admission date.
MA FFS Coverage Responsibility	FFS coverage is effective on the admission date.

RULE: F-4.	
Condition	**A Member is incarcerated in a Penal Facility, Correctional Institution (including work release), or Youth Development Center.**
PH-MCO Coverage Responsibility	The PH-MCO is not responsible for coverage since the Member is no longer eligible for MA upon placement in a correctional facility. The Member is disenrolled from the PH-MCO effective the day before incarceration in the facility or institution.
MA FFS Coverage Responsibility	FFS is not responsible for coverage since the Member is no longer eligible for MA upon placement in a correctional facility,except for inpatient hospital services.
NOTE:	This rule is based upon section 392.2 of the MA Eligibility Handbook which states,

	"For purposes of MA eligibility, other than eligibility for inpatient hospital services, the needs of an inmate in a correctional institution are the responsibility of the governmental authority exercising administrative control over the facility."

RULE: F-5.	
Condition	**A Member is placed in a Juvenile Detention Center (JDC).**
PH-MCO Coverage Responsibility	During the first thirty five (35) days of a Member's placement in a JDC, the PH-MCO is responsible for all covered services that are provided to the Member *outside* of the JDC site. A Member who is placed in a JDC is disenrolled from the PH-MCO after thirty five (35) days.
MA FFS Coverage Responsibility	Services provided to the Member *on-site* at the JDC during the first thirty five (35) days will be covered under the MA FFS Program. FFS coverage is effective on the 36th day.

RULE: F-6.	
Condition	**A Member becomes eligible for the Health Insurance Premium Payment Program (HIPP).**
PH-MCO Coverage Responsibility	A Member determined to be HIPP eligible (Employer Group Health Plan) is disenrolled from the PH-MCO. Additionally, HIPP eligible MA Members are prevented from enrolling in PH-MCOs.
MA FFS Coverage Responsibility	FFS benefits with HIPP insurance coverage begin the day after the disenrollment date.

RULE: F-7.	
Condition	**A Member is enrolled in the Living Independence for the Elderly Program (LIFE) (MA ProviderType/Specialty Code 07/70 – LIFE)** **LIFE is Pennsylvania's managed care demonstration for Nursing Facility eligibles. It provides for long term care needs of frail elderly Recipients who wish to remain independent in their community but require intensive, integrated primary and psychosocial care to do so.**
PH-MCO Coverage Responsibility	A Member enrolled in LIFE is disenrolled from the PH-MCO effective the day before the begin date of LIFE.
MA FFS Coverage Responsibility	LIFE Coverage begins the day after the disenrollment date.

G. Other Facility Placement Coverage. - Refer to the following sections for rules concerning PH-MCO coverage of Recipients placed in other facilities.

RULE: G-1.	
Condition	**A Member is admitted to a state ICF-MR (MA Provider Type/Specialty Code 03/38 – State Mental Retardation Center).**
PH-MCO Coverage Responsibility	A Member admitted to a state ICF-MR is disenrolled from the PH-MCO the day before the admission date.
MA FFS Coverage Responsibility	FFS coverage is effective on the admission date.

RULE: G-2.	
Condition	**A Member is admitted to a private ICF-MR/ICF-ORC (MA Provider Type/Specialty Code 03/32 – ICF/MR 8 Beds or Less, 03/33 – ICF/MR 9 Beds or More, and 03/39 – ICF/ORC).**
PH-MCO Coverage Responsibility	A Member admitted to a private ICF-MR or an ICF-ORC facility will continue to be covered by their selected PH-MCO for all covered physical health services with the exception of those services that the ICF-MR or ICF-ORC has historically and customarily provided to residents of the facility or those services that are covered under the facilities per diem payment. • The residential/treatment costs that are the responsibility of the ICF-MR or ICF-ORC under its agreement with DHS are not the responsibility of the BH-MCO. All other Behavioral Health Services are the responsibility of the BH-MCO.
MA FFS Coverage Responsibility	FFS is responsible for the residential/treatment costs. DHS will make direct payments to the ICF-MR or ICF-ORC facility to cover room, board, MR-specific non-MA services, and physical and behavioral health services to the extent these services have been customarily and historically provided to residents of the facility.

RULE: G-3.	
Condition	**A. A Member is admitted to a JCAHO approved Residential Treatment Facility (RTF) (MA Provider Type/Specialty Code 01/13 – Residential Treatment Facility (JCAHO Certified) Hospital).** **B. A Member is admitted to a non-JCAHO approved Residential Treatment Facility (RTF)** (MA Provider Type/Specialty Code 56/560 – Residential Treatment Facility (Non-JCAHO Certified)**.**
PH-MCO Coverage Responsibility	**A.** With the exception of Children in Substitute Care who are placed in residential facilities by another government agency that has responsibility for these children, a Member placed in a JCAHO approved RTF (MA Provider Type/Specialty Code 01/13 – Residential Treatment Facility (JCAHO Certified) Hospital) remains covered by their selected PH-MCO for all covered physical health services. • The BH-MCO is responsible for the residential/treatment costs. **B.** A Member placed in a non-JCAHO approved RTF (MA Provider Type/Specialty

	Code 56/560 – Residential Treatment Facility (Non-JCAHO Certified) remains covered by their selected PH-MCO for all covered physical health services. • The BH-MCO is responsible for the MA per diem. The Room & Board per diem can be the responsibility of the BH-MCO, Children and Youth or another agency depending on medical necessity and who places the Recipient.
MA FFS Coverage Responsibility	**A.** FFS is responsible for the residential/treatment costs. **B.** FFS is responsible for the facility's per diem payment.

RULE: G-4.	
Condition	**A Member is admitted to an Extended Acute Psychiatric Care Hospital (MA Provider Type/Specialty Code 01/18 – Extended Acute Psych Inpatient Unit)..**
PH-MCO Coverage Responsibility	A Member admitted to an extended acute psychiatric hospital remains covered by the selected PH-MCO for all covered physical health services. • If the Recipient is placed in the facility by the BH-MCO, then the BH-MCO is responsible for the residential/treatment costs.
MA FFS Coverage Responsibility	FFS is responsible for the residential/treatment costs.

RULE: G-5.	
Condition	**A Member is admitted to an Inpatient Private Psychiatric Facility (MA Provider Type/Specialty Code 01/11 – Private Psychiatric Hospital and 01/22 – Private Psychiatric Unit).**
PH-MCO Coverage Responsibility	A Member admitted to a private psychiatric hospital remains covered by the selected PH-MCO for all covered physical health services. • The BH-MCO is responsible for the residential/treatment costs.
MA FFS Coverage Responsibility	FFS is responsible for the residential/treatment costs.

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EXHIBIT CC

DATA SUPPORT FOR PH-MCOs

Each PH-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 PH-MCO is to be used for any purpose other than supporting their program under HealthChoices. Access to the Department's network will continue for the functions not included under PROMIS*e*™.

The PH-MCOs will be required to adhere to Department requirements and HIPAA transactions. Each PH-MCO will need to be certified through PROMIS*e*™ 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 PH-MCO access to the Department's CIS database. This database provides eligibility history, demographic information, and TPL information to support the PH-MCO in meeting their obligations.

2. HealthChoices Intranet

   The Department will make available to each PH-MCO access to the Department's HealthChoices Intranet.

3. DHS Internet

   Each PH-MCO will have access to the Department's Internet at www.dhs.pa.gov.

PROMIS*e*™ INQUIRY ACCESS:

1. Eligibility Verification System (EVS)

   All PH-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);
   - Dial-up access to a Bulletin Board System (BBS)/Modem;
   - Toll free via Provider Electronic Solutions software or point of service (POS) device;
   - Internet; and
   - Direct line.

2. On-Line Inquiry

   Access to the following online screens will be made available to the PH-MCOs:

   - Provider
   - Reference
   - Recipient Eligibility Verification
   - Claims
   - Prior Authorization

DATA FILES:

Following are the descriptions of the data files that will be provided to the PH-MCO by the EAP Contractor, or by the Department.; the data files that the PH-MCO will be required to submit to the EAP Contractor or the Department; and the files that the EAP Contractor 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 HealthChoices Intranet Site.

FILES AND REPORTS PROVIDED TO THE PH-MCO:

NAME	PURPOSE	FREQUENCY
834 Daily Membership File	HIPAA compliant file of any change affecting a Member's demographic, eligibility and enrollment data and TPL information for that day.	Daily
834 Monthly Membership File	HIPAA compliant file containing one record for each recipient who is both MA and managed care 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 File of enrollments and alerts.	Weekly
Pending Enrollment File	File from the EAP contractor that provides the PH-MCOs with pre-enrollment data.	Weekly
Response to the Automated Provider Directory	A response file (from the EAP) 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 Encounter Data File Request	TPL file of Recipients for every PH-MCO where TPL needs adjudicated encounter claims information.	Daily - Urgent Weekly - Non-urgent

NAME	PURPOSE	FREQUENCY
PH-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 Recipients.	Monthly
835 Remittance Advice File	HIPAA compliant file of all maternity care Claims that paid or rejected, as well as 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
36-Month Summary File	A summary file of all Capitation payments by county group, rate cell, and date of service for the last 36 months.	Monthly
List of Active and Closed Providers (PRV-415)	File of enrolled MA 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 MA 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 (PRV435)	File of provider/service locations and special indicators to identify those providers eligible for the enhanced payments.	Weekly
PH-MCO Provider Error Report (PRM640)	Report of PH-MCO Provider records returned by DHS due to error.	Monthly
Daily EDI Claims	Summary report providing EDI encounter	Daily

NAME	PURPOSE	FREQUENCY
Submission Statistics	totals sent to the PROMISe™ claims engine by submission type, listing counts of accepted, rejected, and suspended encounters submitted during the day.	
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 PH-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 PH-MCOs.	Daily
Monthly Rejected Encounter Activity Report	Report sent to the PH-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 physical health and behavioral health plans.	Weekly
Reapplication File	File of recipients who have MA reapplication and SAR (Semi Annual Reporting) due dates that are 90 days in advance of the run date.	Monthly

NAME	PURPOSE	FREQUENCY
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 members.	Monthly
Service History Data Files	Files containing service history data (FFS and encounters) for enrolled members from the DHS data warehouse.	Weekly

FILES PROVIDED BY THE PH-MCO:

NAME	PURPOSE	FREQUENCY
PH-MCO Network Provider file (PRV640)	File provided listing all Providers within the Network to serve Members.	Monthly
PCP File	File provides the PCP assignments for all Members.	Weekly
837P - Maternity Care	HIPAA compliant file of Claims for each PH-MCO where the PH-MCO was responsible for the Recipient on the newborn's date of birth.	Daily
PH-MCO Casualty Claims File	TPL file of adjudicated Claims for Recipients on DHS casualty claims file.	Weekly, sometimes daily
PH-MCO Recovery Flagging File	TPL file provides DHS with a list of encounters on which the PH-MCO intends to pursue recovery.	Monthly/Weekly
PH-MCO Reconciliation File	TPL file provides DHS with a list of encounters on which the PH-MCO has realized a recovery, been denied by the third party, or has abandoned recovery activity.	Monthly/Weekly
PH-MCO Electronic Resource File	TPL file provides the PH-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 PH-MCO providing the Department with Encounter Data for all PH-MCO Recipients.	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 on CIS, a Member's pregnancy not reflected on CIS, or a deceased Recipient with no Date of Death reflected on CIS.	Weekly
Automated Provider Directory File	File contains information on all Providers in the Network for the PH-MCO. The information will be used by the EAP contractor for their Electronic (Online) Provider Directory.	Weekly
PH/BH Pharmacy File	Pharmacy data from the physical health plans to the behavioral health plans	Submission based on schedule developed by the PH-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 DD

PH-MCO MEMBER HANDBOOK

The PH-MCO must ensure that the Member handbook contains written information regarding Member rights and protections and is written at no higher than a sixth grade reading level. The PH-MCO must provide a Member handbook in the appropriate prevalent language, or alternate format, to all members within five (5) business days of being notified of a Member's enrollment, but no sooner than five (5) business days before the member's effective date of enrollment. The PH-MCO may provide the Member handbook in formats other than hard copy. If this option is exercised, the PH-MCO must inform Members what formats are available and how to access each. Upon request, the PH-MCO must provide a hard copy version of the Member handbook to the Member.

At a minimum, the Member handbook shall include:

1. Information about the PH-MCO, its services, the practitioners providing care, and Member's rights and responsibilities.

2. Role of the PCP in directing and managing care and as patient advocate.

3. Information on the role of the Enrollment Assistance Program and how to access services, including but not limited to what services they provide to the Member and contact information.

4. Description of services which should include assistance with changing PH-MCOs, PCPs and the right to request an updated Provider directory.

5. How to access after-hour, non-emergency care.

6. Description of the PH-MCO ID card and the ACCESS card and their uses.

7. Statement that no balance billing allowed.

8. Information about co-payments, service limits, and the exception process.

9. An explanation of the Member's financial responsibilities for payment of services provided by a Non-participating Provider, when service is provided by a Provider without Prior Authorization, or when care rendered is not covered by the PH-MCO.

10. 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 member's responsibility with the following exceptions:

- the non-participating/non-network provider arrangements were approved in advance by the PH-MCO and any prior authorization requirements (if applicable) were met;
- the non-participating/non-network prescriber and the pharmacy are the member's Medicare providers; or
- the member is covered by a third party carrier and the non-participating/non-network prescriber and the pharmacy are the member's third party providers.

11. Information that the Member is not liable for payment of covered services provided in the event that a Pennsylvania Medical Assistance participating Health Care Provider does not receive payment from the PH-MCO.

12. Rights of the Member regarding confidentiality of their medical records.

13. Rights of the Member 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 part 164.524 and 164.526.

14. Rights of members to receive information regarding cost of care.

15. Information on the availability of and how to access or receive assistance in accessing, at no cost to the Member, oral interpretation services for all services provided by the PH-MCO for all non-English languages.. The PH-MCO must make vital documents disseminated to English-speaking Members available in alternative languages, upon request of the member. 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 Member, 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 PH-MCO will arrange for providing these alternate format Member 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 what to do when family size, address or phone number changes.

23. Information regarding appointment standards.

24. Information regarding MA Members' rights and PH-MCOs' responsibilities per Section 1867 of the Social Security Act.

25. A description of all available contract services, including how to access those services, and an explanation of any service limitations or exclusions from coverage, including an explanation that limitations and most exclusions do not apply to Members under the age of 21, specific instructions on how transportation is provided, and a notice stating that the PH-MCO will be liable only for those services that are the responsibility of the PH-MCO.

26. A description of the services not covered if the PH-MCO elects not to provide, reimburse for, or provide coverage of, a counseling or referral service because of an objection on moral or religious grounds.

27. Information on how to request guidelines, including utilization review and clinical practice guidelines.

28. An explanation of the procedures for obtaining benefits, including self-referred services, services requiring Prior Authorization and services requiring a referral.

29. How to contact Member Services, the Special Needs Unit (HealthChoices only) and the Maternal Health/EPSDT Coordinator and a description of their functions.

30. Information regarding the Complaint, Grievance and DHS Fair Hearing processes, as set forth in the Physical Health Member 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).

31. How to contact the Clinical Sentinel Hotline. Please reference Managed Care Ops Memo # 09/2009-018 for required template language guidelines.

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 Member handbook should instruct members to use the emergency medical services (EMS) available and/or activate EMS by dialing 9-1-1 in a life-threatening situation.

48. Information on "Advance Directives" (durable health care power of attorney and living wills) for adult Members including:
    a. The description of State law, if applicable
    b. The process for notifying the Member 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 PH-MCO has regarding implementation of advanced directives as a matter of conscience
    d. The process for Members to file a Complaint concerning noncompliance with the advanced directive requirements with the PH-MCO and the State survey and certification agency
    e. How to request written information on advance directive policies.

49. A statement that all Members will be treated with respect and due consideration for his or her dignity and privacy.

50. A statement that Members may receive, from a Health Care Provider, information on available treatment options and alternatives, presented in a manner appropriate to Member's condition and ability to understand.

51. A statement that Members have the right to participate in decisions regarding his or her health care, including the right to refuse treatment.

52. A statement that Members are guaranteed the right to be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience, or retaliation.

53. A statement that Each Member is free to exercise his or her rights and that the exercise of those rights does not adversely affect the way the PH-MCO and its Providers or the State agency treat the Member.

54. Explanation of PH-MCO's and DHS's Recipient Restriction Program including how to request a DHS Fair Hearing regarding a restriction action and how to request a change of pharmacy or Provider.

55. The Department's MA Provider Compliance Hotline number and explanatory statement.

34. How to obtain emergency transportation and Medically Necessary transportation. Provide the names and telephone numbers for county MATP providers.

35. EPSDT standard services and information regarding Early Intervention services, including dental services that fall under EPSDT. PH-MCOs must update their handbooks to reflect increased access for application of topical fluoride varnish by CRNPs and physicians.

36. How and where to access behavioral health, family planning and vision services.

37. Information on how to obtain prescription drugs, including information on the PH-MCO's formulary and how to request a copy.

38. Information on what to do regarding out of county/out of state moves.

39. Contributions the member can make towards his/her own health.

40. 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 PH-MCO for the entire pregnancy will be advocated.

41. Notification that the selection of certain PCP sites may result in medical residents, nurse practitioners and physicians assistants providing care to Members.

42. Information regarding the availability of second opinions and when and how to access them.

43. Information regarding the right to receive services from an Out-of-Network Provider when the PH-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 a Denial of Services.

44. Information on the availability and process for accessing MA Out-of-Plan Services which are not the responsibility of the PH-MCO, but are available to Members.

45. Information regarding the Women's, Infants' and Children (WIC) Program and how to access the Program.

46. Information regarding HIV/AIDS programs and how to access them.

47. Information on Tobacco Cessation Programs and how to access them.

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EXHIBIT FF

PCP, DENTISTS, SPECIALISTS AND PROVIDERS OF ANCILLARY SERVICES DIRECTORIES

A) PCP and Dentist Directories

The PH-MCO shall be required to provide its Members with PCP and Dentist directories upon request, which include, at a minimum, the following information:

- The names, addresses, and telephone numbers of participating PCPs.
- The hospital affiliations of the PCP.
- Identification of whether the PCP is a Doctor of Medicine or Osteopathy, and whether the PCP is a Pediatrician.
- Identification of whether PCPs are Board-certified and, if so, in what area(s).
- Identification of PCP Teams which include physicians, Certified Registered Nurse Practitioners (CRNPs), Certified Nurse Midwives and physicians' assistants.
- Indication of whether dentist is DDS or DMD, and whether dentist is a periodontist.
- Identification of whether dentists possess anesthesia certificates.
- Identification of whether the dentist is able to serve adults with developmental disabilities.
- Identification of languages spoken by Health Care Providers at the primary care and dental sites.
- Identification of sites which are wheelchair accessible.
- Identification of the days of operation and the hours when the PCP or dentist office is available to Members.

The PH-MCO, at the request of the PCP or dentist, may include the PCP's or dentist's experience or expertise in serving individuals with particular conditions.

B) Specialist and Providers of Ancillary Services Directories

The specialist and providers of ancillary services directories shall include, at a minimum, the following information:

- The names, addresses and telephone numbers of specialists and their hospital affiliations.
- Identification of the specialty area of each specialist's practice.
- Identification of whether the specialist is Board-certified and, if so, in what area(s).
- Experience or expertise in serving individuals with particular conditions.

EXHIBIT GG

COMPLAINT, GRIEVANCE AND DHS FAIR HEARING PROCESSES

A. General Requirements

1. All Complaint, Grievance and DHS Fair Hearing policies and procedures must receive prior written approval by the Department.

2. The PH-MCO may not charge Members a fee for filing a Complaint or Grievance at any level of the process.

3. The PH-MCO must have written policies and procedures for registering, responding to and resolving Complaints and Grievances (at all levels) as they relate to the MA population. These policies and procedures must be made available upon request.

4. The PH-MCO must maintain written documentation of each Complaint and Grievance and the actions taken by the PH-MCO.

5. The PH-MCO must ensure that Members have access to all relevant documentation pertaining to the subject of the Complaint or Grievance.

6. The PH-MCO must have a data system to process, track and trend all Complaints and Grievances.

7. The PH-MCO must ensure that there is a link between the Complaint and Grievance processes and the Quality Management and Utilization Management programs.

8. The PH-MCO must designate and train sufficient staff to be responsible for receiving, processing, and responding to Member Complaints and Grievances in accordance with the requirements in this Exhibit.

9. PH-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 PH-MCO may not use the time frames or procedures of the Complaint and Grievance process to avoid the medical decision process or to discourage or prevent the Member from receiving Medically Necessary care in a timely manner.

11. The PH-MCO must accept Complaints and Grievances from individuals with disabilities which are in alternative formats including: TTY/TDD for telephone inquiries and Complaints and Grievances from Members who are hearing impaired; Braille; tape; or computer disk; and other commonly accepted alternative forms of communication. PH-MCO employees who receive

telephone Complaints and Grievances should also be made aware of the speech limitation of some Members with disabilities so they can treat these individuals with patience, understanding, and respect.

12. The PH-MCO must provide Members with disabilities assistance in presenting their case at Complaint or Grievance reviews at no cost to the Member. This includes:

    - Providing qualified sign language interpreters for Members who are severely hearing impaired;
    - Providing information submitted on behalf of the PH-MCO at the Complaint or Grievance review in an alternative format accessible to the Member filing the Complaint or Grievance. The alternative format version should be supplied to the Member at or before the review, so the Member can discuss and/or refute the content during the review; and
    - Providing personal assistance to Members with other physical limitations in copying and presenting documents and other evidence.

13. The PH-MCO must provide language interpreter services when requested by a Member, at no cost to the Member.

14. The PH-MCO must offer Members the assistance of a PH-MCO staff member throughout the Complaint and Grievance processes at no cost to the Member.

15. The PH-MCO must ensure that anyone who participates in making the decision on a Complaint or Grievance was not involved in any previous level of review or decision-making.

16. The PH-MCO must notify the Member when the PH-MCO fails to decide a first level Complaint or first level Grievance within the timeframes specified in this Exhibit, using the template supplied by the Department (Exhibit GG(1)) on the HealthChoices Intranet. This notice must be mailed one day following the date the decision was to be made (day 31).

17. The PH-MCO must notify the Member when it denies payment after a service has been delivered because the service/item was provided without authorization by a Provider not enrolled in the Pennsylvania Medical Assistance Program using the template supplied by the Department (Exhibit GG(11)). This notice must be mailed to the Member on the day the decision was made to deny payment.

18. The PH-MCO must notify the Member when it denies payment after a service has been delivered because the service/item provided is not a covered benefit for the Member, using the template supplied by the Department (Exhibit GG(12)). This notice must be mailed to the Member on the day the decision is made to deny payment.

19. The PH-MCO must notify the Member when it denies payment after a service has been delivered because the PH-MCO determined that the service was not

Medically Necessary, using the template supplied by the Department (Exhibit GG(13)). This notice must be mailed to the Member on the day the decision is made to deny payment.

20. The PH-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 Member requests an in-person review, the PH-MCO must notify the Member of the location of the review and who will be present at the review using the template supplied by the Department (Exhibit GG(14)).

21. The PH-MCO must ensure that any location where it will hold in-person reviews is physically accessible for persons with disabilities.

B. Complaint Requirements

Complaint: A dispute or objection regarding a participating Health Care Provider or the coverage, operations or management policies of a Physical Health Managed Care Organization (PH-MCO), which has not been resolved by the PH-MCO and has been filed with the PH-MCO or with the Department of Health or the Insurance Department of the Commonwealth, including but not limited to:

i. a denial because the requested service/item is not a covered benefit; or

ii. a failure of the PH-MCO to meet the required timeframes for providing a service/item; or

iii. a failure of the PH-MCO to decide a Complaint or Grievance within the specified timeframes; or

iv. a denial of payment by the PH-MCO after a service has been delivered because the service/item was provided without authorization by a Provider not enrolled in the Pennsylvania Medical Assistance Program; or

v. A denial of payment by the PH-MCO after a service has been delivered because the service/item provided is not a covered service/item for the Member.

The term does not include a Grievance.

1. **First Level Complaint Process**

a. A PH-MCO must permit a Member or Member's representative, which may include the Member's Provider, with proof of the Member's written authorization for the representative to be involved and/or act on the Member's behalf, to file a Complaint either in writing or orally. Oral requests must be committed to writing by the PH-MCO if not confirmed in writing by the Member and must be provided to the Member or the Member'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 PH-MCO to decide a Complaint or Grievance within the specified timeframes; challenges the failure to meet the required timeframes 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 Member, the Member must file a Complaint within forty-five (45) days from the date of the incident complained of or the date the Member receives written notice of the decision. For all other Complaints, there is no time limit for filing a Complaint.

b. The PH-MCO must provide Members with a toll free number to file a Complaint, request information about the Complaint process, and ask any questions the Member may have about the status of a Complaint.

c. If a Member files a Complaint to dispute a decision to discontinue, reduce, or change a service/item that the Member has been receiving on the basis that the service/item is not a covered benefit, the Member 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 PH-MCO shall send the Member and Member's representative, if the Member has designated one, an acknowledgment letter using the template supplied by the Department (Exhibits GG(2a) and GG(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 PH-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 PH-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 Member must be afforded a reasonable opportunity to present evidence, and allegations of fact or law, in person as well as in writing. The

PH-MCO shall be flexible when scheduling the review to facilitate the Member's attendance. The Member shall be given at least seven (7) days advance written notice of the review date using the template supplied by the Department (Exhibits GG(14a) and GG(14b)). If the Member cannot appear in person at the review, an opportunity to communicate with the first level Complaint review committee by telephone or videoconference must be provided. The Member may elect not to attend the first level Complaint meeting but the meeting must be conducted with the same protocols as if the Member was present.

h. If a Member requests an in-person first level Complaint review, at a minimum, a member of the first level Complaint review committee must be physically present at the location where the first level Complaint review will be held and the other members of the first level Complaint review committee must participate in the review through the use of videoconferencing.

i. The first level Complaint review committee shall complete its review of the Complaint as expeditiously as the Member'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 Member.

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 PH-MCO must send a written notice of the first level Complaint decision, using the template supplied by the Department (Exhibit GG(3a)), to the Member, Member's representative, if the Member has designated one, service provider and prescribing PCP, if applicable, within five (5) Business Days from the first level Complaint review committee's decision.

l. The Member or the Member's representative, with proof of the Member's written authorization for the representative to be involved and/or act on the Member's behalf, may file a request for a second level Complaint review ("second level Complaint") within forty-five (45) days from the date the Member receives written notice of the PH-MCO's first level Complaint decision.

m. If the Complaint disputes the failure of the PH-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 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 Member, the Member may file a request for a DHS Fair Hearing within thirty (30) days from the mail date on the written notice of the PH-MCO's first level Complaint decision.

2. **Second Level Complaint Process**

a. Upon receipt of the second level Complaint, the PH-MCO shall send the Member and Member's representative, if the Member has designated one, an acknowledgment letter using the template supplied by Department (Exhibit GG(4)).

b. If a Member files a second level Complaint to dispute a decision to discontinue, reduce, or change a service/item that the Member has been receiving on the basis that the service/item is not a covered benefit, the Member 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 PH-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 PH-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 videoconference and has the opportunity to review all information introduced during the review.

f. The Member must be provided the opportunity to appear before the second level Complaint review committee. The PH-MCO shall be flexible when scheduling the second level Complaint review to facilitate the Member's attendance. The Member shall be given at least fifteen (15) days advance written notice of the review date using the template supplied by the Department (Exhibits GG(14a) and GG(14b)). If the Member cannot appear in person at the second level Complaint review, an opportunity to communicate with the second level Complaint review committee by telephone or videoconference must be provided. The Member may elect not to attend the second level Complaint meeting but the meeting must be conducted with the same protocols as if the Member was present.

g. If a Member requests an in-person second level Complaint review, at a minimum, a member of the second level Complaint review committee must be physically present at the location where the second level Complaint review will be held and the other members of the second level Complaint review committee must participate in the review through the use of videoconferencing.

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 PH-MCO's receipt of the Member's second level Complaint.

i. Testimony taken by the second level Complaint review committee (including the Member's comments) must be either tape-recorded and a summary prepared or transcribed verbatim and a summary prepared and maintained as part of the Complaint record.

j. The PH-MCO must send a written notice of the second level Complaint decision, using the template supplied by the Department (Exhibit GG(5)) to the Member, Member's representative, if the Member has designated one, service Provider and prescribing Provider, if applicable within five (5) Business Days from the second level Complaint review committee's decision.

k. The Member or the Member's representative, with proof of the Member's written authorization for the representative to be involved and/or act on the Member's behalf, may file a request for an external review of the second level Complaint decision with either the Department of Health or the Insurance Department within fifteen (15) days from the date the Member receives the written notice of the PH-MCO's second level Complaint decision.

l. If the second level Complaint disputes the failure of the PH-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 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 Member, the Member may file a request for a DHS Fair Hearing within thirty (30) days from the mail date on the written notice of the PH-MCO's second level Complaint decision.

3. **External Review of Second Level Complaint Review Decision**

a. If a Member files a request for an external review of a second level Complaint decision to dispute a decision to discontinue, reduce, or change a service/item that the Member has been receiving on the basis that the service/item is not a covered benefit, the Member 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 PH-MCO's second level Complaint decision.

b. Upon the request of either the Department of Health or the Insurance Department, all records from the first level review and second level review shall be transmitted to the appropriate department by the PH-MCO within thirty (30) days from the request in the manner prescribed by that department. The Member, the Health Care Provider or the PH-MCO may submit additional materials related to the Complaint.

c. The Department of Health and the Insurance Department will determine the appropriate agency for the review.

4. **Expedited Complaint Process**

a. The PH-MCO must conduct expedited review of a Complaint at any point prior to the second level Complaint decision, if a Member or Member's representative, with proof of the Member's written authorization for the representative to be involved and/or act on the Member's behalf, provides the PH-MCO with a certification from his or her Provider that the Member's life, health or ability to attain, maintain or regain maximum function would be placed in jeopardy by following the regular Complaint process. This certification is necessary even when the Member's request for the expedited 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 PH-MCO. The Member's signature is not required.

c. Upon receipt of an oral or written request for expedited review, the PH-MCO must inform the Member of the right to present evidence and allegations of fact or of law in person as well as in writing and of the limited time available to do so.

d. If the Provider certification is not included with the request for an expedited review, the PH-MCO, must inform the Member that the Provider must submit a certification as to the reasons why the expedited review is needed. The PH-MCO must make a reasonable effort to obtain the certification from the Provider. If the Provider certification is not received within three (3) Business Days of the Member's request for expedited review, the PH-MCO shall decide the Complaint within the standard timeframes as set forth in this Exhibit. The PH-MCO must make a reasonable effort to give the Member prompt oral notice that the Complaint is to be decided within the standard timeframe and send a written notice within two (2) days of the decision to deny expedited review, using the template supplied by the Department (Exhibit GG(6b)).

e. If a Member files a request for expedited review of a Complaint to dispute a decision to discontinue, reduce, or change a service/item that the Member

has been receiving on the basis that the service/item is not a covered benefit, the Member 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.

f. 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.

g. The PH-MCO must issue the decision resulting from the expedited review in person or by phone to the Member, the Member's representative, if the Member has designated one, and the Member's Health Care Provider within either forty-eight (48) hours of receiving the Provider certification or three (3) Business Days of receiving the Member's request for an expedited review, whichever is shorter. In addition, the PH-MCO must mail written notice of the decision to the Member, the Member's representative, if the Member has designated one, and the Member's Health Care Provider within two (2) days of the decision using the template supplied by the Department (Exhibit GG(6a)).

h. The PH-MCO must prepare a summary of the issues presented and decisions made, which must be maintained as part of the expedited Complaint record.

i. The Member, or the Member's representative, with proof of the Member's written authorization for the representative to be involved and/or act on the Member's behalf, may file a request for an expedited external Complaint review with the PH-MCO within two (2) Business Days from the date the Member receives the PH-MCO's expedited Complaint decision.

j. The PH-MCO shall follow Department of Health guidelines relating to submission of requests for expedited external reviews.

k. The PH-MCO must ensure that punitive action is not taken against a Provider who either requests expedited resolution of a Complaint or supports a Member's request for expedited review of a Complaint.

l. The Member may file a request for a DHS Fair Hearing within thirty (30) days from the mail date on the written notice of the PH-MCO's expedited Complaint decision.

C. Grievance Requirements

Grievance: A request to have a PH-MCO or utilization review entity reconsider a

decision solely concerning the Medical Necessity and appropriateness of a health care service. A Grievance may be filed regarding a PH-MCO decision to 1) deny, in whole or in part, payment for a service/item; 2) deny or issue a limited authorization of a requested service/item, including the type or level of service/item; 3) reduce, suspend, or terminate a previously authorized service/item; 4) deny the requested service/item but approve an alternative service/item; 5) deny a request for a benefit limit exception (BLE).

The term does not include a Complaint.

1. **First Level Grievance Process**

   a. A PH-MCO shall permit a Member or the Member representative, which may include the Member's Provider, with proof of the Member's written authorization for the representative to be involved and/or act on the Member's behalf, to file a Grievance either in writing or orally. Oral requests must be committed to writing by the PH-MCO if not confirmed in writing by the Member and must be provided to the Member for signature. The Member's signature may be obtained at any point in the process, and failure to obtain a signed Grievance may not delay the Grievance process. Members will be given forty-five (45) days from the date the Member receives the written notice to file a Grievance.

   b. The PH-MCO must provide Members with a toll free number to file a Grievance, request information about the Grievance process, and ask questions the Member may have about the status of a Grievance.

   c. A Member who files a Grievance to dispute a decision to discontinue, reduce or change a service/item that the Member 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 PH-MCO shall send the Member and Member's representative, if the Member has designated one, an acknowledgment letter using the template supplied by the Department (Exhibit GG(7)).

   e. A Member who consents to the filing of a Grievance by a Health Care Provider may not file a separate Grievance. The Member retains the right to rescind consent throughout the Grievance process upon written notice to the PH-MCO and the Provider.

   f. In order for the Provider to represent the Member in the conduct of a Grievance, the Provider must obtain the written consent of the Member. A Provider may obtain the Member's written permission at the time of treatment. A Provider may NOT require a Member to sign a document

authorizing the Provider to file a Grievance as a condition of treatment. The written consent must include:

i. The name and address of the Member, the Member's date of birth and identification number;

ii. If the Member is a minor, or is legally incompetent, the name, address and relationship to the Member of the person who signed the consent;

iii. The name, address and PH-MCO identification number of the Provider to whom the Member is providing consent;

iv. The name and address of the PH-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 Member to which the consent will apply;

vi. The following statement: "The Member or the Member's representative may not submit a Grievance concerning the services/items listed in this consent form unless the Member or the Member's representative rescinds consent in writing. The Member or the Member's representative has the right to rescind consent at any time during the Grievance process.";

vii. The following statement: "The consent of the Member or the Member's representative shall be automatically rescinded if the Provider fails to file a Grievance or fails to continue to prosecute the Grievance through the second level review process.";

viii. The following statement: "The Member or the Member's representative, if the Member is a minor or is legally incompetent, has read, or has been read this consent form, and has had it explained to his/her satisfaction. The Member or the Member's representative understands the information in the Member's consent form."; and

ix. The dated signature of the Member, or the Member'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 PH-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 Member must be afforded a reasonable opportunity to present evidence, and allegations of fact or law, in person as well as in writing. The PH-MCO shall be flexible when scheduling the review to facilitate the Member's attendance. The Member shall be given at least seven (7) days advance written notice of the review date using the template supplied by the Department (Exhibits GG(14a) and GG(14b)). If the Member cannot appear in person at the review, an opportunity to communicate with the first level Grievance review committee by telephone or videoconference must be provided. The Member may elect not to attend the first level Grievance meeting but the meeting must be conducted with the same protocols as if the Member was present.

j. If a Member 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 videoconferencing.

k. The first level Grievance review committee shall complete its review of the Grievance as expeditiously as the Member'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 Member.

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.

l. The PH-MCO must send a written notice of the first level Grievance decision, using the template supplied by the Department (Exhibit GG(3b)), to the Member, Member's representative, if the Member has designated one, service Provider and prescribing PCP, if applicable, within five (5) Business Days from the first level Grievance review committee's decision.

m. The Member or the Member's representative, with proof of the Member's written authorization for the representative to be involved and/or act on the Member's behalf, may file a request for a second level Grievance review ("second level Grievance") within forty-five (45) days from the date the Member receives the written notice of the PH-MCO's first level Grievance decision.

n. The Member may file a request for a DHS Fair Hearing within thirty (30) days from the mail date on the written notice of the PH-MCO's first level Grievance decision.

2. **Second Level Grievance Process**

a. Upon receipt of the second level Grievance, the PH-MCO shall send the Member and the Member's representative, if the Member has designated

one, an acknowledgment letter using the template supplied by the Department (Exhibit GG(8)).

b. A Member who files a second level Grievance to dispute a decision to discontinue, reduce, or change a service/item that the Member 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 PH-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 PH-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 Member must be provided the opportunity to appear before the second level Grievance review committee. The PH-MCO shall be flexible when scheduling the second level review to facilitate the Member's attendance. The Member shall be given at least fifteen (15) days advance written notice of the review date using the template supplied by the Department (Exhibits GG(14a) and GG(14b)). If the Member cannot appear in person at the second level review, an opportunity to communicate with the second level Grievance review committee by telephone or videoconference must be provided. The Member may elect not to attend the second level Grievance meeting but the meeting must be conducted with the same protocols as if the Member was present.

f. If a Member 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 videoconferencing.

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 Member's second level Grievance.

i. Testimony taken by the second level Grievance review committee (including the Member's comments) must be either tape-recorded and a summary prepared or transcribed verbatim and a summary prepared and maintained as part of the Grievance record.

j. The PH-MCO must send a written notice of the second level Grievance decision, using the template supplied by the Department (Exhibit GG(9)), to the Member, Member's representative, if the Member 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 Member or Member representative, which may include the Member's Provider, with proof of the Member's written authorization for a representative to be involved and/or act on the Member's behalf, may file a request with the PH-MCO for an external review ("external Grievance review") of the second level Grievance decision by a certified review entity appointed by the Department of Health. The request must be filed within fifteen (15) days from the date the Member receives the written notice of the PH-MCO's second level Grievance decision.

l. The Member may file a request for a DHS Fair Hearing within thirty (30) days from the mail date on the written notice of the PH-MCO's second level Grievance decision.

3. **External Review of Second Level Grievance Decision:**

a. All requests for external Grievance review are processed through the PH-MCO. The PH-MCO has the responsibility to follow the protocols established by the Department of Health in meeting all time frames and requirements necessary in coordinating the request and notification of the decision to the Member, Member's representative, if the Member has designated one, service Provider and prescribing Provider.

b. A Member who files a request for an external Grievance review to dispute a decision to discontinue, reduce or change a service/item that the Member 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 PH-MCO's second level Grievance decision.

c. Within five (5) Business Days of receipt of the request for an external Grievance review, the PH-MCO shall notify the Member, the Member's representative, if the Member has designated one, or the Health Care Provider, and the Department of Health that the request for 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 PH-MCO.

e. Within two (2) Business Days from receipt of the request for an external Grievance review, the Department of Health randomly assigns a CRE to conduct the review. The PH-MCO and assigned CRE entity will be notified of this decision.

f. If the Department of Health fails to select a CRE within two (2) Business Days from receipt of a request for an external Grievance review, the PH-MCO may designate a CRE to conduct a review from the list of CREs approved by the Department of Health. The PH-MCO may not select a CRE that has a current contract or is negotiating a contract with the PH-MCO or its Affiliates or is otherwise affiliated with the PH-MCO or its Affiliates.

g. The PH-MCO must forward all documentation regarding the decision, including all supporting information, a summary of applicable issues and the basis and clinical rationale for the decision, to the CRE conducting the external Grievance review. This transmission of information must take place within fifteen (15) days from receipt of the Member's request for an external Grievance review.

h. Within fifteen (15) days from receipt of the request for an external Grievance review by the PH-MCO, the Member or the Member's representative, which may include the Member's Provider, with proof of the Member's written authorization for the representative to be involved and/or act on the Member's behalf, may supply additional information to the CRE conducting the external Grievance review for consideration. Copies must also be provided at the same time to the PH-MCO so that the PH-MCO has an opportunity to consider the additional information.

i. Within sixty (60) 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 PH-MCO, the Member, the Member's representative and the Provider (if the Provider filed the Grievance with the Member's consent), that includes the basis and clinical rationale for the decision. The standard of review shall be whether the service/item was Medically Necessary and appropriate under the terms of the PH-MCO's contract.

j. The external Grievance decision may be appealed by the Member, the Member's representative, or the Health Care Provider to a court of competent jurisdiction within sixty (60) days from the date the Member receives notice of the external Grievance decision.

4. **Expedited Grievance Process**

a. The PH-MCO must conduct expedited review of a Grievance at any point prior to the second level Grievance decision, if a Member or Member representative, with proof of the Member's written authorization for a representative to be involved and/or act on the Member's behalf, provides the

PH-MCO with a certification from his or her Provider that the Member's life, health or ability to attain, maintain, or regain maximum function would be placed in jeopardy by following the regular Grievance process. This certification is necessary even when the Member's request for the expedited 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 PH-MCO. The Member'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 time frames, which are modified as specified in this section.

d. Upon receipt of an oral or written request for expedited review, the PH-MCO must inform the Member of the right to present evidence and 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 PH-MCO, must inform the Member that the Provider must submit a certification as to the reasons why the expedited review is needed. The PH-MCO must make a reasonable effort to obtain the certification from the Provider. If the Provider certification is not received within three (3) Business Days of the Member's request for expedited review, the PH-MCO shall decide the Grievance within the standard timeframes as set forth in this Exhibit. The PH-MCO must make a reasonable effort to give the Member prompt oral notice that the Grievance is to be decided within the standard timeframe and send a written notice within two (2) days of the decision to deny expedited review, using the template supplied by the Department (Exhibit GG(6b)).

f. A Member who files a request for expedited review of a Grievance to dispute a decision to discontinue, reduce or change a service/item that the Member 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 PH-MCO must issue the decision resulting from the expedited review in

person or by phone to the Member, the Member's representative, if the Member has designated one, and the Member's Provider within either forty-eight (48) hours of receiving the Provider certification, or three (3) Business Days of receiving the Member's request for an expedited review, whichever is shorter. In addition, the PH-MCO must mail written notice of the decision to the Member, the Member's representative, if the Member has designated one, and the Member's Health Care Provider within two (2) days of the decision using the template supplied by the Department (Exhibit GG(10)).

i. The Member, or the Member's representative, with proof of the Member's written authorization for the representative to be involved and/or act on the Member's behalf, may file a request for an expedited external Grievance review with the PH-MCO; within two (2) Business Days from the date the Member receives the PH-MCO's expedited Grievance decision.

j. The PH-MCO shall follow Department of Health guidelines relating to submission of requests for expedited external reviews.

k. The PH-MCO must ensure that punitive action is not taken against a Provider who either requests expedited resolution of a Grievance or supports a Member's request for expedited review of a Grievance.

l. The Member may file a request for a DHS Fair Hearing within thirty (30) days from the mail date on the written notice of the PH-MCO's expedited Grievance decision.

D. Department's Fair Hearing Requirements

DHS Fair Hearing: A hearing conducted by the Department of Human Services, Bureau of Hearings and Appeals or its subcontractor.

1. Department's Fair Hearing Process

a. Members do not have to exhaust the Complaint or Grievance process prior to filing a request for a DHS Fair Hearing.

b. The Member or the Member's representative may request DHS Fair Hearings 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 PH-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 benefit;

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 PH-MCO to provide services/items in a timely manner, as defined by the Department;

vii) the failure of the PH-MCO to decide a Complaint or Grievance within the timeframes 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 Member.

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:

Department of Human Services
OMAP – HealthChoices Program
Complaint, Grievance and Fair Hearings
P.O. Box 2675
Harrisburg, Pennsylvania 17105-2675

d. A Member who files a request for a DHS Fair Hearing to dispute a decision to discontinue, reduce or change a service/item that the Member 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 Bureau of Hearings and Appeals or a designee will schedule a hearing. The Member and the PH-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 Member. 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 PH-MCO is a party to the hearing and must be present. The PH-MCO, which may be represented by an attorney, must be prepared to explain and defend the issue on appeal. The Department's decision is based solely on the evidence presented at the hearing. The failure of the PH-MCO to

participate in the hearing will not be reason to postpone the hearing.

g. The PH-MCO must provide Members, at no cost, with records, reports, and documents, relevant to the subject of the DHS Fair Hearing.

h. If the Bureau of Hearings and Appeals has not taken final administrative action within ninety (90) days of the receipt of the request for a DHS Fair Hearing, the PH-MCO shall follow the requirements at 55 Pa. Code 275.4 regarding the provision of interim assistance upon the request for such by the Member. When the Member is responsible for delaying the hearing process, the time limit for final administrative action will be extended by the length of the delay attributed to the Member (55 Pa. Code 275.4).

i. The Bureau of Hearings and Appeals' adjudication is binding on the PH-MCO unless reversed by the Secretary of Human Services. Either party may request reconsideration from the Secretary within fifteen (15) days from the date of the adjudication. Only the Member 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 PH-MCO.

2. **Expedited Fair Hearing Process**

a. A request for an expedited DHS Fair Hearing may be filed by the Member or the Member's representative, with proof of the Member's written authorization for the representative to be involved and/or act on the Member's behalf, with the Department either in writing or orally.

b. Members 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 Member or a Member's representative provides the Department with written certification from the Member's Provider that the Member's life, health or ability to attain, maintain or regain maximum function would be placed in jeopardy by following the regular DHS Fair Hearing process. This certification is necessary even when the Member's request for the expedited Fair Hearing is made orally. The certification must include the Provider's signature. The Provider may also testify at the DHS Fair Hearing to explain why using the usual timeframes would place the Member's health in jeopardy.

d. A Member who files a request for an expedited Fair Hearing to dispute a decision to discontinue, reduce or change a service/item that the Member 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 Bureau of Hearings and Appeals or a designee will schedule a hearing.

f. The PH-MCO is a party to the hearing and must participate in the hearing. The PH-MCO, which may be represented by an attorney, must be prepared to explain and defend the issue on appeal. The failure of the PH-MCO to participate in the hearing will not be reason to postpone the hearing.

g. The PH-MCO must provide Member, at no cost, with records, reports, and documents, relevant to the subject of the DHS Fair Hearing.

h. The Bureau of Hearings and Appeals has three (3) Business Days from the receipt of the Member's oral or written request for an expedited review to process final administrative action.

i. The Bureau of Hearings and Appeals adjudication is binding on the PH-MCO unless reversed by the Secretary of Human Services. Either party may request reconsideration from the Secretary within fifteen (15) days from the date of the adjudication. Only the Member 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 PH-MCO.

E. Provision of and Payment for Services/Items following Decision

1. If the PH-MCO or the Bureau of Hearings and Appeals reverses a decision to deny, limit, or delay services/items that were not furnished during the Complaint, Grievance or DHS Fair Hearing process, the PH-MCO must authorize or provide the disputed services/items promptly and as expeditiously as the Member's health condition requires. If the PH-MCO requests reconsideration from the Secretary of Human Services, the PH-MCO must authorize or provide the disputed services/items pending reconsideration unless the PH-MCO requests a stay of the Bureau of Hearings and Appeals decision and the stay is granted.

2. If the PH-MCO or the Bureau of Hearings and Appeals reverses a decision to deny authorization of services/items, and the Member received the disputed services/items during the Complaint, Grievance or DHS Fair Hearing process, the PH-MCO must pay for those services/items.

EXHIBIT GG(1)

NOTICE FOR FAILURE OF PH-MCO TO MEET COMPLAINT OR GRIEVANCE TIMEFRAMES

[Date Notice Mailed (1 day after the date the decision was to be made)]

Member Name
Address
City, State Zip

Member ID: *********

Subject: Your **[Complaint] [Grievance]** About **[Issue]**

Dear **[Member Name]**:

[PH-MCO Name] has not decided your **[complaint] [grievance]** about **[identify subject of complaint/grievance]**, filed on **[date]**, within **[number that is fewer than 30 days]** days, as required. We expect to be able to decide the **[complaint] [grievance]** by **[date]**.

If you are unhappy that **[MCO Name]** has not decided your **[complaint] [grievance]** within **[#]** days of receiving it, you can do one or both of the following:

File a Complaint

You may file a complaint with **[PH-MCO Name]** about the delay in deciding your **[complaint] [grievance]**. You must file the complaint **within 45 days from the date you get this notice.**

A decision will be made on your complaint no later than **[30, unless PH-MCO will be using a shorter time frame to decide 1st level complaints]** days from when we receive it.

To file a complaint:

- Call **[PH-MCO Name] at [Phone #/Toll-free TTY #]**;
- Fax [PH-MCO Fax #]; **or**
- Send your complaint to **[PH-MCO Name]** at the following address:

[PH-MCO Address for filing complaint]

Request a Fair Hearing

You may ask for a Fair Hearing from the Department of Human Services. Your request for a Fair Hearing must be in writing and must be postmarked **within 30 days from the date on this notice**. Your request should include the following information:

- Your (the Member's) name, social security number, and date of birth;
- A telephone number where you can be reached during the day;
- Whether you want to have a hearing in person or by telephone;
- The reason(s) you are asking for a Fair Hearing, or a copy of this notice.

Your request for a Fair Hearing must be sent to the following address:

Department of Human Services
OMAP – HealthChoices Program
Complaint, Grievance and Fair Hearings
P.O. Box 2675
Harrisburg, PA 17105-2675

The Department will issue a decision between 60 and 90 days from when it receives your request (see your Member handbook for more details).

Get Help with Grievances, Complaints, or Fair Hearings

If you need help filing a grievance, complaint, or request a Fair Hearing, you can call:

- [PH MCO Name] at [Phone #/Toll-free TTY#]

To ask for free legal help with your grievance, complaint, or Fair Hearing, or with filing your grievance, complaint or request for Fair Hearing, you can call:

- Pennsylvania Health Law Project at 1-800-274-3258 (www.phlp.org) <OR>

- Pennsylvania Legal Aid Network at 1-800-322-7572 (www.palegalaid.net)

Sincerely,

[PH-MCO Name]

cc: **[Provider, if BBA complaint or grievance]**
[Member Representative, if designated]

[PH-MCO, the following statement must appear in English, Russian, Cambodian, Vietnamese, Spanish, Chinese, and any other language as required by the contract:]

The information in this notice is about the [complaint] [grievance] you filed with [PH-MCO Name]. It is available in other languages and formats by calling [PH-MCO Name] at [Phone #/Toll-free TTY #].

EXHIBIT GG(2a)

1ST LEVEL COMPLAINT ACKNOWLEDGMENT LETTER

[Date Letter Mailed]

Member Name
Address
City, State Zip

Member ID: *********

Subject: Your Complaint About ***[Complaint Issue]***

Dear **[Member Name]**:

[PH-MCO Name] received your complaint about **[identify subject of complaint]** on **[date of receipt]**.

The First Level Complaint Process

A committee of one or more **[PH-MCO Name]** staff who have not been involved in the issue you filed your complaint about will make a decision about your complaint by **[date that is no more than 30 days from receipt of the complaint]**. This is called the "complaint review." A letter will be mailed to you within five business days after the decision is made, telling you each reason for the decision.

At any time during the complaint process, you can have someone you know represent you or act on your behalf. This person will be "your representative." If you decide to have someone represent you or act for you, tell **[PH-MCO Name]**, in writing, the name of that person and how we can reach him or her.

You or your representative may ask **[PH-MCO Name]** to see any information relevant to your complaint. You may also send information that you have about your complaint to **[PH-MCO Name]**:

[PH-MCO Address]

You and your representative may appear at the complaint review in person, by phone or by videoconference, if available, by calling **[PH-MCO Name]** at **[PH-MCO Phone #/Toll-free TTY #]**. Please note, for videoconference you must contact the PH-MCO within 10 days of this notice. You may also bring a family member, friend, lawyer or other person to help you. If you decide that you do not want to attend, that will not affect the decision of the committee.

If you think your issue is really a grievance and should not be treated as a complaint, you may call or write to the Pennsylvania Department of Health:

Pennsylvania Department of Health
Bureau of Managed Care
Health and Welfare Building, Room 912
625 Forster Street
Harrisburg, Pennsylvania 17120-0701
Telephone: 1-888-466-2787; Fax: 1-717-705-0947
AT&T Relay: 1-800-654-5984 (for persons with hearing impairments)

If you need more information on what a grievance is, you can read your Member handbook or call **[PH-MCO Name]** at **[PH-MCO Phone #/Toll-free TTY #].**

Get Help with Grievances, Complaints, or Fair Hearings

If you need help filing a grievance, complaint, or request a Fair Hearing, you can call:

- [PH MCO Name] at [Phone #/Toll-free TTY#]

To ask for free legal help with your grievance, complaint, or Fair Hearing, or with filing your grievance, complaint or request for Fair Hearing, you can call:

- Pennsylvania Health Law Project at 1-800-274-3258 (www.phlp.org) <OR>
- Pennsylvania Legal Aid Network at 1-800-322-7572 (www.palegalaid.net)

If your complaint is described correctly at the top of this letter, please sign below and return this letter to:

[PH-MCO Address]

If your complaint is not described correctly, please call **[PH-MCO Name]** at **[PH-MCO Phone #/Toll-free TTY #]**.

Sincerely,

[PH-MCO Name]

,cc: **[Member Representative, if designated]**
[PH-MCO, the following statement must appear in English, Russian, Cambodian, Vietnamese, Spanish, Chinese, and any other language as required by the contract:]

The information in this letter is about the complaint you filed with [PH-MCO Name]. It is available in other languages and formats by calling [PH-MCO Name] at [Phone #/Toll-free TTY #].

Member ID: _____

I agree that my complaint is described correctly.

_____ _____

Member's or Member's Representative Signature Date

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EXHIBIT GG(2b)

FAILURE TO PROVIDE SERVICE(S)/ITEM(S) IN A TIMELY MANNER ACKNOWLEDGMENT LETTER

[Date Letter Mailed]

Member Name
Address
City, State Zip

Member ID#: *********

Subject: Your Complaint About **[*Complaint Issue*]**

Dear **[Member Name]**:

[PH-MCO Name] received your complaint on **[date of oral complaint]** that you did not receive your **[type of services/items]** in the time you should have received them.

The First Level Complaint Process

A committee of one or more **[PH-MCO Name]** staff who have not been involved in the issue you filed your complaint about will make a decision about your complaint by **[date that is no more than 30 days from receipt of the complaint]**. This is called the "complaint review." A letter will be mailed to you within five business days after the decision is made, telling you each reason for the decision.

At any time during the complaint process, you can have someone you know represent you or act on your behalf. This person will be "your representative." If you decide to have someone represent you or act for you, tell **[PH-MCO Name]**, in writing, the name of that person and how we can reach him or her.

You or your representative may ask **[PH-MCO Name]** to see any information relevant to your complaint. You may also send information that you have about your complaint to **[PH-MCO Name]**:

[PH-MCO Address]

You and your representative may appear at the complaint review in person, by phone or by videoconference, if available, by calling **[PH-MCO Name]** at **[PH-MCO Phone #/Toll-free TTY #] within ten days from the date on this letter.** You may also bring a family member, friend, lawyer or other person to help you. If you decide that you do not want to attend, that will not affect the decision of the committee.

To ask for an early decision

If your doctor or dentist believes that waiting **[30, unless PH-MCO will be using a shorter time frame to decide 1st level complaints]** days to get a decision could harm your health, you may ask that your complaint be decided more quickly. To do this:

- Call **[PH-MCO Name]** at **[PH-MCO Phone #/Toll-free TTY #]**; **OR**
- Fax a letter to **[PH-MCO Name]** at **[PH-MCO Fax #];**

AND

- Your doctor or dentist must fax a signed letter to **[PH-MCO Fax #]** explaining why taking **[30, unless PH-MCO will be using a shorter time frame to decide 1st level complaints]** days to decide your complaint could harm your health.

[PH-MCO Name] will notify you of the decision within 48 hours from when we receive your doctor's or dentist's letter, or within 3 business days from when we receive your request for an early decision, whichever is sooner.

The Fair Hearing Process

At any point before **[PH-MCO Name]** makes its decision, you may ask for a Fair Hearing from the Department of Human Services. Your request for a Fair Hearing must be in writing and must be postmarked **within 30 days from the date on this letter**. Your request should include the following information:

- Your (the Member's) name, social security number, and date of birth;
- A telephone number where you can be reached during the day;
- Whether you want to have a hearing in person or by telephone;
- The reason(s) you are asking for a Fair Hearing, or a copy of this letter.

Your request for a Fair Hearing must be sent to the following address:

Department of Human Services
OMAP – HealthChoices Program
Complaint, Grievance and Fair Hearings
P.O. Box 2675
Harrisburg, PA 17105-2675

The Department will issue a decision between 60 and 90 days from when it receives your request (see your Member handbook for more details).

To ask for an early decision

If your doctor or dentist believes that the usual time frame for deciding a Fair Hearing could harm your health, you may ask that the Fair Hearing take place more quickly. To do this:

- Call the Department at 1-800-798-2339, or fax your request to the Department at 1-717-772-6328;

- Your doctor or dentist must fax a signed letter to 1-717-772-6328 explaining why taking the usual amount of time to decide your request for a Fair Hearing could harm your health. If your doctor or dentist does not send a letter, your doctor or dentist must testify at the Fair Hearing to explain why taking the usual amount of time to decide your request for a Fair Hearing could harm your health.

The Department will schedule a telephone hearing and notify you of its decision within three business days from when it receives your request.

Get Help with Complaints or Fair Hearings

If you need help filing a complaint or request a Fair Hearing, you can call:

- [PH MCO Name] at [Phone #/Toll-freeTTY#]

To ask for free legal help with your complaint or Fair Hearing, or with filing your complaint or request for Fair Hearing, you can call:

- Pennsylvania Health Law Project at 1-800-274-3258 (www.phlp.org) <OR>
- Pennsylvania Legal Aid Network at 1-800-322-7572 (www.palegalaid.net)

If your complaint is described correctly at the top of this letter, please sign below and return this letter to:

[PH-MCO Address]

If your complaint is not described correctly, please call **[PH-MCO Name]** at **[PH-MCO Phone #/Toll-free TTY #]**.

Sincerely,

[PH-MCO Name]

cc: **[Member Representative, if designated]**

[PH-MCO, the following statement must appear in English, Russian, Cambodian, Vietnamese, Spanish, Chinese, and any other language as required by the contract:]

The information in this letter is about the complaint you made with [PH-MCO Name]. It is available in other languages and formats by calling [PH-MCO Name] at [Phone #/Toll-free TTY #].

Member ID: _____

I agree that my complaint is described correctly.

_____ _____

Member's or Member's Representative Signature Date

EXHIBIT GG(3a)

1ST LEVEL COMPLAINT DECISION NOTICE

[Date Notice Mailed (no more than 5 business days after the first level complaint decision)]

Member Name
Address
City, State Zip

Member ID: *********

Subject: Decision About Your Complaint

Dear **[Member Name]**:

[PH-MCO Name] has reviewed your complaint about **[issue]**, received on **[date]**.

Based on a review of all information provided, the first level complaint review committee has decided that **[state decision in detail]**.

The reasons for this decision are:

[Explain in detail every reason for decision. In addition to explanation for decision, include specific references to approved criteria, rules or protocols on which decision is based. If unable to make a decision because of insufficient information, identify all additional information needed to render decision.]

[PH-MCO: Include the following paragraph only if the complaint challenges a denial because the service/item is not a covered benefit.]

To continue getting services:
If you have been receiving the services/items that are being reduced, changed, or denied and you file a second level complaint or request for a Fair Hearing (see instructions below) that is postmarked or hand-delivered **within 10 days from the date on this notice**, the services/items will continue until a decision is made.

IF YOU DO NOT AGREE WITH THIS DECISION, YOU MAY DO ONE OR ALL OF THE FOLLOWING:

File a Second Level Complaint

You may file a second level complaint with **[PH-MCO Name]** **within 45 days from the date you get this notice.** A decision will be made on your second level complaint no

later than **[45, unless the PH-MCO will be using a shorter time frame to decide 2nd level complaints]** days from when we receive it.

To file a second level complaint:

- Call **[PH-MCO Name]** at **[Phone #/Toll-free TTY #]**;
- Fax **[PH-MCO Fax #]**; **or**
- Send your complaint to **[PH-MCO Name]** at the following address:

[PH-MCO Address for filing complaint]

[PH-MCO: Include the following paragraph on expedited complaints only if the complaint is about the failure to provide services/items in a timely manner or denial of service/item as not a covered benefit.]

To ask for an early decision

If your doctor or dentist believes that waiting **[45, unless the PH-MCO will be using a shorter time frame to decide 2nd level complaints]** days to get a decision could harm your health, you may ask that your complaint be decided more quickly. To do this:

- Call **[PH-MCO Name]** at **[Phone #/Toll-free TTY #]**; **OR**
- Fax a letter to **[PH-MCO Name]** at **[PH-MCO Fax #];**

AND

- Your doctor or dentist must fax a signed letter to **[PH-MCO Fax #]** explaining why taking **[45, unless PH-MCO will be using a shorter time frame to decide 2nd level complaints]** days to decide your complaint could harm your health.

[PH-MCO Name] will notify you of the decision within 48 hours from when we receive your doctor's or dentist's letter, or within 3 business days from when we receive your request for an early decision, whichever is sooner.

[PH-MCO: Include the following paragraphs on Fair Hearings and Expedited Fair Hearings only if the complaint is about one of the following: Failure to provide services/items in a timely manner; failure to decide a complaint or grievance within 30 days; or denial of service/item as not a covered benefit (whether prior authorization or payment denial); or denial because the service/item was provided without authorization by a non-MA enrolled provider.]

Request a Fair Hearing

You may ask for a Fair Hearing from the Department of Human Services. Your request for a Fair Hearing must be in writing and must be postmarked **within 30 days from the date on this notice**. Your request should include the following information:

- Your (the Member's) name, social security number, and date of birth;
- A telephone number where you can be reached during the day;
- Whether you want to have a hearing in person or by telephone;
- The reason(s) you are asking for a Fair Hearing, or a copy of this notice;
- A copy of the original denial notice, if available. **[PH-MCO: Include this last item only for complaints challenging a denial because service/item is not a covered benefit or because the service/item was provided without authorization by a non-MA provider.]**

Your request for a Fair Hearing must be sent to the following address:

Department of Human Services
OMAP – HealthChoices Program
Complaint, Grievance and Fair Hearings
P.O. Box 2675
Harrisburg, PA 17105-2675

The Department will issue a decision between 60 and 90 days from when it receives your request (see your Member handbook for more details).

To ask for an early decision

If your doctor or dentist believes that the usual time frame for deciding a Fair Hearing could harm your health, you may ask that the Fair Hearing take place more quickly. To do this:

- Call the Department at 1-800-798-2339, or fax your request to the Department at 1-717-772-6328;
- Your doctor or dentist must fax a signed letter to 1-717-772-6328 explaining why taking the usual amount of time to decide your request for a Fair Hearing could harm your health. If your doctor or dentist does not send a letter, your doctor or dentist must testify at the Fair Hearing to explain why taking the usual amount of time to decide your request for a Fair Hearing could harm your health.

The Department will schedule a telephone hearing and notify you of its decision within three business days from when it receives your request.

Request Guidelines

You may ask for a copy of the rules or other guidelines on which the decision was based by sending a written request to:

[PH-MCO Name and Address]

Get Help with Complaints or Fair Hearings

If you need help filing a complaint or request a Fair Hearing, you can call:

- [PH MCO Name] at [Phone #/Toll-freeTTY#]

To ask for free legal help with your complaint or Fair Hearing, or with filing your complaint or request for Fair Hearing, you can call:

- Pennsylvania Health Law Project at 1-800-274-3258 (www.phlp.org) <OR>

- Pennsylvania Legal Aid Network at 1-800-322-7572 (www.palegalaid.net)

Sincerely,

[PH-MCO Name]

cc: **[Provider, if BBA complaint]**
[Member representative, if designated]

[PH-MCO, the following statement must appear in English, Russian, Cambodian, Vietnamese, Spanish, Chinese, and any other language as required by the contract:]

The information in this notice is about the complaint you filed with [PH-MCO Name]. It is available in other languages and formats by calling [PH-MCO Name] at [Phone #/Toll-free TTY #].

EXHIBIT GG(3b)

1ST LEVEL GRIEVANCE DECISION NOTICE

[Date Notice Mailed (no more than 5 business days after the date of the first level grievance decision)]

Member Name
Address
City, State Zip

Member ID: *********

Subject: Decision About Your Grievance

Dear **[Member Name]**:

[PH-MCO Name] has reviewed your grievance about **[issue]**, received on **[date]**.

Based on a review of all information provided, the first level grievance review committee has decided that **[state decision in detail]**.

The reasons for this decision are:
[Explain in detail every reason for decision. In addition to explanation for decision, include specific references to approved criteria, rules or protocols on which decision is based. If denied because of insufficient information, identify all additional information needed to render decision.]

To continue getting services:
If you have been receiving the services/items that are being reduced, changed, or denied and you file a second level grievance or request for a Fair Hearing (see instructions below) that is postmarked or hand-delivered **within 10 days from the date on this notice**, the services/items will continue until a decision is made.

IF YOU DO NOT AGREE WITH THIS DECISION, YOU MAY DO ONE OR ALL OF THE FOLLOWING:

File a Second Level Grievance

You may file a second level grievance with **[PH-MCO Name]** **within 45 days from the date you get this notice.** A decision will be made on your second level grievance no later than **[45, unless PH-MCO will be using a shorter time frame to decide 2nd level grievances]** days from when we receive it.

To file a second level grievance:

- Call **[PH-MCO Name]** at **[Phone #/Toll-free TTY #];**
- Fax **[PH-MCO Fax #]**; **or**
- Send your grievance to **[PH-MCO Name]** at the following address:

[PH-MCO Address for filing grievance]

❖ **To ask for an early decision**

If your doctor or dentist believes that waiting **[45, unless the PH-MCO will be using a shorter time frame to decide 2nd level grievances]** days to get a decision could harm your health, you may ask that your grievance be decided more quickly. To do this:

- Call **[PH-MCO Name]** at **[Phone #/Toll-free TTY #]**; **OR**
- Fax a letter to **[PH-MCO Name]** at **[PH-MCO Fax#]**;

AND

- Your doctor or dentist must fax a signed letter to **[PH-MCO Fax #]** explaining why taking **[45, unless the PH-MCO will be using a shorter time frame to decide 2nd level grievances]** days to decide your grievance could harm your health.

[PH-MCO Name] will notify you of the decision within 48 hours from when we receive your doctor's or dentist's letter, or within 3 business days from when we receive your request for an early decision, whichever is sooner.

Request a Fair Hearing

You may ask for a Fair Hearing from the Department of Human Services. Your request for a Fair Hearing must be in writing and must be postmarked **within 30 days from the date on this notice**. Your request should include the following information:

- Your (the Member's) name, social security number, and date of birth;
- A telephone number where you can be reached during the day;
- Whether you want to have a hearing in person or by telephone;
- The reason(s) you are asking for a Fair Hearing, or a copy of this notice;
- A copy of the original denial notice, if available.

Your request for a Fair Hearing must be sent to the following address:

Department of Human Services
OMAP – HealthChoices Program
Complaint, Grievance and Fair Hearings
P.O. Box 2675
Harrisburg, PA 17105-2675

The Department will issue a decision between 60 and 90 days from when it receives your request (see your Member handbook for more details).

❖ **To ask for an early decision**

If your doctor or dentist believes that the usual time frame for deciding a Fair Hearing could harm your health, you may ask that the Fair Hearing take place more quickly. To do this:

- Call the Department at 1-800-798-2339, or fax your request to the Department at 1-717-772-6328;
- Your doctor or dentist must fax a signed letter to 1-717-772-6328 explaining why taking the usual amount of time to decide your request for a Fair Hearing could harm your health. If your doctor or dentist does not send a letter, your doctor or dentist must testify at the Fair Hearing to explain why taking the usual amount of time to decide your request for a Fair Hearing could harm your health.

The Department will schedule a telephone hearing and notify you of its decision within three business days from when it receives your request.

Request Criteria

You may ask for a copy of the medical necessity criteria or other rules on which the decision was based by sending a written request to:

[PH-MCO Name and Address]

Get Help with Grievances or Fair Hearings

If you need help filing a grievance or request a Fair Hearing, you can call:

- [PH MCO Name] at [Phone #/Toll-freeTTY#]

To ask for free legal help with your grievance or Fair Hearing, or with filing your grievance or request for Fair Hearing, you can call:

- Pennsylvania Health Law Project at 1-800-274-3258 (www.phlp.org) <OR>
- Pennsylvania Legal Aid Network at 1-800-322-7572 (www.palegalaid.net)

Sincerely,

[PH-MCO Name]

cc: **[Provider]**
[Member representative, if designated]

[PH-MCO, the following statement must appear in English, Russian, Cambodian, Vietnamese, Spanish, Chinese, and any other language as required by the contract:]

The information in this notice is about the grievance you filed with [PH-MCO Name]. It is available in other languages and formats by calling [PH-MCO Name] at [Phone #/Toll-free TTY #].

EXHIBIT GG(4)

2ND LEVEL COMPLAINT ACKNOWLEDGMENT LETTER

[Date Letter Mailed]

Member Name
Address
City, State Zip

Member ID: *********

Subject: Your Second Level Complaint About ***[Complaint Issue]***

Dear **[Member Name]**:

[PH-MCO Name] received your second level complaint about **[identify subject of complaint]** on **[date of receipt]**.

The Second Level Complaint Process

A committee of three or more people, including at least one person who does not work for **[PH-MCO Name]**, who have not been involved in the issue you filed your complaint about will make a decision about your complaint by **[date that is no more than 45 days from receipt of the complaint]**. This is called the "complaint review." A letter will be mailed to you within five business days after the decision is made, telling you each reason for the decision.

At any time during the complaint process, you can have someone you know represent you or act on your behalf. This person will be "your representative." If you decide to have someone represent you or act for you, tell **[PH-MCO Name]**, in writing, the name of that person and how we can reach him or her.

You or your representative may ask **[PH-MCO Name]** to see any information relevant to your complaint. You may also send information that you have about your complaint to **[PH-MCO Name]**:

[PH-MCO Address]

You and your representative may appear at the complaint review in person, by phone or by videoconference, if available, by calling **[PH-MCO Name]** at **[PH-MCO Phone #/Toll-free TTY #]**. Please note, for videoconference you must contact the PH-MCO within 10 days of this notice. You may also bring a family member, friend, lawyer or other person to help you. We will send you another letter at least 15 days before the date of the complaint review, telling you the place, date and time of the review. If you decide that you do not want to attend, that will not affect the decision of the committee.

Get Help with Complaints, or Fair Hearings

If you need help filing a complaint or request a Fair Hearing, you can call:

- [PH MCO Name] at [Phone #/Toll-freeTTY#]

To ask for free legal help with your complaint or Fair Hearing, or with filing your complaint or request for Fair Hearing, you can call:

- Pennsylvania Health Law Project at 1-800-274-3258 (www.phlp.org) <OR>
- Pennsylvania Legal Aid Network at 1-800-322-7572 (www.palegalaid.net)

If your second level complaint is described correctly at the top of this letter, please sign below and return this letter to:

[PH-MCO Address]

If your second level complaint is not described correctly, please call **[PH-MCO Name]** at **[PH-MCO Phone #/Toll-free TTY #]**.

Sincerely,

[PH-MCO Name]

cc: **[Member Representative, if designated]**

[PH-MCO, the following statement must appear in English, Russian, Cambodian, Vietnamese, Spanish, Chinese, and any other language as required by the contract:]

The information in this letter is about the complaint you filed with [PH-MCO Name]. It is available in other languages and formats by calling [PH-MCO Name] at [Phone #/Toll-free TTY #].

Member ID: _____

I agree that my second level complaint is described correctly.

_____ _____

Member's or Member's Representative Signature Date

EXHIBIT GG(5)

2ND LEVEL COMPLAINT DECISION NOTICE

[Date Notice Mailed (no more than 5 business days after the second level complaint decision)]

Member Name
Address
City, State Zip

Member ID: *********

Subject: Decision About Your Second Level Complaint

Dear **[Member Name]**:

[PH-MCO Name] has reviewed your second level complaint about **[issue]**, received on **[date]**.

Based on a review of all information provided, the second level complaint review committee has decided that **[state decision in detail]**.

The reasons for this decision are: **[Explain in detail every reason for decision. In addition to explanation for decision, include specific references to approved criteria, rules or protocols on which decision is based. If unable to make a decision because of insufficient information, identify all additional information needed to render decision.]**

[PH-MCO: Include the following paragraph only if the complaint challenges a denial because the service/item is not a covered benefit.]

To continue getting services:
If you have been receiving the services/items that are being reduced, changed, or denied and you file a request for an external review or request for a Fair Hearing (see instructions below) that is postmarked or hand-delivered **within 10 days from the date on this notice**, the services/items will continue until a decision is made.

IF YOU DO NOT AGREE WITH THIS DECISION, YOU MAY DO ONE OR ALL OF THE FOLLOWING

Request an External Review

You may ask for an "external review" of the second level complaint decision from the Pennsylvania Department of Health or the Pennsylvania Insurance Department **within 15 days from the date you get this notice**.

Send your request to one of the following addresses:

Pennsylvania Department of Health
Bureau of Managed Care
Health and Welfare Building, Room 912
625 Forster Street
Harrisburg, Pennsylvania 17120-0701
Telephone: 1-888-466-2787; Fax: 1-717-705-0947
AT&T Relay: 1-800-654-5984 (for persons with hearing impairments)

Pennsylvania Insurance Department
Bureau of Customer Service
1321 Strawberry Square
Harrisburg, PA 17120
Telephone: 1-877-881-6388

Your request for external review by either Department must include the following information:

- Your (the Member's) name, address, and daytime telephone number;
- Your (the Member's) **[PH-MCO Name]** identification number;
- **[PH-MCO Name]'**s name;
- A brief description of the issue;
- A copy of this notice.

If you send your request for external review to the wrong Department, that Department will send it to the other Department.

[PH-MCO: Include the following paragraphs on Fair Hearings and Expedited Fair Hearings only if the complaint is about one of the following: Failure to provide services/items in a timely manner; failure to decide a complaint or grievance within 30 days; or denial of service/item as not a covered benefit (whether prior authorization or payment denial); or denial because the service/item was provided without authorization by a non-MA enrolled provider.]

Request a Fair Hearing

You may ask for a Fair Hearing from the Department of Human Services. Your request for a Fair Hearing must be in writing and must be postmarked **within 30 days from the date on this notice**. Your request should include the following information:

- Your (the Member's) name, social security number, and date of birth;
- A telephone number where you can be reached during the day;
- Whether you want to have a hearing in person or by telephone;
- The reason(s) you are asking for a Fair Hearing, or a copy of this notice;

- A copy of the original denial notice, if available. **[PH-MCO: Include this last item only for complaints challenging a denial because a service/item is not a covered benefit or because the service/item was provided without authorization by a non-MA provider.]**

Your request for a Fair Hearing must be sent to the following address:

Department of Human Services
OMAP – HealthChoices Program
Complaint, Grievance and Fair Hearings
P.O. Box 2675
Harrisburg, PA 17105-2675

The Department will issue a decision within 90 days from when it receives your request.

To ask for an early decision

If your doctor or dentist believes that the usual time frame for deciding a Fair Hearing could harm your health, you may ask that the Fair Hearing take place more quickly. To do this:

- Call the Department at 1-800-798-2339, or fax your request to the Department at 1-717-772-6328;
- Your doctor or dentist must fax a signed letter to 1-717-772-6328 explaining why taking the usual amount of time to decide your request for a Fair Hearing could harm your health. If your doctor or dentist does not send a letter, your doctor or dentist must testify at the Fair Hearing to explain why taking the usual amount of time to decide your request for a Fair Hearing could harm your health.

  The Department will schedule a telephone hearing and notify you of its decision within three business days from when it receives your request.

Request Guidelines

You may ask for a copy of the rules or other guidelines on which the decision was based by sending a written request to:

[PH-MCO Name and Address]

[PH-MCO: Choose one of the following two paragraphs, depending on whether Fair Hearing paragraphs are included in notice:]

To get help with a request for external review or Fair Hearing

- If you need help filing a request for an external review, call **[PH-MCO Name]** at **[PH-MCO Phone #/Toll-free TTY #]** and **[PH-MCO Name]** will assign a staff person who has not been involved in the complaint issue to help you.
- If you have any other questions, or need help filing a request for a Fair Hearing, you may call **[PH-MCO Name]** at **[PH-MCO Phone #/Toll-free TTY #]**, Pennsylvania Legal Services at 1-800-322-7572 www.palegalaid.net), or the Pennsylvania Health Law Project at 1-800-274-3258 (www.phlp.org).

OR

To get help with a request for external review

If you need help filing a request for external review, you can call:

- [PH MCO Name] at [Phone #/Toll-free TTY#]

To ask for free legal help with your request for external review or with filing your request for external review, you can call:

- Pennsylvania Health Law Project at 1-800-274-3258 (www.phlp.org) <OR>
- Pennsylvania Legal Aid Network at 1-800-322-7572 (www.palegalaid.net)

Sincerely,

[PH-MCO Name]

cc: **[Provider, if BBA complaint]**
[Member Representative, if designated]

[PH-MCO, the following statement must appear in English, Russian, Cambodian, Vietnamese, Spanish, Chinese, and any other language as required by the contract:]

The information in this notice is about the complaint you filed with [PH-MCO Name]. It is available in other languages and formats by calling [PH-MCO Name] at [Phone #/Toll-free TTY #].

EXHIBIT GG(6a)

EXPEDITED COMPLAINT DECISION NOTICE

[Date Notice Mailed (no more than 2 days after the date of the decision)]

Member Name
Address
City, State Zip

Member ID: *********

Subject: "Expedited" Decision About Your Complaint

Dear **[Member Name]**:

[PH-MCO Name] has reviewed your complaint about **[issue]**, received on **[date]**.

Based on a review of all information provided, the review committee has decided that **[state decision in detail].**

The reasons for this decision are:
[Explain in detail every reason for decision. In addition to explanation for decision, include specific references to approved criteria, rules or protocols on which decision is based. If unable to make a decision because of insufficient information, identify all additional information needed to render decision.]

[PH-MCO: Include the following paragraph only if the complaint challenges a denial because the service/item is not a covered benefit.]

To continue getting services
If you have been receiving the services/items that are being reduced, changed, or denied and you file a second level complaint or request for a Fair Hearing (see instructions below) that is postmarked or hand-delivered **within 10 days from the date on this notice**, the services/items will continue until a decision is made.

IF YOU DO NOT AGREE WITH THIS DECISION, YOU MAY DO ONE OR ALL OF THE FOLLOWING:

Request an Expedited External Review

You may ask for an "expedited external review" of the complaint decision from the Pennsylvania Department of Health. You must ask for the external review **within 2 business days from the date you get this notice.**

To ask for an expedited external review:

- Call **[PH-MCO Name]** at **[Phone #/Toll-free TTY #]**; **or**
- Fax a letter to **[PH-MCO Name]** at **[PH-MCO Fax #]**;
- Send your request to **[PH-MCO Name]** at the following address:

[PH-MCO Address for requesting external review]

Request a Fair Hearing

To ask for an early decision

You may ask for a Fair Hearing from the Department of Welfare. If your doctor or dentist still believes that the usual time frame for deciding a Fair Hearing (between 60 and 90 days) could harm your health, you may ask that the Fair Hearing take place more quickly. To do this:

- Call the Department at 1-800-798-2339, or fax your request to the Department at 1-717-772-6328;
- Your doctor or dentist must fax a signed letter to 1-717-772-6328 explaining why taking the usual amount of time to decide your request for a Fair Hearing could harm your health. If your doctor or dentist does not send a letter, your doctor or dentist must testify at the Fair Hearing to explain why taking the usual amount of time to decide your request for a Fair Hearing could harm your health.

The Department will schedule a telephone hearing and notify you of its decision within three business days from when it receives your request.

Even if you no longer need an early decision, you may ask for a Fair Hearing from the Department of Human Services. Your request for a Fair Hearing must be in writing and must be postmarked **within 30 days from the date on this notice**. Your request should include the following information:

- Your (the Member's) name, social security number, and date of birth;
- A telephone number where you can be reached during the day;
- Whether you want to have a hearing in person or by telephone;
- The reason(s) you are asking for a Fair Hearing, or a copy of this notice;
- A copy of the original denial notice, if available. **[PH-MCO: include this last item only for complaints challenging a denial because service/item is not a covered benefit.]**

Your request for a Fair Hearing must be sent to the following address:

Department of Human Services
OMAP – HealthChoices Program

Complaint, Grievance and Fair Hearings
P.O. Box 2675
Harrisburg, PA 17105-2675

The Department will issue a decision between 60 and 90 days from when it receives your request (see your Member handbook for more details).

Request Guidelines

You may ask for a copy of the rules or other guidelines on which the decision was based by sending a written request to:

[PH-MCO Name and Address]

To get help with a request for external review or Fair Hearing

If you need help filing a request for an external review or Fair Hearing, you can call:

- [PH MCO Name] at [Phone #/Toll-free TTY#]

To ask for free legal help with your request for external review or Fair Hearing, you can call:

- Pennsylvania Health Law Project at 1-800-274-3258 (www.phlp.org) <OR>
- Pennsylvania Legal Aid Network at 1-800-322-7572 (www.palegalaid.net)

Sincerely,

[PH-MCO Name]

cc: **[Provider]**
[Member Representative, if designated]

[PH-MCO, the following statement must appear in English, Russian, Cambodian, Vietnamese, Spanish, Chinese, and any other language as required by the contract:]

The information in this notice is about the complaint you filed with [PH-MCO Name]. It is available in other languages and formats by calling [PH-MCO Name] at [Phone #/Toll-free TTY #].

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EXHIBIT GG(6b)

NOTICE OF FAILURE TO RECEIVE PROVIDER CERTIFICATION FOR AN EXPEDITED COMPLAINT OR GRIEVANCE

[Date Notice Mailed (no more than 2 days after date of decision to deny expedited review)]

Member Name
Address
City, State Zip

Member ID: *********

Subject: Request for "Expedited" **[complaint][grievance]**

Dear **[Member Name]**:

[PH-MCO Name] received your **[complaint] [grievance]** about **[identify subject of complaint/grievance]**, on **[date]** and your request to have the **[complaint] [grievance]** decided more quickly than the usual **[30, unless the PH-MCO will be using a shorter time frame to decide 1st level complaints/grievances]**-day time frame. As we told you when you filed your **[complaint] [grievance]**, in order for your **[complaint] [grievance]** to be decided more quickly, your **[doctor] [dentist]** needed to send us a signed, written statement that taking the usual amount of time to decide the **[complaint] [grievance]** could harm your health. **[PH-MCO Name]** also asked your **[doctor] [dentist]** for this statement.

[PH-MCO Name] has not received your **[doctor's] [dentist's]** statement, so your **[complaint] [grievance]** will be decided within the usual time frame of **[30, unless the PH-MCO will be using a shorter time frame to decide 1st level complaints/grievances]** days from when we first got your **[complaint] [grievance]**.

[PH-MCO: Choose one of the following two paragraphs:]

The First Level Complaint Process

A committee of one or more **[PH-MCO Name]** staff who have not been involved in the issue you filed your complaint about will make a decision about your complaint by **[date that is no more than 30 days from receipt of the complaint]**. This is called the "complaint review." A letter will be mailed to you within five business days after the decision is made, telling you each reason for the decision.

OR

The First Level Grievance Process

A committee of one or more **[PH-MCO Name]** staff, that includes a licensed doctor, who have not been involved in the issue you filed your grievance about, will review your grievance. This is called the "grievance review." A decision will be made by **[date that is no more than 30 days from receipt of the grievance]**. A letter will be mailed to you within five business days after the decision is made, telling you each reason for the decision.

At any time during the **[complaint] [grievance]** process, you can have someone you know represent you or act on your behalf. This person will be "your representative." If you decide to have someone represent you or act for you, tell **[PH-MCO Name]**, in writing, the name of that person and how we can reach him or her.

You or your representative may ask **[PH-MCO Name]** to see any information relevant to your **[complaint] [grievance]**. You may also send information that you have about your **[complaint] [grievance]** to **[PH-MCO Name]**:

[PH-MCO Address]

You and your representative may appear at the **[complaint] [grievance]** review in person, by phone or by videoconference, if available, by calling **[PH-MCO Name]** at **[PH-MCO Phone #] within ten days from the date on this notice**. You may also bring a family member, friend, lawyer or other person to help you. If you decide that you do not want to attend, that will not affect the decision of the committee.

[PH-MCO: For complaints, include the following paragraphs on Fair Hearings and Expedited Fair Hearings only if the complaint is about one of the following: Failure to provide services/items in a timely manner; failure to decide a complaint or grievance within 30 days; or denial of service/item as not a covered benefit (whether prior authorization or payment denial); or denial because the service/item was provided without authorization by a non-MA enrolled provider. Include the paragraphs for all grievances.]

The Fair Hearing Process

You may also ask for a Fair Hearing from the Department of Human Services. Your request for a Fair Hearing must be in writing and must be postmarked **within 30 days from the date on this notice.** Your request should include the following information:

- Your (the Member's) name, social security number, and date of birth;
- A telephone number where you can be reached during the day;
- Whether you want to have a hearing in person or by telephone;
- The reason(s) you are asking for a Fair Hearing, or a copy of this notice;
- A copy of the original denial notice, if available. **[PH-MCO: Include this last item for complaints challenging a denial because service/item is not a covered benefit or because the service/item was provided without authorization by a non-MA provider, and for all grievances.]**

Your request for a Fair Hearing must be sent to the following address:

Department of Human Services
OMAP – HealthChoices Program
Complaint, Grievance and Fair Hearings
P.O. Box 2675
Harrisburg, PA 17105-2675

The Department will issue a decision between 60 and 90 days from when it receives your request (see your Member handbook for more details).

To ask for an early decision

If your doctor or dentist believes that the usual time frame for deciding a Fair Hearing could harm your health, you may ask that the Fair Hearing take place more quickly. To do this:

- Call the Department at 1-800-798-2339, or fax your request to the Department at 1-717-772-6328;
- Your doctor or dentist must fax a signed letter to 1-717-772-6328 explaining why taking the usual amount of time to decide your request for a Fair Hearing could harm your health. If your doctor or dentist does not send a letter, your doctor or dentist must testify at the Fair Hearing to explain why taking the usual amount of time to decide your request for a Fair Hearing could harm your health.

The Department will schedule a telephone hearing and notify you of its decision within three business days from when it receives your request.

Get Help with Grievances, Complaints, or Fair Hearings

If you need help filing a grievance, complaint, or request a Fair Hearing, you can call:

- [PH MCO Name] at [Phone #/Toll-free TTY#]

To ask for free legal help with your grievance, complaint, or Fair Hearing, or with filing your grievance, complaint or request for Fair Hearing, you can call:

- Pennsylvania Health Law Project at 1-800-274-3258 (www.phlp.org) <OR>
- Pennsylvania Legal Aid Network at 1-800-322-7572 (www.palegalaid.net)

Sincerely,

[PH-MCO Name]

cc: **[Provider]**

[Member Representative, if designated]

[PH-MCO, the following statement must appear in English, Russian, Cambodian, Vietnamese, Spanish, Chinese, and any other language as required by the contract:]

The information in this notice is about the [complaint] [grievance] you filed with [PH-MCO Name]. It is available in other languages and formats by calling [PH-MCO Name] at [Phone #/Toll-free TTY #].

EXHIBIT GG(7)

1ST LEVEL GRIEVANCE ACKNOWLEDGMENT LETTER

[Date Letter Mailed]

Member Name
Address
City, State Zip

Member ID: *********

Subject: Your Grievance About ***[Grievance Issue]***

Dear **[Member Name]**:

[PH-MCO Name] received your grievance about **[identify subject of grievance]** on **[date of receipt]**.

The First Level Grievance Process

A committee of one or more **[PH-MCO Name]** staff, that includes a licensed doctor, who have not been involved in the issue you filed your grievance about, will review your grievance. This is called the "grievance review." A decision will be made by **[date that is no more than 30 days from receipt of the grievance]**. A letter will be mailed to you within five business days after the decision is made, telling you each reason for the decision.

At any time during the grievance process, you can have someone you know represent you or act on your behalf. This person will be "your representative." If you decide to have someone represent you or act for you, tell **[PH-MCO Name]**, in writing, the name of that person and how we can reach him or her.

You or your representative may ask **[PH-MCO Name]** to see any information relevant to your grievance. You may also send information that you have about your grievance to **[PH-MCO Name]**:

[PH-MCO Address]

You and your representative may appear at the grievance review in person, by phone or by videoconference, if available, by calling **[PH-MCO Name]** at **[PH-MCO Phone #/Toll-free TTY #].** Please note, for videoconference you must contact the PH-MCO within 10 days of this notice. You may also bring a family member, friend, lawyer or other person to help you. If you decide that you do not want to attend, that will not affect the decision of the committee.

If you think your issue is really a complaint and should not be treated as a grievance, you may call or write to the Pennsylvania Department of Health:

Pennsylvania Department of Health
Bureau of Managed Care
Health and Welfare Building, Room 912
625 Forster Street
Harrisburg, Pennsylvania 17120-0701
Telephone: 1-888-466-2787; Fax: 1-717-705-0947
AT&T Relay: 1-800-654-5984 (for persons with hearing impairments)

If you need more information on what a complaint is, you can read your Member handbook or call **[PH-MCO Name]** at **[PH-MCO Phone #/Toll-free TTY #].**

Get Help with Grievances or Fair Hearings

If you need help filing a grievance or request a Fair Hearing, you can call:

- [PH MCO Name] at [Phone #/Toll-free TTY#]

To ask for free legal help with your grievance or Fair Hearing, or with filing your grievance or request for Fair Hearing, you can call:

- Pennsylvania Health Law Project at 1-800-274-3258 (www.phlp.org) <OR>
- Pennsylvania Legal Aid Network at 1-800-322-7572 (www.palegalaid.net)

If your grievance is described correctly at the top of this letter, please sign below and return this letter to:

[PH-MCO Address]

If your grievance is not described correctly, please call **[PH-MCO Name]** at **[PH-MCO Phone #/Toll-free TTY #]**.

Sincerely,

[PH-MCO Name]

cc: **[Provider]**
[Member Representative, if designated]

[PH-MCO, the following statement must appear in English, Russian, Cambodian, Vietnamese, Spanish, Chinese, and any other language as required by the contract:]

The information in this letter is about the grievance you filed with [PH-MCO Name]. It is available in other languages and formats by calling [PH-MCO Name] at [Phone #/Toll-free TTY #].

Member ID: _____

I agree that my grievance is described correctly.

_____ _____

Member's or Member's Representative Signature Date

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EXHIBIT GG(8)

2ND LEVEL GRIEVANCE ACKNOWLEDGMENT LETTER

[Date Letter Mailed]

Member Name
Address
City, State Zip

Member ID: *********

Subject: Your Second Level Grievance About ***[Grievance Issue]***

Dear **[Member Name]**:

[PH-MCO Name] received your second level grievance about **[identify subject of grievance]** on **[date of receipt].**

The Second Level Grievance Process

A committee of three or more people, which includes a licensed doctor, who have not been involved in the issue you filed your grievance about, will review your grievance. This is called the "grievance review." A decision will be made by **[date that is no more than 45 days from receipt of the grievance]**. A letter will be mailed to you within five business days after the decision is made, telling you each reason for the decision.

At any time during the grievance process, you can have someone you know represent you or act on your behalf. This person will be "your representative." If you decide to have someone represent you or act for you, tell **[PH-MCO Name]**, in writing, the name of that person and how we can reach him or her.

You or your representative may ask **[PH-MCO Name]** to see any information relevant to your grievance. You may also send information that you have about your grievance to **[PH-MCO Name]**:

[PH-MCO Address]

You and your representative may appear at the grievance review in person, by phone or by videoconference, if available, by calling **[PH-MCO Name]** at **[PH-MCO Phone #/Toll-free TTY #].** Please note, for videoconference you must contact the PH-MCO within 10 days of this notice. You may also bring a family member, friend, lawyer or other person to help you. We will send you another letter at least 15 days before the date of the grievance review, telling you the place, date and time of the review. If you decide that you do not want to attend, that will not affect the decision of the committee.

Get Help with Grievances or Fair Hearings

If you need help filing a grievance or request a Fair Hearing, you can call:

- [PH MCO Name] at [Phone #/Toll-free TTY#]

To ask for free legal help with your grievance or Fair Hearing, or with filing your grievance or request for Fair Hearing, you can call:

- Pennsylvania Health Law Project at 1-800-274-3258 (www.phlp.org) <OR>
- Pennsylvania Legal Aid Network at 1-800-322-7572 (www.palegalaid.net)

If your second level grievance is described correctly at the top of this letter, please sign below and return this letter to:

[PH-MCO Address]

If your second level grievance is not described correctly, please call **[PH-MCO Name]** at **[PH-MCO Phone #/Toll-free TTY #]**.

Sincerely,

[PH-MCO Name]

cc: **[Provider]**
[Member Representative, if designated]

[PH-MCO, the following statement must appear in English, Russian, Cambodian, Vietnamese, Spanish, Chinese, and any other language as required by the contract:]

The information in this letter is about the grievance you filed with [PH-MCO Name]. It is available in other languages and formats by calling [PH-MCO Name] at [Phone #/Toll-free TTY #].

Member ID: _____

I agree that my second level grievance is described correctly.

_____ _____
Member's or Member's Representative Signature Date

EXHIBIT GG(9)

2ND LEVEL GRIEVANCE DECISION NOTICE

[Date Notice Mailed (no more than 5 business days after the date of the second level grievance decision)]

Member Name
Address
City, State Zip

Member ID: *********

Subject: Decision About Your Second Level Grievance

Dear **[Member Name]**:

[PH-MCO Name] has reviewed your second level grievance about **[issue],** received on **[date]**.

Based on a review of all information provided, the second level grievance review committee has decided that **[state decision in detail]**.

The reasons for this decision are:
[Explain in detail every reason for decision. In addition to explanation for decision, include specific references to approved criteria, rules or protocols on which decision is based. If denied because of insufficient information, identify all additional information needed to render decision.]

To continue getting services
If you have been receiving the services/items that are being reduced, changed or denied and you file a request for an external review or request for a Fair Hearing (see instructions below) that is postmarked or hand-delivered **within 10 days from the date on this notice**, the services/items will continue until a decision is made.

IF YOU DO NOT AGREE WITH THIS DECISION, YOU MAY DO ONE OR ALL OF THE FOLLOWING

Request an External Review

You may ask for an "external review" of the second level grievance decision **within 15 days from the date you get this notice.** An external review is a review by a licensed doctor who does not work for **[PH-MCO Name].**

Your request for an external review must be sent to the following address:

[PH-MCO Address for requesting external review]

A decision will be issued within 60 days from when we receive your request.

Request a Fair Hearing

You may ask for a Fair Hearing from the Department of Human Services. Your request for a Fair Hearing must be in writing and must be postmarked **within 30 days from the date on this notice**. Your request should include the following information:

- Your (the Member's) name, social security number, and date of birth;
- A telephone number where you can be reached during the day;
- Whether you want to have a hearing in person or by telephone;
- The reason(s) you are asking for a Fair Hearing, or a copy of this notice;
- A copy of the original denial notice, if available.

Your request for a Fair Hearing must be sent to the following address:

Department of Human Services
OMAP – HealthChoices Program
Complaint, Grievance and Fair Hearings
P.O. Box 2675
Harrisburg, PA 17105-2675

The Department will issue a decision within 90 days from when it receives your request.

To ask for an early decision

If your doctor or dentist believes that the usual time frame for deciding a Fair Hearing could harm your health, you may ask that the Fair Hearing take place more quickly. To do this:

- Call the Department at 1-800-798-2339, or fax your request to the Department at 1-717-772-6328;
- Your doctor or dentist must fax a signed letter to 1-717-772-6328 explaining why taking the usual amount of time to decide your request for a Fair Hearing could harm your health. If your doctor or dentist does not send a letter, your doctor or dentist must testify at the Fair Hearing to explain why taking the usual amount of time to decide your request for a Fair Hearing could harm your health.

The Department will schedule a telephone hearing and notify you of its decision within three business days from when it receives your request.

Request Criteria

You may ask for a copy of the medical necessity criteria or other rules on which the decision was based by sending a written request to:

[PH-MCO Name and Address]

To get help with a request for external review or Fair Hearing

If you need help filing a request for external review or Fair Hearing, you can call:

- [PH MCO Name] at [Phone #/Toll-free TTY#]

To ask for free legal help with your request for external review or Fair Hearing, or with filing your request for external review or request for Fair Hearing, you can call:

- Pennsylvania Health Law Project at 1-800-274-3258 (www.phlp.org) <OR>
- Pennsylvania Legal Aid Network at 1-800-322-7572 (www.palegalaid.net)

Sincerely,

[PH-MCO Name]

cc: **[Provider]**
[Member Representative, if designated]

[PH-MCO, the following statement must appear in English, Russian, Cambodian, Vietnamese, Spanish, Chinese, and any other language as required by the contract:]

The information in this notice is about the grievance you filed with [PH-MCO Name]. It is available in other languages and formats by calling [PH-MCO Name] at [Phone #/ Toll-free TTY #].

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EXHIBIT GG(10)

EXPEDITED GRIEVANCE DECISION NOTICE

[Date Notice Mailed (no more than 2 days after the date of the decision)]

Member Name
Address
City, State Zip

Member ID: *********

Subject: "Expedited" Decision About Your Grievance

Dear **[Member Name]**:

[PH-MCO Name] has reviewed your grievance about **[issue]**, received on **[date]**.

Based on a review of all information provided, the review committee has decided that **[state decision in detail]**.

The reasons for this decision are:
[Explain in detail every reason for decision. In addition to explanation for decision, include specific references to approved criteria, rules or protocols on which decision is based. If denied because of insufficient information, identify all additional information needed to render decision.]

To continue getting services
If you have been receiving the services/items that are being reduced, changed, or denied and you file a request for an external review or request for a Fair Hearing (see instructions below) that is postmarked or hand-delivered **within 10 days from the date on this notice**, the services/items will continue until a decision is made.

IF YOU DO NOT AGREE WITH THIS DECISION, YOU MAY DO ONE OR ALL OF THE FOLLOWING:

Request an Expedited External Review

You may ask for an "expedited external review" of the grievance decision. An external review is a review by a licensed doctor who does not work for **[PH-MCO Name].** You must ask for the external review **within two business days from the date you get this notice**. A decision will be issued within five business days from when we receive your request.

To ask for an external review:

- Call **[PH-MCO Name]** at **[Phone #/Toll-free TTY #]**;
- Fax a letter to **[PH-MCO Name]** at **[PH-MCO Fax#]; or**

- Send your request to **[PH-MCO Name]** at the following address:

[PH-MCO Address for requesting external review]

Request a Fair Hearing

To ask for an early decision

You may ask for a Fair Hearing from the Department of Human Services. If your doctor or dentist still believes that the usual time frame for deciding a Fair Hearing (between 60 and 90 days) could harm your health, you may ask that the Fair Hearing take place more quickly. To do this:

- Call the Department at 1-800-798-2339, or fax your request to the Department at 1-717-772-6328;
- Your doctor or dentist must fax a signed letter to 1-717-772-6328 explaining why taking the usual amount of time to decide your request for a Fair Hearing could harm your health. If your doctor or dentist does not send a letter, your doctor or dentist must testify at the Fair Hearing to explain why taking the usual amount of time to decide your request for a Fair Hearing could harm your health.

The Department will schedule a telephone hearing and notify you of its decision within three business days from when it receives your request.

Even if you no longer need an early decision, you may ask for a Fair Hearing from the Department of Human Services. The request for a Fair Hearing must be in writing and must be postmarked **within 30 days from the date on this notice**. Your request should include the following information:

- Your (the Member's) name, social security number, and date of birth;
- A telephone number where you can be reached during the day;
- Whether you want to have a hearing in person or by telephone;
- The reason(s) you are asking for a Fair Hearing, or a copy of this notice;
- A copy of the original denial notice, if available.

Your request for a Fair Hearing must be sent to the following address:

Department of Human Services
OMAP – HealthChoices Program
Complaint, Grievance and Fair Hearings
P.O. Box 2675
Harrisburg, PA 17105-2675

The Department will issue a decision between 60 and 90 days from when it receives your request (see you Member handbook for more details).

Request Criteria

You may ask for a copy of the medical necessity criteria or other rules on which the decision was based by sending a written request to:

[PH-MCO Name and Address]

To get help with a request for external review or Fair Hearing

If you need help filing a request for external review or Fair Hearing, you can call:

- [PH MCO Name] at [Phone #/Toll-free TTY#]

To ask for free legal help with your request for external review or Fair Hearing, or with filing your request for external review or request for Fair Hearing, you can call:

- Pennsylvania Health Law Project at 1-800-274-3258 (www.phlp.org) <OR>
- Pennsylvania Legal Aid Network at 1-800-322-7572 (www.palegalaid.net)

Sincerely,

[PH-MCO Name]

cc: **[Provider]**
[Member Representative, if designated]

[PH-MCO, the following statement must appear in English, Russian, Cambodian, Vietnamese, Spanish, Chinese, and any other language as required by the contract:]

The information in this notice is about the grievance you filed with [PH-MCO Name]. It is available in other languages and formats by calling [PH-MCO Name] at [Phone #/Toll-free TTY #].

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EXHIBIT GG(11)

NOTICE FOR PAYMENT DENIAL BECAUSE THE SERVICE(S)/ITEM(S) WAS PROVIDED WITHOUT AUTHORIZATION BY A PROVIDER NOT ENROLLED IN THE PENNSYLVANIA MEDICAL ASSISTANCE PROGRAM

THIS IS NOT A BILL

[Date Notice Mailed (date decision is made to deny payment)]

Member Name
Address
City, State Zip

Member ID: ********

Dear **[Member Name]**:

[PH-MCO Name] has reviewed the request for payment from **[provider's name]** for **[identify specific service/item]**, which you received on **[date]**. Your provider's request for payment has been denied because **[provider's name]** is not enrolled in the Pennsylvania Medical Assistance Program and did not ask **[PH-MCO Name]** for approval to provide the service/item to you.

[PROVIDER'S NAME] MAY BILL YOU FOR THIS SERVICE/ITEM.

IF YOU DO NOT AGREE WITH THIS DECISION, YOU MAY DO ONE OR BOTH OF THE FOLLOWING:

File a Complaint

You may file a complaint with **[PH-MCO Name]** **within 45 days from the date you get this notice.** A decision will be made on your complaint no later than **[30, unless the PH-MCO will be using a shorter time frame to decide 1st level complaints]** days from when we receive it.

To file a complaint:

- Call **[PH-MCO Name]** at **[Phone #/Toll-free TTY #]**;
- Fax **[PH-MCO Fax #]**; **or**
- Send your complaint to **[PH-MCO Name]** at the following address:

[PH-MCO Address for filing complaint]

Request a Fair Hearing

You may ask for a Fair Hearing from the Department of Human Services. Your request for a Fair Hearing must be in writing and must be postmarked **within 30 days from the date on this notice.** Your request should include the following information:

- Your (the Member's) name, social security number, and date of birth;
- A telephone number where you can be reached during the day;
- Whether you want to have a hearing in person or by telephone;
- The reason(s) you are asking for a Fair Hearing, or a copy of this notice.

Your request for a Fair Hearing must be sent to the following address:

Department of Human Services
OMAP – HealthChoices Program
Complaint, Grievance and Fair Hearings
P.O. Box 2675
Harrisburg, PA 17105-2675

The Department will issue a decision between 60 and 90 days from when it receives your request (see your Member handbook for more details).

You may appear in person or by telephone at both the complaint review and the Fair Hearing, and you may bring a family member, friend, lawyer or other person to help you.

If you file a complaint or a request for a Fair Hearing, you may ask to see any information relevant to this decision by sending a written request for the information to the following address:

[PH-MCO Address for records information]

Get Help with Complaints or Fair Hearings

If you need help filing a complaint or request a Fair Hearing, you can call:

- [PH MCO Name] at [Phone #/Toll-free TTY#]

To ask for free legal help with your complaint or Fair Hearing, or with filing your complaint or request for Fair Hearing, you can call:

- Pennsylvania Health Law Project at 1-800-274-3258 (www.phlp.org) <OR>

- Pennsylvania Legal Aid Network at 1-800-322-7572 (www.palegalaid.net)

Sincerely,

[PH-MCO Name]

cc: **[Provider]**

[PH-MCO, the following statement must appear in English, Russian, Cambodian, Vietnamese, Spanish, Chinese, and any other language as required by the contract:]

The information in this notice is about payment for medical services. It is available in other languages and formats by calling [PH-MCO Name] at [Phone #/Toll-free TTY #].

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EXHIBIT GG(12)

NOTICE FOR PAYMENT DENIAL BECAUSE THE SERVICE(S)/ITEMS(S) WAS NOT A COVERED BENEFIT FOR THE MEMBER

THIS IS NOT A BILL

[Date Notice Mailed (date decision is made to deny payment)]

Member Name
Address
City, State Zip

Member ID: *********

Dear **[Member Name]**:

[PH-MCO Name] has reviewed the request for payment from **[Provider's name]** for **[identify specific service/item]**, which you received on **[date**]. Your Provider's request for payment has been denied. The service/item you received is not a covered benefit because:

___ It is not covered under the Medical Assistance Program; **OR**

___ It is not part of your benefit package.

___ The **[Provider Name]** is not in **[PH-MCO Name]** Provider network and provided the service without **[PH-MCO Name]** authorization.

[PROVIDER'S NAME] MAY BILL YOU FOR THIS SERVICE/ITEM ONLY IF [PROVIDER'S NAME] TOLD YOU THAT THE SERVICE/ITEM WAS NOT COVERED FOR YOU BEFORE YOU GOT THE SERVICE/ITEM.

IF YOU DO NOT AGREE WITH THIS DECISION, YOU MAY DO ONE OR BOTH OF THE FOLLOWING:

File a Complaint

You may file a complaint with **[PH-MCO Name] within 45 days from the date you get this notice.** A decision will be made on your complaint no later than **[30, unless PH-MCO will be using shorter time frame to decide 1st level complaints]** days from when we receive it.

To file a complaint:

- Call **[PH-MCO Name]** at **[Phone #/Toll-free TTY #];**
- Fax **[PH-MCO Fax #]**; **or**
- Send your complaint to **[PH-MCO Name]** at the following address:

[PH-MCO Address for filing complaint]

Request a Fair Hearing

You may ask for a Fair Hearing from the Department of Human Services. Your request for a Fair Hearing must be in writing and must be postmarked **within 30 days from the date on this notice**. Your request should include the following information:

- Your (the Member's) name, social security number, and date of birth;
- A telephone number where you can be reached during the day;
- Whether you want to have a hearing in person or by telephone;
- The reason(s) you are asking for a Fair Hearing, or a copy of this notice.

Your request for a Fair Hearing must be sent to the following address:

Department of Human Services
OMAP – HealthChoices Program
Complaint, Grievance and Fair Hearings
P.O. Box 2675
Harrisburg, PA 17105-2675

The Department will issue a decision between 60 and 90 days from when it receives your request (see your Member handbook for more details).

You may appear in person or by telephone at both the complaint review and the Fair Hearing, and you may bring a family member, friend, lawyer or other person to help you.

If you file a complaint or a request for a Fair Hearing, you may ask to see all information relevant to this decision by sending a written request for the information to the following address:

[PH-MCO Address for records information]

Get Help with Complaints or Fair Hearings

If you need help filing a complaint or request a Fair Hearing, you can call:

- [PH MCO Name] at [Phone #/Toll-free TTY#]

To ask for free legal help with your complaint or Fair Hearing, or with filing your complaint or request for Fair Hearing, you can call:

- Pennsylvania Health Law Project at 1-800-274-3258 (www.phlp.org) <OR>

- Pennsylvania Legal Aid Network at 1-800-322-7572 (www.palegalaid.net)

Sincerely,

[PH-MCO Name]

cc: **[Provider]**

[PH-MCO, the following statement must appear in English, Russian, Cambodian, Vietnamese, Spanish, Chinese, and any other language as required by the contract:]

The information in this notice is about payment for medical services. It is available in other languages and formats by calling [PH-MCO Name] at [Phone #/Toll-free TTY #].

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EXHIBIT GG(13)

NOTICE FOR DENIAL OF PAYMENT AFTER A SERVICE(S) HAS BEEN DELIVERED BECAUSE THE EMERGENCY ROOM SERVICE(S) WAS NOT MEDICALLY NECESSARY

THIS IS NOT A BILL

[Date Notice Mailed (date decision is made to deny payment)]

Member Name
Address
City, State Zip

Member ID: *********

Dear **[Member Name]**:

[PH-MCO Name] has reviewed the request for payment from **[Provider's name]** for **[identify specific service]**, which you received on **[date]**. Your Provider's request for payment has been denied.

The service you received was not Medically Necessary because: **[Explain in detail every reason for denial. In addition to explanation for decision, include specific references to approved criteria, rules or protocols on which decision is based. If denied because of insufficient information, identify all additional information needed to render decision.]**

[PROVIDER'S NAME] MAY NOT BILL YOU FOR THIS SERVICE. YOU CAN SHOW THIS NOTICE TO [PROVIDER'S NAME] IF [PROVIDER'S NAME] SENDS YOU A BILL.

Sincerely,

[PH-MCO Name]

cc: **[Provider]**

[PH-MCO, the following statement must appear in English, Russian, Cambodian, Vietnamese, Spanish, Chinese, and any other language as required by the contract:]

The information in this notice is about payment for medical services. It is available in other languages and formats by calling [PH-MCO Name] at [Phone #/Toll-free TTY #].

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EXHIBIT GG(14a)

IN-PERSON (FIRST/SECOND LEVEL) (COMPLAINT/GRIEVANCE) REVIEW TEMPLATE

Date Letter Mailed (For first level complaints or grievances must be at least 7 days prior to the review date. For second level complaints or grievances must be at least 15 days prior to the review date.)

Member Name
Address
City, State Zip

Member ID: *********

Subject: Your [**complaint/grievance**] about **[Issue]**

Dear **[Member Name]**:

[PH-MCO Name] received your request for an in-person review of your (**first/second level**) **(complaint/grievance**) about **[identify subject of complaint]**.

The review will be held at [**Location of Review; including address**] on [**Date**] at [**Time**]. This location is physically accessible for persons with disabilities. IF APPLICABLE, INCLUDE THE FOLLOWING: We have included with this letter directions to the location of the review and information on parking. When you arrive for the review, please inform the [**Staff person, front desk, receptionist**] and they will direct you to the meeting room where the review will take place.

If you wish to cancel, need to reschedule the in-person review, or have decided to participate by telephone instead, please contact [**PH-MCO Name**] as soon as possible by calling Member Services at [**insert Member Services Number**] If you do not appear at the scheduled date and time the review will go on without you.

At your review the (**first/second level) (complaint/grievance)** Committee **[member/members]** who will be physically present will be [**insert titles and committee role; if licensed physician include specialty**]. IF NOT ALL MEMBERS WILL BE PRESENT ENTER THE FOLLOWING: Other Committee **[member/members]** who will take part in the review will participate by secure video-conference include [**insert titles and committee role; if licensed physician include specialty**].IF THE LICENSED PHYSICIAN IN THE SAME OR SIMILAR SPECIALITY WILL NOT BE PRESENT OR PARTICIPATING BY VIDEOCONFERENCE ENTER THE FOLLOWING: **[insert title and specialty]** will participate by telephone.

You can have someone you know represent you or act on your behalf during the in-person review of your **(first/second level) (complaint/grievance**). If you decide to have someone represent you or act for you and you have not already told **[PH-MCO Name]**, tell **[PH-MCO Name]** in writing the name of that person and how we can reach him or her. This should be sent to: [Name, address, fax #].

You or your representative may ask **[PH-MCO Name]** to see any information relevant to your **(complaint/grievance)**. You can do that by calling: You may also send information that you have about your **(complaint/grievance)** before the in-person review to **[PH-MCO Name, address, fax #].** If you are unable to send the information before the in-person review, bring the information with you to the in-person review and **[PH-MCO Name]** will [**scan/fax**] the information to any members of the review panel who will not be physically present at the review before the start of the committee review.

If you have any questions about this notice please contact me [**insert name**] at [**enter phone number**]

Sincerely,

[STAFF NAME]

[PH-MCO Name]

cc: **[Member Representative, if designated]**

[PH-MCO, the following statement must appear in English, Russian, Cambodian, Vietnamese, Spanish, Chinese, and any other language as required by the contract:]

The information in this letter is about the (**first/second level**) (**complaint/grievance**) you filed with **[PH-MCO Name]**. It is available in other languages and formats by calling **[PH-MCO Name]** at **[Phone #/Toll-free TTY #]**.

EXHIBIT GG(14b)

GENERAL (FIRST/SECOND LEVEL) (COMPLAINT/GRIEVANCE) REVIEW TEMPLATE

Date Letter Mailed (For first level complaints or grievances, member must be given at least 7 days advance notice of the review date. For second level complaints or grievances, member must be given at least 15 days advance notice of the review date.)

Member Name
Address
City, State Zip

Member ID: *********

Subject: Your [**first/second**] level [**complaint/grievance**] review

Dear **[Member Name]**:

[PH-MCO Name] received your request for a review regarding **[identify the subject of the complaint/grievance]**.

The meeting to review your **[first/second]** level **[complaint/grievance]** will be held at:

[time of committee meeting] on **[date of committee meeting]** at **[location of the meeting]**

You can have someone you know represent you or act on your behalf during the review. If you or your representative wishes to participate in the review, please contact [**PH-MCO name**] **as soon as possible** by calling Member Services at [**PH-MCO Member Services Number**]. If you or your representative are not available at the scheduled date and time and you or your representative wish to participate in the review, **[PH-MCO name]** will reschedule the review. You may attend the meeting by phone, in person, or by videoconference (if available). If you decide not to attend the review meeting, it will not affect the review committee's decision.

You or your representative may ask **[PH-MCO Name]** to see any information relevant to your **(complaint/grievance)**. If you want to see any information relevant to your **(complaint/grievance)**, call **[Phone #/Toll-free TTY #]**.

You may also send information that you have about your **(complaint/grievance)** before the review to:

[PH-MCO Name
Complaint/grievance Address]
or faxed to the following number: **[PH-MCO complaint/grievance fax #].**

If you have any questions about this notice, please contact [**PH-MCO**] at [**PH-MCO phone #**].

Sincerely,

[STAFF NAME]

[PH-MCO Name]

cc: **[Member Representative, if designated]**

[PH-MCO, the following statement must appear in English, Russian, Cambodian, Vietnamese, Spanish, Chinese, and any other language as required by the contract:]

The information in this letter is about the (**first/second level**) (**complaint/grievance**) you filed with **[PH-MCO Name]**. It is available in other languages and formats by calling **[PH-MCO Name]** at **[Phone #/Toll-free TTY #]**.

EXHIBIT II

REQUIRED CONTRACT TERMS FOR ADMINISTRATIVE SUBCONTRACTORS

All subcontracts must be in writing and must include, at a minimum, the following provisions:

- The specific activities and report responsibilities delegated to the subcontractor;
- A provision for revoking delegation or imposing other sanctions if the subcontractor's performance is inadequate;
- All subcontractors shall comply with all applicable requirements of the Agreement between the PH-MCO and the Department concerning the HealthChoices Program;
- Meet the applicable requirements of 42 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 PH-MCO either directly or indirectly through capitation, that data for all services provided will be reported timely to the PH-MCO. Penalties and sanctions will be imposed for failure to comply. The data is to be included in the utilization and encounter data provided to the Department in the format required;
- Contain a provision in all subcontracts with any individual, firm, corporation or any other entity which provides medical services to HealthChoices members, that the subcontractor will report all new third party resources to the PH-MCO identified through the provision of medical services, which previously did not appear on the Department's recipient information files provided to the PH-MCO;
- Contain a hold harmless clause that stipulates that the PH-MCO subcontractor agrees to hold harmless the Commonwealth, all Commonwealth officers and employees and all PH-MCO members in the event of nonpayment by the PH-MCO to the subcontractor. The subcontractor shall further indemnify and hold harmless the Commonwealth and their agents, officers and employees against all injuries, death, losses, damages, claims, suits, liabilities, judgments, costs and expenses which may in any manner accrue against the Commonwealth or their agents, officers or employees, through the intentional conduct, negligence or omission of the subcontractor, its agents, officers, employees or the PH-MCO;
- Contain a provision in all subcontracts 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 HealthChoices members, that prohibits gag clauses which limit the subcontractor from disclosure of medical necessary or appropriate health care information or alternate therapies to members, other health care professionals or the Department;

- Contain provisions in all employee contracts prohibiting gag clauses which limit said employees from the disclosure of information pertaining to the HealthChoices Program; and

- Contain provisions in all subcontracts with any individual, firm, corporation or any other entity which provides medical services to HealthChoices members, that limits incentives to those permissible under the applicable Federal regulation.

The PH-MCO shall require as a written provision in all subcontracts that the Department has ready access to any and all documents and records of transactions pertaining to the provision of services to Medical Assistance consumers.

The PH-MCO and its subcontractor(s) must agree to maintain books and records relating to the HealthChoices Program services and expenditures, including reports to the Department and source information used in preparation of these reports. These records include but are not limited to financial statements, records relating to quality of care, medical records and prescription files.

The PH-MCO and its subcontractor(s) also must agree to comply with all standards for practice and medical records keeping specified by the Commonwealth.

The PH-MCO and its subcontractor(s) 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 PH-MCO's chosen location, subject to approval of the Commonwealth. The PH-MCO must fully cooperate with any and all reviews and/or audits by state or federal agencies or their agents, such as the Independent Assessment Contractor, by assuring that appropriate employees and involved parties are available for interviews relating to reviews or audits. All records to be sent by mail shall be sent to the requesting entity in the form of accurate, legible paper copies, unless otherwise indicated, within 15 calendar days of such request and at no expense to the requesting entity. Such requests made by the Commonwealth shall not be unreasonable.

The PH-MCO 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 PH-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 PH-MCO shall require, as a written provision in all subcontracts that the subcontractor recognize that payments made to the subcontractor are derived from federal and state funds. Additionally, the PH-MCO shall require, as a written provision in all contracts for services rendered to Recipient, that the subcontractor shall be held civilly and/or criminally liable to both the PH-MCO and the Department, in the event of nonperformance, misrepresentation, fraud, or abuse. The PH-MCO shall notify its PCPs and all subcontractors of the prohibition and sanctions for the submission of false claims and statements.

The PH-MCO shall require, as a written provision in all subcontracts that the subcontractor cooperate with Quality Management/Utilization Management Program requirements.

The PH-MCO shall monitor the subcontractor's performance on an on-going basis and subject it to formal review according to a periodic schedule established by the Department, consistent with industry standards or State laws and regulations. If the PH-MCO identifies deficiencies or areas needing improvement, the PH-MCO and the subcontractor must take corrective action.

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MANAGEMENT DIRECTIVE

305.16
Amended
Number

COMMONWEALTH OF PENNSYLVANIA
GOVERNOR'S OFFICE

Subject:

Lobbying Certification and Disclosure

By Direction Of:

Michael J. Masch, Secretary of the Budget

Date: July 3, 2003

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 ensure 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 Disclosure of Lobbying Activities Standard Form LLL has been deleted from this amendment (Enclosure 2) and may be accessed at www.whitehouse.gov/omb/grants.

1. PURPOSE. To ensure that all Commonwealth agencies understand and comply with federal regulations prohibiting the use of federal funds for lobbying and requiring disclosure of non-federal funds used for lobbying.

2. SCOPE. This directive applies to all agencies under the Governor's jurisdiction. It is recommended that other agencies adopt similar policy and procedures.

3. OBJECTIVE. To announce policy and provide procedures regarding required certification and disclosure of the use of funds for lobbying.

4. DEFINITION. For the purpose of this directive, **lobbying** means influencing or attempting to influence an officer or employee of any federal agency, a member of Congress, an officer or employee of Congress, or an employee of a member of Congress in connection with the awarding of any federal contract, the making of any federal grant, the making of any federal loan, the entering into of any cooperative agreement, and the extension, continuation, renewal, amendment, or modification of any federal contract, grant, loan, or cooperative agreement.

5. POLICY. Commonwealth agencies shall not contract with outside firms or individuals to perform lobbying services, regardless of the source of funds.

Distribution: B

6. RESPONSIBILITIES. 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 ensure or guarantee a loan exceeding $150,000, **agencies** are responsible for:

a. Completing and filing with federal agencies Lobbying Certification Forms as required (see Enclosure 1).

b. Providing to subgrantees, with all grant awards, Lobbying Certification Forms, and Disclosure of Lobbying Activities forms with instructions for completion and return. See **www.whitehouse.gov/omb/grants** for current form.

c. Forwarding to federal agencies, as required, certification and disclosure forms received from subgrantees.

7. PROCEDURES. 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 ensure or guarantee a loan exceeding $150,000:

a. Agency.

(1) Completes Lobbying Certification Form.

(2) Includes in all award documents language requiring certification and disclosure of lobbying (see Enclosure 1).

b. Grantee.

(1) Completes Lobbying Certification Form and, if applicable, Disclosure of Lobbying Activities form.

(2) Forwards to agency completed Lobbying Certification Form(s) and, if applicable, Disclosure of Lobbying Activities forms.

c. Agency.

(1) Receives from grantee(s) completed Lobbying Certification and Disclosure of Lobbying Activities Forms.

(2) Forwards completed Lobbying Certification and Disclosure of Lobbying Activities Forms to federal agency as required.

Enclosure:

1 – Lobbying Certification Form

This directive replaces, in its entirety, Management Directive 305.16 dated August 6, 1990, copy of which should be recycled.

LOBBYING CERTIFICATION FORM

Certification for Contracts, Grants, Loans, and Cooperative Agreements

The undersigned certifies, to the best of his or her knowledge and belief, that:

(1) No federal appropriated funds have been paid or will be paid, by or on behalf of the undersigned, to any person for influencing or attempting to influence an officer or employee of any agency, a member of Congress, an officer or employee of Congress, or an employee of a member of Congress in connection with the awarding of any federal contract, the making of any federal grant, the making of any federal loan, the entering into of any cooperative agreement, and the extension, continuation, renewal, amendment, or modification of any federal contract, grant, loan, or cooperative agreement.

(2) If any funds other than federal appropriated funds have been paid or will be paid to any person for influencing or attempting to influence an officer or employee of any agency, a member of Congress, an officer or employee of Congress, or an employee of a member of Congress in connection with this federal contract, grant, loan, or cooperative agreement, the undersigned shall complete and submit Standard Form-LLL, Disclosure of Lobbying Activities, in accordance with its instructions.

(3) The undersigned shall require that the language of this certification be included in the award documents for all subawards at all tiers (including subcontracts, subgrants, and contracts under grants, loans, and cooperative agreements) and that all subrecipients shall certify and disclose accordingly.

This certification is a material representation of fact upon which reliance was placed when this transaction was made or entered into. Submission of this certification is a prerequisite for making or entering into this transaction imposed under *Section 1352, Title 31, U. S. Code.* Any person who fails to file the required certification shall be subject to a civil penalty of not less than $10,000 and not more than **$100,000** for such failure.

SIGNATURE: _____

TITLE: _____

DATE: _____

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EXHIBIT KK

REPORTING SUSPECTED FRAUD AND ABUSE TO THE DEPARTMENT

The following requirements are adapted from 55 PA Code §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 PS §1407, (also referred to as Act 105 of 1980, Fraud and Abuse Control Act). The basis for Recipient referrals is 55 PA Code §1101.92, Recipient Prohibited Acts. For information on these regulations, go to http://www.pacode.com.

Reporting Requirements:

PH-MCOs are required to report to the Department any act by Providers/Recipients/employees that may affect the integrity of the HealthChoices Program under the Medical Assistance Program. Specifically, if the PH-MCO suspects that either Fraud or Abuse (as discussed in Section V.O.6, Fraud and Abuse, of the Agreement) may have occurred, the PH-MCO shall report the issue to the Department's Bureau of Program Integrity (BPI). Depending on the nature or extent of the problem, it may also be advisable to place the individual Provider on prepayment review to avoid unnecessary expenditures during the review process.

PH-MCOs are also required to report quality issues to the Department for further investigation. Quality issues are those which, on an individual basis, affect the Recipient's health (e.g. poor quality services, inappropriate treatment, aberrant and/or abusive prescribing patterns, and withholding of Medically Necessary services from Recipient).

All Fraud, Abuse, or quality referrals must be made within thirty (30) days of the identification of the problem/issue. The PH-MCO must send to BPI all relevant documentation collected to support the referral. Such information includes, but is not limited to, the materials listed on the "Checklist of Supporting Documentation for Referrals" located at the end of this exhibit. The Fraud and Abuse Coordinator, or the responsible party completing the referral, should check the appropriate boxes on the "Checklist of Supporting Documentation for Referrals" form 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 Member or significant financial loss to the Department or its agent) must be referred immediately to the Department's Bureau of Program Integrity for further investigation.

The following processes are required unless prior approval is received from BPI. Reports must be submitted online using the PH-MCO Referral Form. The instructions and form templates are located at http://dpwintra.dpw.state.pa.us/HealthChoices/custom/general/forms/forms.asp. Once completed, the form must be submitted electronically to BPI. The following must then be faxed or mailed to BPI:

- Checklist of Supporting Documentation for Referrals, accessible on the PH-MCO Referral Form,
- A copy of the confirmation page which will appear after “Submit” button is clicked, submitting the PH-MCO Referral Form, and
- All supporting documentation

BPI FAX Number 717-772-4638, Attn: PH-MCO Unit

DPW 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 –

- ☐ confirmation page from online referral
- ☐ encounter forms (lacking signatures or forged signatures)
- ☐ timesheets
- ☐ attendance records of recipient
- ☐ written statement from parent, provider, school officials or client that services were not rendered or a forged signature
- ☐ progress notes
- ☐ internal audit report
- ☐ interview findings
- ☐ sign-in log sheet
- ☐ complete medical records
- ☐ résumé and supporting résumé documentation (college transcripts, copy of degree)
- ☐ credentialing file (DEA license, CME, medical license, board certification)
- ☐ copies of complaints filed by members
- ☐ admission of guilty statement
- ☐ other: _____

Example of materials for pharmacy referrals –

- ☐ paid claims
- ☐ prescriptions
- ☐ signature logs
- ☐ encounter forms
- ☐ purchase invoices
- ☐ EOB's
- ☐ delivery slips
- ☐ licensing information
- ☐ other: _____

Example of materials for RTF referrals –

- ☐ complete medical records
- ☐ discharge summary
- ☐ progress notes from providers, nurses, other staff
- ☐ psychological evaluation
- ☐ other: _____

Example of materials for behavioral health referrals –

- ☐ complete medical and mental health record
- ☐ results of treatment rendered/ ordered, including the results of all lab tests and diagnostic studies
- ☐ summaries of all hospitalizations
- ☐ all psychiatric examinations
- ☐ all psychological evaluations
- ☐ treatment plans
- ☐ all prior authorizations request packets and the resultant prior authorization number
- ☐ encounter forms (lacking signatures or forged signatures)
- ☐ plan of care summaries
- ☐ documentation of treatment team or Interagency Service Planning Team meetings
- ☐ progress notes
- ☐ other: _____

Example of materials for DME referrals –

- ☐ orders, prescriptions, and/or certificates of medical necessity (CMN for the equipment)
- ☐ delivery slips and/or proof of delivery of equipment
- ☐ copies of checks or proof of copay payment by recipient
- ☐ diagnostic testing in the records
- ☐ copy of company's current licensure
- ☐ copy of the Policy and Procedure manual applicable to DME items
- ☐ other: _____

EXHIBIT LL

GUIDELINES FOR SANCTIONS REGARDING FRAUD AND ABUSE

The Department recognizes its responsibility to administer the HealthChoices Program and ensure that the public funds which pay for this program are properly spent.

To maintain the integrity of the HealthChoices Program and to ensure that PH-MCOs comply with pertinent contract provisions and related state and federal policies, rules and regulations involving Fraud and Abuse issues, the Department will impose sanctions as deemed appropriate where there is evidence of violations involving Fraud and Abuse issues in the HealthChoices Program. Below are some general guidelines that the Department intends to use when imposing sanctions. Note that the Department also retains discretion to impose additional remedies available to it under applicable law and regulations.

FRAUD AND ABUSE ISSUES WHICH MAY RESULT IN SANCTIONS

Fraud and Abuse issues, which may result in sanctions, include, but are not limited to, the following:

A. Failure to implement, develop, continue or maintain the required policies and procedures directly related to the detection, prevention, referral or sanction of Fraud and Abuse.

B. Failure to cooperate with reviews conducted by the Department or its agents, Office of Attorney General, Office of Inspector General of the U.S. DHHS, other state or federal agencies or auditors under contract to the Department.

C. Failure to adhere to applicable state and federal laws and regulations.

D. Failure to adhere to the terms of the HealthChoices RFP, the Agreement, and the relevant Exhibits which relate to Fraud and Abuse issues.

RANGE OF SANCTIONS

The range of sanctions that may be imposed by the Department include, but are not limited to, the following:

A. Corrective Action Plan

B. Monetary Penalties

C. Enrollment Restrictions

D. Withholding of Capitation Payments

E. Preclusion of Corporate Officers and other individuals identified as being involved in fraudulent or abusive practices

F. Termination of Contract

These sanctions may, but need not be, progressive. It is the Department's intent to maintain an effective, reasonable and consistent sanctioning process as deemed necessary to protect the integrity of the HealthChoices Program.

EXHIBIT NN

SPECIAL NEEDS UNIT

The circumstances for which a member will be classified as having a special need will be based on a non-categorical or generic perspective that identifies key attributes of ongoing physical, developmental, emotional, or behavioral conditions, including, but not limited to, HIV/AIDS, Children in Substitute Care, and Intellectual Disabilities/developmental disabilities. Examples of factors in the determination of a Member with a Special Need(s) include, but are not limited to, the following:

- Require care and/or services of a type or amount that is beyond what is typically required;
- Require extensive rehabilitative, habilitative, or other therapeutic interventions to maintain or improve the level of functioning for the individual;
- May require that primary care be managed by a specialist, due to the nature of the condition;
- May incur higher morbidity without intervention and coordination in the care of the individual;
- Require care and/or services that necessitate coordination and communication among Network Providers and/or Out-of-Network Providers;
- Require care and/or services that necessitate coordination and collaboration with public and private community services organizations outside the PH-MCO;
- Require coordination of care and/or services between the acute inpatient setting and other facilities and Community Providers;
- Result in the Member requiring assistance to schedule or make arrangements for appointments or services, including arranging for transportation to and from appointments;
- Result in the need for language, communication, or mobility accommodations; or
- Result in the need for a Member to be accompanied or assisted while seeking or receiving care by an individual who may act on the Member's behalf.

The PH-MCO will be required to develop, train, and maintain a unit within its organization structure whose primary responsibility will be to deal, in a timely manner, with issues relating to Members with Special Needs. This unit will be headed by a Special Needs Coordinator who must have access to and periodically consult with the Medical Director. The staff members of this unit will work in close collaboration with the Special Needs Section (SNS) operated by the Department and the Enrollment Assistance Program contractor’s Special Needs contact person. The Department

expects the PH-MCO's Special Needs Unit to be staffed by individuals with either a medical and/or social services background, in sufficient number to initiate a response to a Member's inquiry within two (2) Business Days or sooner in urgent situations. The Department expects the core staff members of the Special Needs Unit to be responsible primarily for the functions and operations associated with the unit. The Department also expects that at times the Special Needs Unit staff will have access to the resources of other departments within the PH-MCO to supplement the Special Needs Unit in assisting Members with Special Needs. The PH-MCO must show evidence of their access to and use of individuals with expertise in the treatment of Members with Special Needs to provide consultation to the Special Needs Unit staff, as needed.

The PH-MCO shall use knowledgeable and independent organizations such as consumer groups, disability advocacy groups, Special Needs consumers, the Department of Health District Offices and the DOH's Special Kids Network (http://www.portal.state.pa.us/portal/server.pt/community/special_kids_network/14205) for Children with Special Needs, when providing training to its Special Needs Unit staff, whenever possible.

The primary purpose of the Special Needs Unit is to ensure that each Member with Special Needs receives access to appropriate primary care, access to specialists trained and skilled in the needs of the Member, information about the access to a specialist as PCP if appropriate, information about and access to all covered services appropriate to the Member's condition or circumstance, including pharmaceuticals and DME, and access to needed community services. The Special Needs Unit must have a direct link to the Utilization Management functions of the PH-MCO and have input into the case review process. The PH-MCO must have procedures in place that ensure the proactive identification of and outreach to Members with Special Needs who may not self-identify as having a Special Need.

Special Needs Unit Functions and Requirements

The staff of the PH-MCO Special Needs Unit will ensure the receipt of care and/or services by acting as the PH-MCO case manager for each Member with an identified Special Need. The case manager will be responsible for coordinating the delivery of all services for which the Member is eligible under the PH-MCO benefit package. In the event that a Member is not satisfied with PH-MCO performance in any area, the Special Needs Unit case manager will be responsible for facilitating dispute resolution and for informing the Member of the Complaint, Grievance, and DHS Fair Hearing mechanisms that are available. Members with Special Needs will be assigned to a particular Special Needs Unit case manager and will have ready access to their Special Needs Unit case manager as long as they are enrolled in the PH-MCO. Members with Special Needs are permitted to change case managers as needed during their enrollment. The PH-MCO must be able to demonstrate that its staff will perform the following functions:

- Conduct necessary training for all PH-MCO staff to acquaint them with the purpose and function of the Special Needs Unit and the need to coordinate within departments to serve Members with Special Needs.

- Ensure coordination between the PH-MCO and other health, education, and human services systems.

- Ensure adherence to state and federal laws, regulations, Departmental agreements and court requirements relating to individuals with Special Needs.

- A contact within the Special Needs Unit must be designated to act as a liaison with Office of Medical Assistance Program's Special Needs Section and the Enrollment Assistance Program contractor's Special Needs contact person. The Department expects the PH-MCO to develop an appropriate automated process to operationalize the information on Special Needs individuals supplied by the Enrollment Assistance Program contractor.

- Sufficient telephone and alternative communication channels must be established to allow ready and timely interactions between the PH-MCO Special Needs Unit Coordinator and case managers and the Office of Medical Assistance Programs, the Enrollment Assistance Program contractor, Members with Special Needs, Providers (Network and Out-of-Network) servicing Members with Special Needs and involved agencies.

- Ensure appropriate arrangements are made to effectively assist Members with Special Needs who speak languages other than English, which include interpreter services and translation of documents, in accordance with the RFP and Agreement requirements. In addition, efforts must be made to match Members with communication barriers due to disability or linguistic background with Providers with whom they can effectively communicate.

- Serve on interagency teams upon request by a Member or their family to facilitate and coordinate delivery of Physical Health Services contained in treatment plans for children and/or adults including, but not limited to, Individual Family Service Plans, Individual Educational Plans, Individual Habilitation Plans, and Individual Behavioral Health Treatment Plans.

- Special Needs Unit case managers must have a working knowledge of Children and Adolescent Support Services Program (CASSP), included in Children, Youth and Family Oriented Services and the Community Support Program (CSP) principles, included in Adult Recovery Oriented Services and principles of drug and alcohol treatment.

- Ensure cooperation of the PH-MCO's Provider Network. Special Needs Unit case managers must facilitate communication and coordinate service delivery between primary care, specialty, ancillary, and behavioral health Providers to ensure Member's timely and uninterrupted access to care.

- Assist in the development of adequate Provider Networks, such as pediatric specialists, to serve Special Needs populations. Special Needs Unit case managers must assist and support Members with Special Needs in making an informed choice between Providers of equivalent services within the network. When adequate network

capacity does not exist to allow for choice between network Providers of equivalent services, case managers must facilitate and coordinate services rendered by Out-of-Network Providers.

- Conduct necessary training for PCPs to assist them in providing services to diverse populations including the identification of the PH-MCO's Special Needs Unit contact persons.

- Provide ongoing coordination with PCPs to continually serve Special Needs population's Members.

- Attend ad hoc meetings, workgroups, etc., hosted by the Department that require mandatory attendance by Special Needs Unit staff.

- Attend public/community sponsored meetings with the Department's representative(s) at the discretion of the PH-MCO.

- If the PH-MCO chooses to subcontract any of the Special Needs Unit functions, the PH-MCO must maintain accountability by assigning responsibility for oversight of the subcontract to a senior executive within the organization.

The Special Needs Unit will track, analyze, report, and, when appropriate, develop plans of correction around quality activities for indicators including, but not limited to, Special Needs Unit access measures; PCP access measures; specialist access measures; ancillary services' access measures; and Complaints, Grievances, and DHS Fair Hearings by Members with Special Needs. The Special Needs Unit coordinator will be responsible for the submission of the quarterly reports to the Office of Medical Assistance Programs' Special Needs Section on specified indicators in a format to be determined by the Department. The PH-MCO must submit the report to the Department within thirty (30) calendar days from the end of the quarter being reported. In addition, the PH-MCO will develop, implement, and maintain a targeted Quality Management component focused on Members with Special Needs that is integrated into the Quality Management/Utilization Management Program as outlined in Exhibit M(1), Quality Management and Utilization Management Program Requirements.

EXHIBIT OO

COORDINATION OF CARE ENTITIES

Examples of coordination of care entities are listed below. This list is not inclusive of all coordination of care entities.

- County Office of Drug and Alcohol Programs
- Bureau of Drug and Alcohol Programs (BDAP)
- Office of Children, Youth, and Families (OCYF)
- County Children and Youth Agencies
- Office of Developmental Programs (ODP)
- County Intellectual Disability (ID) Agencies and County ID Health Care Coordination Units
- Intermediate Care Facility Providers
- Office of Mental Health and Substance Abuse Services (OMHSAS)
- Office of Long Term Living (OLTL)
- County Mental Health Agencies
- PA. Department of Health's Community Health District Offices
- County and Municipal Health Departments
- Special Kids Network and Regional Offices
- Childhood Lead Poisoning Prevention Projects (CLPPPs)
- School Districts and Intermediate Units
- School Based Health Centers
- Juvenile Detention Centers
- Juvenile Probation Offices
- Area Agency on Aging (AAA)
- Community Service Organizations
- Public Health Entities
- Consumer Advocacy Groups
- WIC Agencies, Head Start Agencies, and Family Centers
- Public Housing Authorities

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EXHIBIT PP

PROVIDER MANUALS

The PH-MCO shall develop, distribute prior to implementation and maintain a Provider manual. In addition, the PH-MCO and/or PH-MCO Subcontractors will be expected to distribute copies of all manuals and subsequent policy clarifications and procedural changes to participating Providers following advance written approval of the documents by the Department. Provider manuals must be updated to reflect any program or policy change(s) made by the Department via MA Bulletin within six (6) months of the effective date of the change(s), or within six (6) months of the issuance of the MA Bulletin, whichever is later, when such change(s) affect(s) information that the PH-MCO is required to include in its provider manual, as set forth in this Exhibit. The Provider manual must include, at a minimum, the following information:

A. A description of the case management system and protocols;

B. A description of the role of a PCP as described in Section II, Definitions, and Section V.S.3, Primary Care Practitioner (PCP) Responsibilities, of the Agreement;

C. Information on how Members may access specialists, including standing referrals and specialists as PCPs;

D. A summary of the guidelines and requirements of Title VI of the Civil Rights Act of 1964 and its guidelines, and how Providers can obtain qualified interpreters familiar with medical terminology;

E. Contact information to access the PH-MCO, DHS, advocates, other related organizations, etc;

F. A copy of the PH-MCO's Formulary, Prior Authorization, and Program Exception process;

G. Contact follow-up responsibilities for missed appointments;

H. Description of role of Special Needs Unit and how to refer patients;

I. Description of drug and alcohol treatment available and how to make referrals;

J. Complaint, Grievance and DHS Fair Hearing information;

K. Information on Provider Disputes;

L. PH-MCO policies, procedures, available services, sample forms, and fee schedule applicable to the Provider type;

M. A full description of covered services, listing all applicable services under the Medical Assistance Fee-for-Service Program;

N. Billing instructions;

O. Information regarding applicable portions of 55 PA Code, Chapter 1101, General Provisions;

P. Information on self-referred services and services which are not the responsibility of the PH-MCO but are available to Members on a Fee-for-Service basis;

Q. Provider performance expectations, including disclosure of Quality Management and Utilization Management criteria and processes;

R. Information on procedures for sterilizations, hysterectomies and abortions (if applicable);

S. Information about EPSDT screening requirements and EPSDT services, including information on the dental referral process);

T. A description of certain Providers' obligations, under law, to follow applicable procedures in dealing with Members on "Advance Directives" (durable health care power of attorney and living wills). This includes notification and record keeping requirements;

U. Information on ADA and Section 504 of the Rehabilitation Act of 1973, other applicable laws, and available resources related to the same;

V. A definition of “Medically Necessary” consistent with the language in the Agreement;

W. Information on Member confidentiality requirements;

X. Information regarding school-based/school-linked services in this HealthChoices zone; and

Y. The Department’s MA Provider Compliance Hotline (formerly the Fraud and Abuse Hotline) number and explanatory statement.

Z. Explanation of Contractor’s and DHS’s Recipient Restriction Program.

AA. Information regarding written translation and oral interpretation services for Members with LEP and alternate methods of communication for those requesting communication in alternate formats.

BB. List and scope of services for referral and Prior Authorization.

The PH-MCO is required to provide documented training to its Providers and their staffs and to Subcontractors, regarding the contents and requirements of the Provider manuals.

EXHIBIT WW

HEALTHCHOICES AUDIT CLAUSE

AUDITS

Annual Contract Audits

The PH-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 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 PH-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 PH-MCO is responsible to provide Medical Assistance benefits to HealthChoices recipients shall be submitted to the Commonwealth within 180 days after the contract termination date or the last date the PH-MCO is responsible to provide Medical Assistance benefits.

The PH-MCO shall ensure that audit working papers and audit reports are retained by the PH-MCO's auditor for a minimum of five (5) years from the date of final payment under the contract, unless the PH-MCO's auditor is notified in writing by the Commonwealth to extend the retention period. Audit working papers shall be made available, upon request, to authorized representatives of the Commonwealth or Federal agencies. Copies of working papers deemed necessary shall be provided by the PH-MCO's auditor.

Annual Entity-Wide Financial Audits

The PH-MCO shall provide to the Commonwealth a copy of its annual entity-wide financial audit, performed by an independent, licensed Certified Public Accountant. Such audit shall be made in accordance with generally accepted auditing standards. Such audit shall be submitted to the OMAP, BMCO via E-FRM within 30 days from the date it is made available to the PH-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 PH-MCO, its subcontractors or Providers. Any such additional audit work will rely on work already performed by the PH-MCO's auditor to the extent possible.

The costs incurred by the federal or state agencies for such additional work will be borne by those agencies.

Audits of the PH-MCO, its subcontractors or Providers may be performed by the Commonwealth or its designated representatives and include, but are not limited to:

1. Financial and compliance audits of operations and activities for the purpose of determining the compliance with financial and programmatic record keeping and reporting requirements of this 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; and

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 PH-MCO or its subcontractor's operations will generally be performed on an annual basis. However, the Commonwealth reserves the right to audit more frequently, to vary the audit period, and to determine the type and duration of these audits. Audits of subcontractors or Providers will be performed at the Commonwealth's discretion.

The following provisions apply to the PH-MCO, its subcontractors and Providers:

1. Except in cases where advance notice is not possible or advance notice may render the audit less useful, the Commonwealth will give the entity at least three (3) weeks advance written notice of the start date, expected staffing, and estimated duration of the audit. In the event of a claims processing audit, the Commonwealth will strive to provide advance written notice of a minimum of thirty (30) calendar days. While the audit team is on-site, the entity shall provide the team with adequate workspace; access to a telephone, photocopier and facsimile machine; electrical outlets; and privacy for conferences. The PH-MCO shall also provide, at its own expense, necessary systems and staff support to timely extract and/or download information stored in electronic format, gather requested documents or information, complete forms or questionnaires, and respond to auditor inquiries. The entity shall cooperate fully with the audit team in furnishing, either in advance or during the course of the audit, any policies, procedures, job descriptions, 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 PH-MCO shall, at its own expense, make all records available for audit, review or evaluation by the Commonwealth, its designated representatives or federal agencies. Access shall be provided either on-site, during normal business hours, or through the mail. During the contract and record retention period, these records shall be available at the PH-MCO's chosen location, subject to approval of the Commonwealth. All records to be sent by mail shall be sent to the requesting entity within fifteen (15) calendar days of such request and at no expense to the requesting entity. Such requests made by the Commonwealth shall not be unreasonable.

The PH-MCO shall maintain books, records, documents, and other evidence pertaining to all revenues, expenditures and other financial activity pursuant to this Agreement as well as to all required programmatic activity and data pursuant to this Agreement. Records other than medical records may be kept in an original paper state or preserved on micro media or electronic format. Medical records shall be maintained in a format acceptable by the Department. These books, records, documents and other evidence shall be available for review, audit or evaluation by authorized Commonwealth personnel or their representatives during the 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.

Audits of Subcontractors

The PH-MCO shall include in all risk sharing PH-MCO subcontract agreements clauses, which reflect the above provisions relative to "Annual Contract Audits", "Annual Entity-Wide Financial Audits", "Other Financial and Performance Audits" and "Record Availability, Retention, and Access."

The PH-MCO shall include in all contract agreements with other subcontractors or Providers, clauses which reflect the above provisions relative to "Other Financial and Performance Audits" and "Record Availability, Retention, and Access."

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EXHIBIT XX
ENCOUNTER DATA SUBMISSION REQUIREMENTS
And
PENALTY APPLICATIONS

The submission of timely and accurate encounter data is critical to the Commonwealth's ability to establish and maintain cost effective and quality managed care programs. Consequently, the requirements for submission and metrics for measuring the value of the data for achieving these goals are crucial.

- CERTIFICATION REQUIREMENT

  All MCOs must be certified through PROMISe prior to the submission of live encounter data. The certification process is detailed at: https://dpwintra.dpw.state.pa.us/HealthChoices/custom/program/encounter/promise/documents/encounter_updated_certification_process_for_promise_v1.0_to_dpw_ph.doc
- SUBMISSION REQUIREMENTS

  Timeliness:

  With the exception of pharmacy encounters, all MCO approved encounters and those specified MCO denied encounters must be approved in PROMISe by the last day of the third month following the month of initial MCO adjudication. Pharmacy encounters must be submitted and approved in PROMISe within 30 days following the MCO adjudication.

  Metric: During the sixth months 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 98% of all MCO paid/approved and specified MCO denied encounters by the last day of the third month following initial MCO adjudication may result in a penalty.
  - Any encounter corrected or initially submitted after the last day of the third month following initial MCO adjudication may be subject to a penalty.

  Accuracy and Completeness:

  Accuracy and completeness are based on the consistency between encounter information submitted to the Commonwealth and information for the same service maintained by the MCO in their claims/service history data base.

  Metric: Accuracy and completeness will be determined through a series of analyses applied to 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 MCO claims history. A sample may also be drawn from the MCO service history and compared against encounters processed through PROMISe.

Samples will be drawn proportionally based on the MCO financial expenditures for each transaction type submitted during the review period. Each annual or semi-annual analysis will be based on a statistically valid sample of no less than 200 records.

- PENALTY PROVISION

  Timeliness

  - Failure to comply with timeliness requirements will result in a sanction of up to $10,000 for each program month.

  Completeness and Accuracy

  - Errors in accuracy or completeness that are identified by the Department in an annual or semi-annual analysis will result in sanctions as follows. An error in accuracy or completeness or both, in one sample record, counts as one error.

Percentage of the sample that includes an error	Sanction
Less than 1.0 percent	None
1.0 – 1.4 percent	$4,000
1.5 – 2.0 percent	$10,000
2.1 - 3.0 percent	$16,000
3.1 – 4.0 percent	$22,000
4.1 – 5.0 percent	$28000
5.1 – 6.0 percent	$34,000
6.1 – 7.0 percent	$40,000
7.1 – 8.0 percent	$46,000
8.1 – 9.0 percent	$52,000
9.1 – 10.0 percent	$58,000
10.1 percent and higher	$100,000

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EXHIBIT AAA (1)

PROVIDER NETWORK COMPOSITION/SERVICE ACCESS

1. Network Composition

The PH-MCO must consider the following in establishing and maintaining its Provider Network:

- The anticipated MA enrollment,
- The expected utilization of services, taking into consideration the characteristics and health care needs of specific MA populations represented in the PH-MCO,
- The number and types, in terms of training, experience, and specialization, of Providers required to furnish the contracted MA services,
- The number of Network Providers who are not accepting new MA patients, and
- The geographic location of Providers and Members, considering distance, travel time, the means of transportation ordinarily used by Members, and whether the location provides physical access for Members with disabilities.

The PH-MCO must ensure that its Provider Network is adequate to provide its Members in this HealthChoices Zone with access to quality Member care through participating professionals, in a timely manner, and without the need to travel excessive distances. Upon request from the Department, the PH-MCO must supply geographic access maps using Member level data detailing the number, location and specialties of their Provider Network to the Department in order to verify accessibility of Providers within their Network in relation to the location of its Members. The Department may require additional numbers of specialists and ancillary Providers should it be determined that geographic access is not adequate. The PH-MCO must also have a process in place which ensures that the PH-MCO knows the capacity of their Network PCP panels at all times and have the ability to report on this capacity.

The PH-MCO must make all reasonable efforts to honor a Member's choice of Providers who are credentialed in the Network. Additionally, the PH-MCO must ensure and demonstrate that the following Provider Network and access requirements are established and maintained for the entire HealthChoices Zone in which the PH-MCO operates if providers exist:

a. PCPs

Make available to every Member a choice of at least two (2) appropriate PCPs with open panels whose offices are located within a travel time no greater than thirty (30) minutes (Urban) and sixty (60) minutes (Rural). This travel time is measured via public transportation, where available.

Members may, at their discretion, select PCPs located further from their homes.

b. Pediatricians as PCPs

Ensure an adequate number of pediatricians with open panels to permit all Members who want a pediatrician as a PCP to have a choice of two (2) for their child(ren) within the travel time limits (30 minutes Urban, 60 minutes Rural).

c. Specialists

i. For the following provider types, the PH-MCO must ensure a choice of two (2) providers who are accepting new patients within the travel time limits (30 minutes Urban, 60 minutes Rural):

General Surgery	Cardiology
Obstetrics & Gynecology	Pharmacy
Oncology	Orthopedic Surgery
Physical Therapy	General Dentistry
Radiology	

ii. For the following provider types, the PH-MCO must ensure a choice of one (1) provider who is accepting new patients within the travel time limits (30 minutes Urban, 60 minutes Rural) and a second choice, within the HealthChoices Zone:

Oral Surgery	Urology
Nursing Facility	Neurology
Dermatology	Otolaryngology

iii. For all other specialists and subspecialists, the PH-MCO must have a choice of two (2) providers who are accepting new patients within the HealthChoices Zone.

d. Hospitals

Ensure at least one (1) hospital within the travel time limits (30 minutes Urban, 60 minutes Rural) and a second choice within the HealthChoices Zone.

e. Special Health Needs

Ensure the provision of services to persons who have special health needs or who face access barriers to health care. If the PH-MCO does not have at least two (2) specialists or sub-specialists qualified to meet the

particular needs of the individuals, then the PH-MCO must allow Members to pick an Out-of-Network Provider if not satisfied with the Network Provider. The PH-MCO must develop a system to determine Prior Authorization for Out-of-Network Services, including provisions for informing the Recipient of how to request this authorization for Out-of-Plan Services. For children with special health needs, the PH-MCO must offer at least two (2) pediatric specialists or pediatric sub-specialists.

f. Anesthesia for Dental Care

For Members needing anesthesia for dental care, the PH-MCO must ensure a choice of at least two (2) dentists within the Provider Network with privileges or certificates to perform specialized dental procedures under general anesthesia or pay out of Network.

g. Rehabilitation Facilities

Ensure a choice of at least two (2) rehabilitation facilities within the Provider Network, at least one (1) of which must be located within this HealthChoices Zone.

h. CNMs / CRNPs, Other Health Care Providers

Ensure access to Certified Nurse Midwives (CNMs) and Certified Registered Nurse Practitioners (CRNPs) and other Health Care Providers. The PH-MCO must demonstrate its attempts to contract in good faith with a sufficient number of CNMs and CRNPs and other Health Care Providers and maintain payment policies that reimburse CNMs and CRNPs and other Health Care Providers for all services provided within the scope of their practice and allow them to practice to the fullest extent of their education, training and licensing.

i. Qualified Providers

The PH-MCO must limit its PCP Network to appropriately qualified Providers. The PH-MCO's PCP Network must meet the following:

- 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, internal medicine or pediatrics; and

- No more than twenty-five percent (25%) of the Network consists of PCPs without appropriate residencies but who have, within the past seven (7) years, five (5) years of post-training clinical practice experience in family medicine, osteopathic general medicine, internal

medicine or pediatrics. Post-training experience is defined as having practiced at least as a 0.5 full-time equivalent in the practice areas described.

j. Members Freedom of Choice

The PH-MCO must demonstrate its ability to offer its Members freedom of choice in selecting a PCP. At a minimum, the PH-MCO must have or provide one (1) full-time equivalent (FTE) PCP who serves no more than one thousand (1,000) Recipients. For the purposes of this section, a full-time equivalent PCP must be a physician involved in clinical care. The minimum weekly work hours for 1.0 FTE is the number of hours that the practice considers to be a normal work week, which may be 37.5, 40, or 50 hours. A physician cannot be counted as more than 1.0 FTE regardless of the number of hours worked. If the PCP/PCP Site employs Certified Registered Nurse Practitioners (CRNPs)/Physician Assistants (PAs), then the Provider/Provider Site will be permitted to add an additional one thousand (1,000) Members to the panel. The number of Members assigned to a PCP may be decreased by the PH-MCO if necessary to maintain the appointment availability standards.

k. PCP Composition and Location

The PH-MCO and the Department will work together to avoid the PCP having a caseload or medical practice composed predominantly of HC Members. In addition, the PH-MCO must organize its PCP Sites so as to ensure continuity of care to Members and must identify a specific PCP or PCP group for each Member. The PH-MCO may apply to the Department for a waiver of these requirements. The Department may waive these requirements for good cause demonstrated by the PH-MCO. The PH-MCO will comply with the program standards regarding PCP assignment as set forth in Section V.Q. of the Agreement, Assignment of PCPs.

l. FQHCs / RHCs

The PH-MCO must include in its Provider Network every FQHC and RHC that are willing to accept PPS rates as payment in full and are located within the operational HealthChoices Zones in which the PH-MCO has an agreement. If the PH-MCO's primary care Network includes FQHCs and RHCs, these sites may be designated as PCP sites.

m. Medically Necessary Emergency Services

The PH-MCO must comply with the provisions of Act 112 of 1996 (H.B. 1415, P.N. 3853, signed July 11, 1996), the Balanced Budget Reconciliation Act of 1997 and Act 68 of 1998, the Quality Health Care

Accountability and Protection Provisions, 40 P.S. 991.2101 et seq. pertaining to coverage and payment of Medically Necessary Emergency Services. The definition of such services is set forth herein at Section II of this Agreement, Definitions.

n. ADA Accessibility Guidelines

The PH-MCO must inspect the office of any PCP or dentist who seeks to participate in the PH-MCO's Provider Network (excluding offices located in hospitals) to determine whether the office is architecturally accessible to persons with mobility impairments. Architectural accessibility means compliance with ADA accessibility guidelines with reference to parking (if any), path of travel to an entrance, and the entrance to both the building and the office of the Provider, if different from the building entrance.

The PH-MCO must submit quarterly reports to the Department, in a format to be specified by the Department, on the results of the inspections.

If the office or facility is not accessible under the terms of this paragraph, the PCP or dentist may participate in the PH-MCO's Provider Network provided that the PCP or dentist: 1) requests and is determined by the PH-MCO to qualify for an exemption from this paragraph, consistent with the requirements of the ADA, or 2) agrees in writing to remove the barrier to make the office or facility accessible to persons with mobility impairments within six (6) months after the PH-MCO identified the barrier.

The PH-MCO must document its efforts to determine architectural accessibility. The PH-MCO must submit this documentation to the Department upon request.

o. Laboratory Testing Sites

The PH-MCO must ensure that all laboratory testing sites providing services have either a Clinical Laboratory Improvement Amendment (CLIA) certificate of waiver or a certificate of registration along with a CLIA identification number in accordance with CLIA 1988. Those laboratories with certificates of waiver will provide only the eight (8) types of tests permitted under the terms of their waiver. Laboratories with certificates of registration may perform a full range of laboratory tests. The PCP must provide all required demographics to the laboratory when submitting a specimen for analysis.

p. PH-MCO Discrimination

The PH-MCO must not discriminate with respect to participation, reimbursement, or indemnification as to any Provider who is acting within

the scope of the Provider's license or certification under applicable State law, solely on the basis of such license or certification. This paragraph must not be construed to prohibit a PH-MCO from including Providers only to the extent necessary to meet the needs of the organization's Members or from establishing any measure designed to maintain quality and control costs consistent with the responsibilities of the PH-MCO.

q. Declined Providers

If the PH-MCO declines to include individual Providers or groups of Providers in its Network, it must give the affected Providers written notice of the reason for its decision.

r. Second Opinions

The PH-MCO must provide for a second opinion from a qualified Health Care Provider within the Network, at no cost to the Member. If a qualified Health Care Provider is not available within the Network, the PH-MCO must assist the Member in obtaining a second opinion from a qualified Health Care Provider outside the Network, at no cost to the Member, unless co-payments apply.

2. Appointment Standards

The PH-MCO will require the PCP, dentist, or specialist to conduct affirmative outreach whenever a Member misses an appointment and to document this in the medical record. Such an effort shall be deemed to be reasonable if it includes three (3) attempts to contact the Member. Such attempts may include, but are not limited to: written attempts, telephone calls and home visits. At least one (1) such attempt must be a follow-up telephone call.

a. General

PCP scheduling procedures must ensure that:

i. Emergency Medical Condition cases must be immediately seen or referred to an emergency facility.

ii. Urgent Medical Condition cases must be scheduled within twenty-four (24) hours.

iii. Routine appointments must be scheduled within ten (10) Business Days.

iv. Health assessment/general physical examinations and first examinations must be scheduled within three (3) weeks of Enrollment.

v. The PH-MCO must provide the Department with its protocol for ensuring that a Member's average office waiting time for an appointment for Routine Care is no more than thirty (30) minutes or at any time no more than up to one (1) hour when the physician encounters an unanticipated Urgent Medical Condition visit or is treating a Member with a difficult medical need. The Member must be informed of scheduling time frames through educational outreach efforts.

vi. The PH-MCO must monitor the adequacy of its appointment processes and reduce the unnecessary use of emergency room visits.

b. Persons with HIV/AIDS

The PH-MCO must have adequate PCP scheduling procedures in place to ensure that an appointment with a PCP or specialist must be scheduled within seven (7) days from the effective date of Enrollment for any person known to the PH-MCO to be HIV positive or diagnosed with AIDS (e.g. self-identification), unless the Member is already in active care with a PCP or specialist.

c. Supplemental Security Income (SSI)

The PH-MCO must make a reasonable effort to schedule an appointment with a PCP or specialist within forty-five (45) days of Enrollment for any Member who is an SSI or SSI-related consumer unless the Member is already in active care with a PCP or specialist.

d. Specialty Referrals

For specialty referrals, the PH-MCO must be able to provide for:

i. Emergency Medical Condition appointments immediately upon referral.

ii. Urgent Medical Condition care appointments within twenty-four (24) hours of referral.

iii. Scheduling of appointments for routine care within fifteen (15) business days for the following specialty provider types:

Otolaryngology	Orthopedic Surgery
Dermatology	Pediatric Allergy & Immunology
Pediatric Endocrinology	Pediatric Gastroenterology
Pediatric General Surgery	Pediatric Hematology
Pediatric Infectious Disease	Pediatric Nephrology
Pediatric Neurology	Pediatric Oncology
Pediatric Pulmonology	Pediatric Rehab Medicine
Pediatric Rheumatology	Pediatric Urology
Dentist	

iv. Scheduling of appointments for routine care within ten (10) business days of referral for all other specialty provider types not listed above.

e. Pregnant Women

Should the EAP contractor or Member notify the PH-MCO that a new Member is pregnant or there is a pregnancy indication on the files transmitted to the PH-MCO by the Department, the PH-MCO must contact the Member within five (5) days of the effective date of Enrollment to assist the woman in obtaining an appointment with an OB/GYN or Certified Nurse Midwife. For maternity care, the PH-MCO must arrange initial prenatal care appointments for enrolled pregnant Members as follows:

i. First trimester — within ten (10) Business Days of the Member being identified as being pregnant.

ii. Second trimester — within five (5) Business Days of the Member being identified as being pregnant.

iii. Third trimester — within four (4) Business Days of the Member being identified as being pregnant.

iv. High-risk pregnancies — within twenty-four (24) hours of identification of high risk to the PH-MCO or maternity care Provider, or immediately if an emergency exists.

f. EPSDT

EPSDT screens for any new Member under the age of twenty-one (21) must be scheduled within forty-five (45) days from the effective date of Enrollment unless the child is already under the care of a PCP and the child is current with screens and immunizations.

The PH-MCO must distribute quarterly lists to each PCP in its Provider Networks which identify Members who have not had an Encounter during the previous twelve (12) months or within the time frames set forth in this Exhibit, or Members who have not complied with EPSDT periodicity and immunization schedules for children. The PH-MCO must contact such Members, documenting the reasons for noncompliance and documenting its efforts for bringing the Members' care into compliance.

3. Policies and Procedures for Appointment Standards

The PH-MCO will comply with the program standards regarding service accessibility standards that are set forth in this Exhibit and in Section V.S. of the Agreement, Provider Agreements.

The PH-MCO must have written policies and procedures for disseminating its appointment standards to all Members through its Member handbook and through other means. In addition, the PH-MCO must have written policies and procedures to educate its Provider Network about appointment standard requirements. The PH-MCO must monitor compliance with appointment standards and must have a corrective action plan when appointment standards are not met.

4. Compliance with Access Standards

a. Mandatory Compliance

The PH-MCO must comply with the access standards in accordance with this Exhibit and Section V.S of the Agreement, Provider Agreements. If the PH-MCO fails to meet any of the access standards by the dates specified by the Department, the Department may terminate this Agreement.

b. Reasonable Efforts and Assurances

The PH-MCO must make reasonable efforts to honor a Member's choice of Providers among Network Providers as long as:

i. The PH-MCO's agreement with the Network Provider covers the services required by the Member; and

ii. The PH-MCO has not determined that the Member's choice is clinically inappropriate.

The PH-MCO must provide the Department adequate assurances that the PH-MCO, with respect to this HealthChoices Zone, has the capacity to serve the expected Enrollment in this HealthChoices Zone. The

PH-MCO must provide assurances that it will offer the full scope of covered services as set forth in this Agreement and access to preventive and primary care services. The PH-MCO must also maintain a sufficient number, mix and geographic distribution of Providers and services in accordance with the standards set forth in this Exhibit and Section V.S of the Agreement, Provider Agreements.

c. PH-MCO's Corrective Action

The PH-MCO must take all necessary steps to resolve, in a timely manner, any demonstrated failure to comply with the access standards. Prior to a termination action or other sanction by the Department, the PH-MCO will be given the opportunity to institute a corrective action plan. The PH-MCO must submit a corrective action plan to the Department for approval within thirty (30) days of notification of such failure to comply, unless circumstances warrant and the Department demands a shorter response time. The Department's approval of the PH-MCO's corrective action plan will not be unreasonably withheld. The Department will make its best effort to respond to the PH-MCO within thirty (30) days from the submission date of the corrective action plan. If the Department rejects the corrective action plan, the PH-MCO shall be notified of the deficiencies of the corrective action plan. In such event, the PH-MCO must submit a revised corrective action plan within fifteen (15) days of notification. If the Department does not receive an acceptable corrective action plan, the Department may impose sanctions against the PH-MCO, in accordance with Section VIII.H. of the Agreement, Sanctions. Failure to implement the corrective action plan may result in the imposition of a sanction as provided in this Agreement.

EXHIBIT AAA (2)

PROVIDER NETWORK COMPOSITION/SERVICE ACCESS

1. Network Composition

The PH-MCO must consider the following in establishing and maintaining its Provider Network:

- The anticipated MA enrollment,
- The expected utilization of services, taking into consideration the characteristics and health care needs of specific MA populations represented in the PH-MCO,
- The number and types, in terms of training, experience, and specialization, of Providers required to furnish the contracted MA services,
- All Providers operating within the PH-MCO's Network who provide services to Recipients must be enrolled in the Commonwealth's MA Program and possess an active PROMISe™ Provider ID.
- The number of Network Providers who are not accepting new MA patients, and
- The geographic location of Providers and Members, considering distance, travel time, the means of transportation ordinarily used by Members, and whether the location provides physical access for Members with disabilities.

The PH-MCO must ensure that its Provider Network is adequate to provide its Members in this HealthChoices Zone with access to quality Member care through participating professionals, in a timely manner, and without the need to travel excessive distances. Upon request from the Department, the PH-MCO must supply geographic access maps using Member level data detailing the number, location and specialties of their Provider Network to the Department in order to verify accessibility of Providers within their Network in relation to the location of its Members. The Department may require additional numbers of specialists and ancillary Providers should it be determined that geographic access is not adequate. The PH-MCO must also have a process in place which ensures that the PH-MCO knows the capacity of their Network PCP panels at all times and have the ability to report on this capacity.

The PH-MCO must make all reasonable efforts to honor a Member's choice of Providers who are credentialed in the Network. If the PH-MCO is unable to ensure a Member's access to provider or specialty provider services within the PH-MCO's network, within the travel times set forth in this Exhibit, the PH-MCO must make all reasonable efforts to ensure the Member's access to these services within the travel times herein through out-of-network providers. In locations where the PH-MCO can provide evidence that it has conducted all reasonable efforts to contract with providers and specialists and can provide verification that no providers or specialists exist to ensure a Member's access to

these services within the travel times set forth in this Exhibit, the PH-MCO must work with Members to offer reasonable provider alternatives. Additionally, the PH-MCO must ensure and demonstrate that the following Provider Network and access requirements are established and maintained for the entire HealthChoices Zone in which the PH-MCO operates if providers exist:

a. PCPs

Make available to every Member a choice of at least two (2) appropriate PCPs with open panels whose offices are located within a travel time no greater than thirty (30) minutes in-Erie County) and sixty (60) minutes in all other counties of the New West Zone). This travel time is measured via public transportation, where available. Members may, at their discretion, select PCPs located further from their homes.

b. Pediatricians as PCPs

Ensure an adequate number of pediatricians with open panels to permit all Members who want a pediatrician as a PCP to have a choice of two (2) for their child(ren) within the travel time limits (30 minutes in Erie County, 60 minutes in all other counties of the New West Zone).

c. Specialists

i. For the following provider types, the PH-MCO must ensure a choice of two (2) providers who are accepting new patients within the travel time limits (30 minutes in Erie County, 60 minutes in all other counties of the New West Zone.):

General Surgery
Obstetrics & Gynecology
Orthopedic Surgery
General Dentistry
Cardiology
Pharmacy

ii. For the following provider types, the PH-MCO must ensure a choice of one (1) provider who is accepting new patients within the following travel time limits (30 minutes in Erie County, 90 minutes in all other counties of the New West Zone) and a second choice, within the HealthChoices Zone:

Oral Surgery
Nursing Facility
Dermatology
Oncology
Physical Therapy
Urology
Neurology
Otolaryngology
Radiology

iii. For all other specialists and subspecialists, the PH-MCO must have a choice of two (2) providers who are accepting new patients within the HealthChoices Zone.

d. Hospitals

Ensure at least one (1) hospital within the travel time limits (30 minutes in Erie County, 60 minutes in all other counties of the New West Zone.) and a second choice within the HealthChoices Zone.

e. Special Health Needs

Ensure the provision of services to persons who have special health needs or who face access barriers to health care. If the PH-MCO does not have at least two (2) specialists or sub-specialists qualified to meet the particular needs of the individuals, then the PH-MCO must allow Members to pick an Out-of-Network Provider if not satisfied with the Network Provider. The PH-MCO must develop a system to determine Prior Authorization for Out-of-Network Services, including provisions for informing the Recipient of how to request this authorization for Out-of-Plan Services. For children with special health needs, the PH-MCO must offer at least two (2) pediatric specialists or pediatric sub-specialists.

f. Anesthesia for Dental Care

For Members needing anesthesia for dental care, the PH-MCO must ensure a choice of at least two (2) dentists within the Provider Network with privileges or certificates to perform specialized dental procedures under general anesthesia or pay out of Network.

g. Rehabilitation Facilities

Ensure a choice of at least two (2) rehabilitation facilities within the Provider Network, at least one (1) of which must be located within this HealthChoices Zone.

h. CNMs / CRNPs, Other Health Care Providers

Ensure access to Certified Nurse Midwives (CNMs) and Certified Registered Nurse Practitioners (CRNPs) and other Health Care Providers. In accordance with Rx for PA principles, the PH-MCO must demonstrate its attempts to contract in good faith with a sufficient number of CNMs and CRNPs and other Health Care Providers and maintain payment policies that reimburse CNMs and CRNPs and other Health Care Providers for all

services provided within the scope of their practice and allow them to practice to the fullest extent of their education, training and licensing.

i. Qualified Providers

The PH-MCO must limit its PCP Network to appropriately qualified Providers. The PH-MCO's PCP Network must meet the following:

- No less than Seventy–five percent (75) of the Network consists of PCPs who have completed an approved primary care residency in family medicine, osteopathic general medicine, internal medicine or pediatrics; and

- No more than twenty-five percent (25%) of the Network consists of PCPs without appropriate residencies but who have five (5) years of post-training clinical practice experience in family medicine, osteopathic general medicine, internal medicine or pediatrics, within the past seven (7) years. Post-training experience is defined as having practiced at least as a 0.5 full-time equivalent in the practice areas described.

j. Members Freedom of Choice

The PH-MCO must demonstrate its ability to offer its Members freedom of choice in selecting a PCP. At a minimum, the PH-MCO must have or provide one (1) full-time equivalent (FTE) PCP who serves no more than one thousand (1,000) Recipients. For the purposes of this section, a full-time equivalent PCP must be a physician involved in clinical care. The minimum weekly work hours for 1.0 FTE is the number of hours that the practice considers to be a normal work week, which may be 37.5, 40, or 50 hours. A physician cannot be counted as more than 1.0 FTE regardless of the number of hours worked. If the PCP/PCP Site employs Certified Registered Nurse Practitioners (CRNPs)/Physician Assistants (PAs), then the Provider/Provider Site will be permitted to add an additional one thousand (1,000) Members to the panel. The number of Members assigned to a PCP may be decreased by the PH-MCO if necessary to maintain the appointment availability standards.

k. PCP Composition and Location

The PH-MCO and the Department will work together to avoid the PCP having a caseload or medical practice composed predominantly of HC Members. In addition, the PH-MCO must organize its PCP Sites so as to ensure continuity of care to Members and must identify a specific PCP or PCP group for each Member. The PH-MCO may apply to the Department for a waiver of these requirements. The Department may waive these

requirements for good cause demonstrated by the PH-MCO. The PH-MCO will comply with the program standards regarding PCP assignment as set forth in Section V.Q. of the Agreement, Assignment of PCPs.

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The PH-MCO must comply with the provisions of Act 112 of 1996 (H.B. 1415, P.N. 3853, signed July 11, 1996), the Balanced Budget Reconciliation Act of 1997 and Act 68 of 1998, the Quality Health Care Accountability and Protection Provisions, 40 P.S. 991.2101 et seq. pertaining to coverage and payment of Medically Necessary Emergency Services. The definition of such services is set forth herein at Section II of this Agreement, Definitions.

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The PH-MCO must inspect the office of any PCP or dentist who seeks to participate in the PH-MCO's Provider Network (excluding offices located in hospitals) to determine whether the office is architecturally accessible to persons with mobility impairments. Architectural accessibility means compliance with ADA accessibility guidelines with reference to parking (if any), path of travel to an entrance, and the entrance to both the building and the office of the Provider, if different from the building entrance.

The PH-MCO must submit quarterly reports to the Department, in a format to be specified by the Department, on the results of the inspections.

If the office or facility is not accessible under the terms of this paragraph, the PCP or dentist may participate in the PH-MCO's Provider Network provided that the PCP or dentist: 1) requests and is determined by the PH-MCO to qualify for an exemption from this paragraph, consistent with the requirements of the ADA, or 2) agrees in writing to remove the barrier to make the office or facility accessible to persons with mobility impairments within six (6) months after the PH-MCO identified the barrier.

The PH-MCO must document its efforts to determine architectural accessibility. The PH-MCO must submit this documentation to the Department upon request.

o. Laboratory Testing Sites

The PH-MCO must ensure that all laboratory testing sites providing services have either a Clinical Laboratory Improvement Amendment (CLIA) certificate of waiver or a certificate of registration along with a CLIA identification number in accordance with CLIA 1988. Those laboratories with certificates of waiver will provide only the eight (8) types of tests permitted under the terms of their waiver. Laboratories with certificates of registration may perform a full range of laboratory tests. The PCP must provide all required demographics to the laboratory when submitting a specimen for analysis.

p. PH-MCO Discrimination

The PH-MCO must not discriminate with respect to participation, reimbursement, or indemnification as to any Provider who is acting within the scope of the Provider's license or certification under applicable State law, solely on the basis of such license or certification. This paragraph must not be construed to prohibit a PH-MCO from including Providers only to the extent necessary to meet the needs of the organization's Members or from establishing any measure designed to maintain quality and control costs consistent with the responsibilities of the PH-MCO.

q. Declined Providers

If the PH-MCO declines to include individual Providers or groups of Providers in its Network, it must give the affected Providers written notice of the reason for its decision.

r. Second Opinions

The PH-MCO must provide for a second opinion from a qualified Health Care Provider within the Network, at no cost to the Member. If a qualified Health Care Provider is not available within the Network, the PH-MCO must assist the Member in obtaining a second opinion from a qualified Health Care Provider outside the Network, at no cost to the Member, unless co-payments apply.

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The PH-MCO will require the PCP, dentist, or specialist to conduct affirmative outreach whenever a Member misses an appointment and to document this in the medical record. Such an effort shall be deemed to be reasonable if it includes three (3) attempts to contact the Member. Such attempts may include, but are not limited to: written attempts, telephone

calls and home visits. At least one (1) such attempt must be a follow-up telephone call.

a. General

PCP scheduling procedures must ensure that:

i. Emergency Medical Condition cases must be immediately seen or referred to an emergency facility.

ii. Urgent Medical Condition cases must be scheduled within twenty-four (24) hours.

iii. Routine appointments must be scheduled within ten (10) Business Days.

iv. Health assessment/general physical examinations and first examinations must be scheduled within three (3) weeks of Enrollment.

v. The PH-MCO must provide the Department with its protocol for ensuring that a Member's average office waiting time for an appointment for Routine Care is no more than thirty (30) minutes or at any time no more than up to one (1) hour when the physician encounters an unanticipated Urgent Medical Condition visit or is treating a Member with a difficult medical need. The Member must be informed of scheduling time frames through educational outreach efforts.

vi. The PH-MCO must monitor the adequacy of its appointment processes and reduce the unnecessary use of emergency room visits.

b. Persons with HIV/AIDS

The PH-MCO must have adequate PCP scheduling procedures in place to ensure that an appointment with a PCP or specialist must be scheduled within seven (7) days from the effective date of Enrollment for any person known to the PH-MCO to be HIV positive or diagnosed with AIDS (e.g. self-identification), unless the Member is already in active care with a PCP or specialist.

c. Supplemental Security Income (SSI)

The PH-MCO must make a reasonable effort to schedule an appointment with a PCP or specialist within forty-five (45) days of Enrollment for any

Member who is an SSI or SSI-related consumer unless the Member is already in active care with a PCP or specialist.

d. Specialty Referrals

For specialty referrals, the PH-MCO must be able to provide for:

i. Emergency Medical Condition appointments immediately upon referral.

ii. Urgent Medical Condition care appointments within twenty-four (24) hours of referral.

iii. Scheduling of appointments for routine care within fifteen (15) business days for the following specialty provider types:

Otolaryngology	Orthopedic Surgery
Dermatology	Pediatric Allergy & Immunology
Pediatric Endocrinology	Pediatric Gastroenterology
Pediatric General Surgery	Pediatric Hematology
Pediatric Infectious Disease	Pediatric Nephrology
Pediatric Neurology	Pediatric Oncology
Pediatric Pulmonology	Pediatric Rehab Medicine
Pediatric Rheumatology	Pediatric Urology
Dentist	

iv. Scheduling of appointments for routine care within ten (10) business days of referral for all other specialty provider types not listed above.

e. Pregnant Women

Should the EAP contractor or Member notify the PH-MCO that a new Member is pregnant or there is a pregnancy indication on the files transmitted to the PH-MCO by the Department, the PH-MCO must contact the Member within five (5) days of the effective date of Enrollment to assist the woman in obtaining an appointment with an OB/GYN or Certified Nurse Midwife. For maternity care, the PH-MCO must arrange initial prenatal care appointments for enrolled pregnant Members as follows:

i. First trimester — within ten (10) Business Days of the Member being identified as being pregnant.

ii. Second trimester — within five (5) Business Days of the Member being identified as being pregnant.

iii. Third trimester — within four (4) Business Days of the Member being identified as being pregnant.

iv. High-risk pregnancies — within twenty-four (24) hours of identification of high risk to the PH-MCO or maternity care Provider, or immediately if an emergency exists.

f. EPSDT

EPSDT screens for any new Member under the age of twenty-one (21) must be scheduled within forty-five (45) days from the effective date of Enrollment unless the child is already under the care of a PCP and the child is current with screens and immunizations.

The PH-MCO must distribute quarterly lists to each PCP in its Provider Networks which identify Members who have not had an Encounter during the previous twelve (12) months or within the time frames set forth in this Exhibit, or Members who have not complied with EPSDT periodicity and immunization schedules for children. The PH-MCO must contact such Members, documenting the reasons for noncompliance and documenting its efforts for bringing the Members' care into compliance.

3. Policies and Procedures for Appointment Standards

The PH-MCO will comply with the program standards regarding service accessibility standards that are set forth in this Exhibit and in Section V.S. of the Agreement, Provider Agreements.

The PH-MCO must have written policies and procedures for disseminating its appointment standards to all Members through its Member handbook and through other means. In addition, the PH-MCO must have written policies and procedures to educate its Provider Network about appointment standard requirements. The PH-MCO must monitor compliance with appointment standards and must have a corrective action plan when appointment standards are not met.

4. Compliance with Access Standards

a. Mandatory Compliance

The PH-MCO must comply with the access standards in accordance with this Exhibit and Section V.S of the Agreement, Provider Agreements. If the PH-MCO fails to meet any of the access standards by the dates

specified by the Department, the Department may terminate this Agreement.

b. Reasonable Efforts and Assurances

The PH-MCO must make reasonable efforts to honor a Member's choice of Providers among Network Providers as long as:

i. The PH-MCO's agreement with the Network Provider covers the services required by the Member; and

ii. The PH-MCO has not determined that the Member's choice is clinically inappropriate.

The PH-MCO must provide the Department adequate assurances that the PH-MCO, with respect to this HealthChoices Zone, has the capacity to serve the expected Enrollment in this HealthChoices Zone. The PH-MCO must provide assurances that it will offer the full scope of covered services as set forth in this Agreement and access to preventive and primary care services. The PH-MCO must also maintain a sufficient number, mix and geographic distribution of Providers and services in accordance with the standards set forth in this Exhibit and Section V.S of the Agreement, Provider Agreements.

c. PH-MCO's Corrective Action

The PH-MCO must take all necessary steps to resolve, in a timely manner, any demonstrated failure to comply with the access standards. Prior to a termination action or other sanction by the Department, the PH-MCO will be given the opportunity to institute a corrective action plan. The PH-MCO must submit a corrective action plan to the Department for approval within thirty (30) days of notification of such failure to comply, unless circumstances warrant and the Department demands a shorter response time. The Department's approval of the PH-MCO's corrective action plan will not be unreasonably withheld. The Department will make its best effort to respond to the PH-MCO within thirty (30) days from the submission date of the corrective action plan. If the Department rejects the corrective action plan, the PH-MCO shall be notified of the deficiencies of the corrective action plan. In such event, the PH-MCO must submit a revised corrective action plan within fifteen (15) days of notification. If the Department does not receive an acceptable corrective action plan, the Department may impose sanctions against the PH-MCO, in accordance with Section VIII.I of the Agreement, Sanctions. Failure to implement the corrective action plan may result in the imposition of a sanction as provided in this Agreement.

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EXHIBIT AAA (3)

PROVIDER NETWORK COMPOSITION/SERVICE ACCESS

1. Network Composition

The PH-MCO must consider the following in establishing and maintaining its Provider Network:

- The anticipated MA enrollment,
- The expected utilization of services, taking into consideration the characteristics and health care needs of specific MA populations represented in the PH-MCO,
- The number and types, in terms of training, experience, and specialization, of Providers required to furnish the contracted MA services,
- All Providers operating within the PH-MCO's Network who provide services to Recipients must be enrolled in the Commonwealth's MA Program and possess an active PROMISe™ Provider ID.
- The number of Network Providers who are not accepting new MA patients, and
- The geographic location of Providers and Members, considering distance, travel time, the means of transportation ordinarily used by Members, and whether the location provides physical access for Members with disabilities.

The PH-MCO must ensure that its Provider Network is adequate to provide its Members in this HealthChoices Zone with access to quality Member care through participating professionals, in a timely manner, and without the need to travel excessive distances. Upon request from the Department, the PH-MCO must supply geographic access maps using Member level data detailing the number, location and specialties of their Provider Network to the Department in order to verify accessibility of Providers within their Network in relation to the location of its Members. The Department may require additional numbers of specialists and ancillary Providers should it be determined that geographic access is not adequate. The PH-MCO must also have a process in place which ensures that the PH-MCO knows the capacity of their Network PCP panels at all times and have the ability to report on this capacity.

The PH-MCO must make all reasonable efforts to honor a Member's choice of Providers who are credentialed in the Network. If the PH-MCO is unable to ensure a Member's access to provider or specialty provider services within the PH-MCO's network, within the travel times set forth in this Exhibit, the PH-MCO must make all reasonable efforts to ensure the Member's access to these services within the travel times herein through out-of-network providers. In locations where the PH-MCO can provide evidence that it has conducted all reasonable efforts to contract with providers and specialists and can provide

verification that no providers or specialists exist to ensure a Member's access to these services within the travel times set forth in this Exhibit, the PH-MCO must work with Members to offer reasonable provider alternatives. Additionally, the PH-MCO must ensure and demonstrate that the following Provider Network and access requirements are established and maintained for the entire HealthChoices Zone in which the PH-MCO operates if providers exist:

a. PCPs

Make available to every Member a choice of at least two (2) appropriate PCPs with open panels whose offices are located within a travel time no greater than thirty (30) minutes in-Lackawanna and Luzerne Counties and sixty (60) minutes in all other counties of the New East Zone. This travel time is measured via public transportation, where available. Members may, at their discretion, select PCPs located further from their homes.

b. Pediatricians as PCPs

Ensure an adequate number of pediatricians with open panels to permit all Members who want a pediatrician as a PCP to have a choice of two (2) for their child(ren) within the travel time limits (thirty (30) minutes in Lackawanna and Luzerne Counties, sixty (60) minutes in all other counties of the New East Zone).

c. Specialists

i. For the following provider types, the PH-MCO must ensure a choice of two (2) providers who are accepting new patients within the travel time limits (thirty (30) minutes in Lackawanna and Luzerne Counties, sixty (60) minutes in all other counties of the New East Zone.):

General Surgery	Cardiology
Obstetrics & Gynecology	Pharmacy
Orthopedic Surgery	
General Dentistry	

ii. For the following provider types, the PH-MCO must ensure a choice of one (1) provider who is accepting new patients within the following travel time limits (30 minutes in Lackawanna and Luzerne Counties, 90 minutes in all other counties of the New East Zone) and a second choice, within the HealthChoices Zone:

Oral Surgery	Urology
Nursing Facility	Neurology

Dermatology	Otolaryngology
Oncology	Radiology
Physical Therapy	

iii. For all other specialists and subspecialists, the PH-MCO must have a choice of two (2) providers who are accepting new patients within the HealthChoices Zone.

d. Hospitals

Ensure at least one (1) hospital within the travel time limits (thirty (30) minutes in Lackawanna and Luzerne Counties sixty (60) minutes in all other counties of the New East Zone.) and a second choice within the HealthChoices Zone.

e. Special Health Needs

Ensure the provision of services to persons who have special health needs or who face access barriers to health care. If the PH-MCO does not have at least two (2) specialists or sub-specialists qualified to meet the particular needs of the individuals, then the PH-MCO must allow Members to pick an Out-of-Network Provider if not satisfied with the Network Provider. The PH-MCO must develop a system to determine Prior Authorization for Out-of-Network Services, including provisions for informing the Recipient of how to request this authorization for Out-of-Plan Services. For children with special health needs, the PH-MCO must offer at least two (2) pediatric specialists or pediatric sub-specialists.

f. Anesthesia for Dental Care

For Members needing anesthesia for dental care, the PH-MCO must ensure a choice of at least two (2) dentists within the Provider Network with privileges or certificates to perform specialized dental procedures under general anesthesia or pay out of Network.

g. Rehabilitation Facilities

Ensure a choice of at least two (2) rehabilitation facilities within the Provider Network, at least one (1) of which must be located within this HealthChoices Zone.

h. CNMs / CRNPs, Other Health Care Providers

Ensure access to Certified Nurse Midwives (CNMs) and Certified Registered Nurse Practitioners (CRNPs) and other Health Care Providers. In accordance with Rx for PA principles, the PH-MCO must demonstrate

its attempts to contract in good faith with a sufficient number of CNMs and CRNPs and other Health Care Providers and maintain payment policies that reimburse CNMs and CRNPs and other Health Care Providers for all services provided within the scope of their practice and allow them to practice to the fullest extent of their education, training and licensing.

i. Qualified Providers

The PH-MCO must limit its PCP Network to appropriately qualified Providers. The PH-MCO's PCP Network must meet the following:

- No less than Seventy–five percent (75) of the Network consists of PCPs who have completed an approved primary care residency in family medicine, osteopathic general medicine, internal medicine or pediatrics; and

- No more than twenty-five percent (25%) of the Network consists of PCPs without appropriate residencies but who have five (5) years of post-training clinical practice experience in family medicine, osteopathic general medicine, internal medicine or pediatrics, within the past seven (7) years. Post-training experience is defined as having practiced at least as a 0.5 full-time equivalent in the practice areas described.

j. Members Freedom of Choice

The PH-MCO must demonstrate its ability to offer its Members freedom of choice in selecting a PCP. At a minimum, the PH-MCO must have or provide one (1) full-time equivalent (FTE) PCP who serves no more than one thousand (1,000) Recipients. For the purposes of this section, a full-time equivalent PCP must be a physician involved in clinical care. The minimum weekly work hours for 1.0 FTE is the number of hours that the practice considers to be a normal work week, which may be 37.5, 40, or 50 hours. A physician cannot be counted as more than 1.0 FTE regardless of the number of hours worked. If the PCP/PCP Site employs Certified Registered Nurse Practitioners (CRNPs)/Physician Assistants (PAs), then the Provider/Provider Site will be permitted to add an additional one thousand (1,000) Members to the panel. The number of Members assigned to a PCP may be decreased by the PH-MCO if necessary to maintain the appointment availability standards.

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iv. Scheduling of appointments for routine care within ten (10) business days of referral for all other specialty provider types not listed above.

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f. EPSDT

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The PH-MCO must distribute quarterly lists to each PCP in its Provider Networks which identify Members who have not had an Encounter during the previous twelve (12) months or within the time frames set forth in this Exhibit, or Members who have not complied with EPSDT periodicity and immunization schedules for children. The PH-MCO must contact such Members, documenting the reasons for noncompliance and documenting its efforts for bringing the Members' care into compliance.

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The PH-MCO must comply with the access standards in accordance with this Exhibit and Section V.S of the Agreement, Provider Agreements. If the PH-MCO fails to meet any of the access standards by the dates specified by the Department, the Department may terminate this Agreement.

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ii. The PH-MCO has not determined that the Member's choice is clinically inappropriate.

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The PH-MCO must take all necessary steps to resolve, in a timely manner, any demonstrated failure to comply with the access standards. Prior to a termination action or other sanction by the Department, the PH-MCO will be given the opportunity to institute a corrective action plan. The PH-MCO must submit a corrective action plan to the Department for approval within thirty (30) days of notification of such failure to comply, unless circumstances warrant and the Department demands a shorter response time. The Department's approval of the PH-MCO's corrective action plan will not be unreasonably withheld. The Department will make its best effort to respond to the PH-MCO within thirty (30) days from the submission date of the corrective action plan. If the Department rejects the corrective action plan, the PH-MCO shall be notified of the deficiencies of the corrective action plan. In such event, the PH-MCO must submit a

revised corrective action plan within fifteen (15) days of notification. If the Department does not receive an acceptable corrective action plan, the Department may impose sanctions against the PH-MCO, in accordance with Section VIII.I of the Agreement, Sanctions. Failure to implement the corrective action plan may result in the imposition of a sanction as provided in this Agreement.

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EXHIBIT BBB

OUTPATIENT DRUG SERVICES

1. General Requirements

a. The PH-MCO must cover all Covered Outpatient Drugs listed on the Center for Medicare and Medicaid Services (CMS) Quarterly Drug Information File when determined to be Medically Necessary, unless otherwise excluded from coverage. (See 2. Coverage Exclusions below for exclusions.) This includes brand name and generic drugs, and over-the-counter drugs (OTCs), prescribed by licensed providers enrolled in the MA program, and sold or distributed by drug manufacturers that participate in the Medicaid Drug Rebate Program.

b. The PH-MCO must provide coverage for all medically accepted indications, as described in Section 1927(k)(6) of the Social Security Act, 42 U.S.C.A. 1396r-8(k)(6). This includes any use which is approved under the Federal Food, Drug, and Cosmetic Act, 21 U.S.C.A. 301 et seq. or whose use is supported by the nationally recognized pharmacy compendia, or peer-reviewed medical literature.

c. Unless financial responsibility is otherwise assigned, all Covered Outpatient Drugs are the payment responsibility of the Member's PH-MCO. The only exception is that the behavioral health managed care organization (BH-MCO) is responsible for the payment of methadone when used in the treatment of substance abuse disorders and when prescribed and dispensed by BH-MCO service Providers.

d. All Covered Outpatient Drugs must be dispensed through PH-MCO Network Providers. This includes Covered Outpatient Drugs prescribed by both the PH-MCO and the BH-MCO Providers.

e. Under no circumstances will the PH-MCO permit the therapeutic substitution of an outpatient drug by a pharmacist without explicit authorization from the licensed prescriber.

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 PH-MCO must include in its written policies and procedures an assurance that all requirements and conditions governing coverage and payment for Covered Outpatient Drugs, such as, but not limited to, prior authorization (including step therapy), medical necessity guidelines, age edits, drug rebate encounter submission, reporting, notices of decision, etc. will,

i. Apply, regardless of whether the Covered Outpatient Drug is provided as an outpatient drug benefit or as a “medical benefit” incident to a medical service and billed by the prescribing Provider using codes such as the Healthcare Common Procedure Coding System (HCPCS).

ii. Ensure access for all medically accepted indications as documented by package labeling, nationally recognized pharmacy compendia, peer-reviewed medical literature, and FFS guidelines to determine medical necessity of drugs that require prior authorization in the MA FFS Program, when designated by the Department.

h. The PH-MCO must agree to adopt the same guidelines to determine medical necessity of selected drugs or classes of drugs as those adopted by the MA FFS Program when designated by the Department by publication of Managed Care Operations Memoranda (MC OPS Memos).

i. The PH-MCO must comply with Section 2117 of Article XXI of the Insurance Company Law of 1921, as amended, 40 P.S. 991.2117 regarding continuity of care requirements and 28 PA Code Ch. 9. The PH-MCO must also comply with the procedures outlined in MA Bulletin 99-03-13 and MA Bulletin # 99-96-01. The PH-MCO policy and procedures for continuity of care for outpatient drugs, and all subsequent changes to the Department-approved policy and procedures, must be submitted to the Department for review and approval prior to implementation. The policy and procedures must address how the PH-MCO will ensure no interruption in drug therapy and the course of treatment, and continued access to outpatient drugs that the member was prescribed before enrolling in the PH-MCO.

2. **Coverage Exclusions**

a. In accordance with Section 1927 of the Social Security Act, 42 U.S.C.A. 1396r-8, the PH-MCO must exclude coverage for any drug marketed by a drug company (or labeler) who does not participate in the Medicaid Drug Rebate Program. The PH-MCO is not permitted to provide coverage for any drug product, brand name or generic, legend or non-legend, sold or distributed by a company that did not sign an agreement with the federal government to provide rebates to the Medicaid agency. This requirement does not apply to vaccines, compounding materials, certain vitamins and minerals or diabetic supplies.

b. The PH-MCO must not provide coverage for Drug Efficacy Study Implementation (DESI) drugs under any circumstances.

c. The PH-MCO must exclude coverage of noncompensable drugs in accordance with 55 PA Code §1121.54.

3. Formularies and Preferred Drug Lists (PDLs)

a. The PH-MCO may use a Formulary or a Preferred Drug List (PDL). All drugs must be Covered Outpatient 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 MA 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 MA 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 PH-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 PH-MCO must allow access to all non-formulary or non-preferred drugs that are included in the CMS Quarterly Drug Information File, other than those excluded from coverage by the Department, when determined to be Medically Necessary through a process such as Prior Authorization (including Step Therapy), in accordance with Prior Authorization of Services Section V. B.1. and Exhibit H, Prior Authorization Guidelines for Participating Managed Care Organizations in the HealthChoices Program.

g. The PH-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 PH-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 PH-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 PH-MCO must allow access to all new drugs approved by the Food and Drug Administration (FDA) and meet the definition of a Covered Outpatient Drug either by addition to the Formulary or PDL, or through prior authorization, within 10 days from their availability in the marketplace.

4. Prior Authorization of Outpatient Drugs

a. The PH-MCO may require Prior Authorization (includes step therapy) as a condition of coverage or payment for a Covered Outpatient Drug provided that:

   i. The PH-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, and

   ii. If a Member's prescription for a medication is not filled when a prescription is presented to the pharmacist due to a Prior Authorization requirement, the PH-MCO instructs the pharmacist to dispense either a:

      a) Fifteen (15) day supply if the prescription qualifies as an Ongoing Medication, unless the PH-MCO or its designated subcontractor issued a proper written notice of benefit reduction or termination at least ten (10) days prior to the end of the period for which the medication was previously authorized and a Grievance or DHS Fair Hearing request has not been filed, or

      b) A seventy-two (72) hour supply of a new medication.

b. For drugs not able to be divided and dispensed into individual doses, the PH-MCO must instruct the pharmacist to dispense the smallest amount that will provide at least a seventy-two (72) hour or fifteen (15) day supply, whichever is applicable.

c. The requirement that the Member be given at least a seventy-two (72) hour supply for a new medication or a fifteen (15) day supply for an Ongoing Medication does not apply when a pharmacist determines that the taking of the prescribed medication, either alone or along with other medication that the Member may be taking, would jeopardize the health or safety of the Member.

d. In such an event, the PH-MCO and/or its subcontractor must require that its participating dispensing Provider make good faith efforts to contact the prescriber.

e. If the PH-MCO denies the request for prior authorization, the PH-MCO must issue a written denial notice, using the appropriate Outpatient Drug Denial Notice template listed on the Department Intranet, within twenty-four (24) hours of receiving the request for prior authorization.

f. If the Member files a Grievance or DHS Fair Hearing request from a denial of an Ongoing Medication, the PH-MCO must authorize the medication until the Grievance or DHS Fair Hearing request is resolved.

g. When medication is authorized due to the PH-MCO's obligation to continue services while a Member's Grievance or Fair Hearing is pending, and the final binding decision is in favor of the PH-MCO, a request for subsequent refill of the prescribed medication does not constitute an Ongoing Medication.

h. The PH-MCO must establish and maintain written prior authorization policies, procedures, and guidelines to determine Medical Necessity of Covered Outpatient Drugs that require prior authorization, including drugs that require step therapy and drugs that are designated as non-formulary or non-preferred.

i. The PH-MCO must comply with the requirements for Prior Authorization of Services, Section V. B. 1. and Exhibit H, Prior Authorization Guidelines for Participating Managed Care Organizations in the HealthChoices Program, and receive written approval from the Department prior to implementation.

j. The PH-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 Member Notification

The PH-MCO must have policies and procedures for notification to Providers and Members 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 Members at least thirty (30) days prior to the effective date of the change.

b. The PH-MCO must provide all other Providers and Members written notification of changes to the Formulary or PDL and Prior Authorization requirements upon request.

c. The PH-MCO also must generally notify Providers and Members of Formulary or PDL and Prior Authorization changes through Member and Provider newsletters, its web site, or other regularly published media of general distribution.

6. PH-MCO Pharmacy & Therapeutics (P&T) Committee

a. The P&T Committee membership must include physicians, including a minimum of two (2) behavioral health physicians, pharmacists, MA program consumers and other appropriate clinicians. MA program consumer representative membership must include the following:

   i. One (1) physical health consumer representative. The physical health consumer representative must be a consumer enrolled in the PH-MCO, or a physician, a pharmacist, or a physical health consumer advocate designated by consumers enrolled in the PH-MCO to represent them.

   ii. One (1) behavioral health consumer representative. The behavioral health consumer representative must be a consumer enrolled in the PH-MCO, or a physician, a pharmacist, a behavioral health consumer advocate, or a family member designated by consumers enrolled in the PH-MCO to represent them.

b. The PH-MCO must submit a P&T Committee membership list for Department review and approval upon request.

c. When the P&T Committee addresses specific drugs or entire drug classes requiring medical expertise beyond the P&T Committee membership, specialists with knowledge appropriate to the drug(s) or class of drugs being addressed must be added as non-voting, ad hoc members.

d. The minutes from each PH-MCO P&T Committee meeting must be posted for public view on the PH-MCO's website within 30 days of the date of the meeting at which the minutes are approved. Minutes will include vote totals.

7. Pharmacy Provider Network - Any Willing Pharmacy

The PH-MCO must contract on an equal basis with any pharmacy qualified to participate in the MA Program that is willing to comply with the PH-MCO's payment rates and terms and to adhere to quality standards established by the PH-MCO as required by 62 P.S. 449.

The provisions for any willing pharmacy apply if the PH-MCO Subcontracts with specialty pharmacies, or designates specific network pharmacies as the preferred provider(s) of specialty drugs(s). PH-MCOs are required to contract on an equal basis with any pharmacy qualified to participate in the MA program that is willing to accept the same payment rate(s) 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 MA Program (both FFS and managed care) must sign an agreement with the federal government to provide rebates to the State. The Affordable Care Act (ACA) provides for federal drug rebates for drugs paid for by the PH-MCOs.

a. In order to ensure full compliance with the provisions of the ACA, PH-MCOs must report the necessary encounter data in order for the Department to invoice drug manufacturers for rebates for all Covered Outpatient Drugs. This includes physician-administered drugs, drugs dispensed by 340B covered entities or contract Pharmacies, and drugs dispensed to PH-MCO members with private or public pharmacy coverage and the PH-MCO provided secondary coverage.

b. The PH-MCO must report all outpatient drug information, including National Drug Codes (NDCs) and accurate NDC units for all drug claim types, NCPDP, 837 Professional, 837 Institutional, etc. as designated by the Department.

The PH-MCO may negotiate its own market share rebates for pharmaceutical products with drug companies.

If the PH-MCO fails to submit Outpatient Drug Encounter Data when invoiced to manufacturers for rebate, at least 90% are collectable within 90 calendar days of invoicing by the Commonwealth a sanction of $25,000 per quarter shall be imposed until the PH-MCO reaches the 90% threshold.

9. Outpatient Drug Encounters

a. The PH-MCO shall submit all Outpatient Drug Encounters to the Department within 30 days of the adjudication date of the claim to the MCO for payment.

b. The PH-MCO shall provide all Outpatient Drug Encounter data and supporting information as specified below for the Department to collect rebates through the Medicaid Drug Rebate Program. For all Outpatient Drug Encounter data including pharmacy point-of-sale (NCPDP), physician-administered drugs (837P), outpatient hospital drugs (837I), and drugs dispensed by 340B covered entities and contract pharmacies, the following data elements are required:

   i. Valid NDC for the drug dispensed.

      1. The PH-MCO shall also include the HCPCS code associated with the NDC for all 837P and 837I encounters where payment was made by the MCO based on the HCPCS code and HCPCS code units.

      2. The PH-MCO shall also include the diagnosis codes associated with the NDC for all 837P and 837I encounters where payment was made by the PH-MCO based on the HCPCS code and HCPCS code units.

   ii. Valid NDC units for the drug dispensed

      1. The MCO shall also include the HCPCS units associated with the NDC for all 837P and 837I encounters where payment was made by the MCO based on the HCPCS code and HCPCS code units.

   iii. Actual paid amount by the MCO to the provider for the drug dispensed.

   iv. Actual TPL amount paid by the Member's primary pharmacy coverage to the provider for the drug dispensed.

   v. Actual copayment paid by the Member to the provider for the drug dispensed.

   vi. Actual dispensing fee paid by the 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 PH-MCO to the provider for the drug.

xi. Any other data elements identified by the Department to invoice for drug rebates.

c. The PH-MCO shall edit and validate claim transaction submissions and Outpatient Drug Encounter data for completeness and accuracy in accordance with claim standards such as NCPDP. The actual paid amount by the PH-MCO to the dispensing provider must be accurately submitted on each Outpatient Drug Encounter to the Department.

d. The PH-MCO shall ensure that the NDC on all Outpatient Drug Encounters is appropriate for the HCPCS code based on the NDC and units billed. The NDC must represent a drug that was available to the physician in an outpatient setting for administration.

e. The Department will review the Outpatient Drug Encounters and remove applicable 340B covered entity encounters from the drug rebate invoicing process.

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 PH-MCO shall meet Outpatient Drug Encounter Data accuracy requirements by submitting PH-MCO paid Outpatient Drug Encounters with no more than a 3% error rate, calculated for a month's worth of Encounter submissions. The Department will monitor the PH-MCO's corrections to denied Encounters by random sampling performed quarterly and over the term of this Agreement. The PH-MCO shall have corrected and resubmitted 75% of the denied Encounters for services covered under this Agreement included in the random sample within 30 calendar days of denial

g. If the PH-MCO fails to submit Outpatient Drug Encounter data within timeframes specified, the Department shall assess civil monetary penalties upon the PH-MCO. These penalties shall be $2,000 for each calendar day that the Outpatient Drug Encounter data is not submitted. The Department may waive these sanctions if it is determined that the PH-MCO was not at fault for the late submission of the data.

Drug Utilization Review (DUR) Program

The PH-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 Members.

a. Prospective Drug Utilization Review (Pro-DUR)

i. The PH-MCO must provide for a review of drug therapy before each prescription is filled or delivered to a member at the point-of-sale or point-of-distribution. The review shall include screening for potential drug therapy problems due to therapeutic duplication, drug-disease contraindications, drug-drug interactions, incorrect drug dosage or duration of drug treatment, drug-allergy interactions and clinical abuse/misuse.

ii. The PH-MCO must provide for counseling of members receiving benefits from pharmacists in accordance with State Board of Pharmacy requirements.

b. Retrospective Drug Utilization Review (Retro-DUR)

i. The PH-MCO must, through its drug claims processing and information retrieval system, examine claims data and other records to identify patterns of fraud, abuse, gross overuse, or inappropriate or medically unnecessary care among physicians, pharmacists and members.

ii. The PH-MCO shall, on an ongoing basis, assess data on drug use against explicit predetermined standards (using nationally recognized compendia and peer reviewed medical literature) including but not limited to monitoring for therapeutic appropriateness, overutilization and underutilization, appropriate use of generic products, therapeutic duplication, drug-disease contraindications, drug-drug interactions, incorrect drug dosage or duration of drug treatment, and clinical abuse/misuse and, as necessary, introduce remedial strategies, in order to improve the quality of care.

iii. The PH-MCO shall provide for active and ongoing educational outreach programs to educate practitioners on common drug therapy problems aimed at improving prescribing or dispensing practices.

The PH-MCO must submit an annual report on the operation of its Pennsylvania Medicaid Drug Utilization Review (DUR) program in a format designated by the Department. The format of the report will include a description of the nature and scope of the prospective and retrospective drug use review programs, a summary of the interventions used, an assessment of the impact of these educational

interventions on quality of care, and an estimate of the cost savings generated as a result of the DUR program.

c. Drug Utilization Review Board (DUR Board)

The Department maintains a DUR Board that reflects the structure of the health care delivery model that includes both a managed care and a fee-for-service delivery system. Each PH-MCO and BH-MCO is required to include a representative to serve as a member of the DUR Board. The DUR Board is a standing advisory committee that recommends the application of predetermined standards related to Pro-DUR, Retro-DUR, and related administrative and educational interventions designed to protect the health and safety of the MA program recipients. The Board reviews and evaluates pharmacy claims data and prescribing practices for efficacy, safety, and quality against predetermined standards using nationally recognized drug compendia and peer reviewed medical literature as a source. The Board recommends appropriate utilization controls and protocols including prior authorization, automated prior authorization, system edits, guidelines to determine medical necessity, generic substitution, and quantity limits for individual medications or for therapeutic categories.

10. Pharmacy Benefit Manager (PBM)

The PH-MCO may use a PBM to process prescription Claims only if the PBM Subcontract complies with the provisions in Section XIII: Subcontractural Relationships, and has received advance written approval by the Department. The standards for Network composition and adequacy for outpatient drug services includes the requirements for any willing pharmacy as described above. The PH-MCO must indicate the intent to use a PBM, identify the proposed PBM Subcontract and the ownership of the proposed PBM subcontractor. If the PBM is owned wholly or in part by a PH-MCO, retail pharmacy Provider, chain drug store or pharmaceutical manufacturer, the PH-MCO must submit a written description of the assurances and procedures that will be put in place under the proposed PBM Subcontract, such as an independent audit, to assure confidentiality of proprietary information. These assurances and procedures must be submitted and receive advance written approval by the Department prior to initiating the PBM Subcontract. The Department will allow the continued operation of existing PBM Subcontracts while the Department is reviewing new contracts.

11. Requirements For PH-MCO and BH-MCO Interaction and Coordination of Outpatient Drug Services

a. BH-MCO prescribing Providers must comply with the PH-MCO requirements for utilization management of outpatient behavioral health drugs.

b. The BH-MCO will be required to issue an initial list of BH-MCO Providers to the PH-MCO, and quarterly updates that include additions and terminations. Should the PH-MCO receive a request to dispense medication prescribed by a BH Provider not listed on the BH-MCO's Provider file, the PH-MCO must work through the appropriate BH-MCO to identify the Provider. The PH-MCO is prohibited from denying prescribed medications solely on the basis that the BH-MCO Provider is not clearly identified on the BH-MCO Provider file.

c. Payment for inpatient pharmaceuticals during a BH admission is the responsibility of the BH-MCO and is included in the hospital charge.

d. The PH-MCO may deny payment of a claim for a Covered Outpatient Drug prescribed by a BH-MCO Provider only if one of the following occurs:

   i. The drug is not being prescribed for the treatment of substance abuse/dependency/ addiction or mental illness and any side effects of psychopharmacological agents. Those drugs are to be prescribed by the PH-MCO's PCP or specialists in the Member's PH-MCO Network.

   ii. The prescription has been identified as a case of Fraud, Abuse, or gross overuse, or the dispensing pharmacist determined that taking the medication either alone or along with other medications that the Member may be taking, would jeopardize the health and safety of the Member.

e. The PH-MCO must receive written approval from the Department of the policies and procedures for the PH-MCO and BH-MCO to:

   i. When deemed advisable, require consultation between practitioners before prescribing medication, and sharing complete, up-to-date medication records.

   ii. Timely resolve disputes which arise from the payment for or use of drugs, including a mechanism for timely, impartial mediation when resolution between the PH-MCO and BH-MCO does not occur.

   iii. Share independently developed Quality Management/Utilization Management information related to outpatient drug services, as applicable.

   iv. Collaborate in adhering to a drug utilization review program approved by the Department. Collaborate in identifying and reducing the frequency of patterns of Fraud, Abuse, gross overuse, inappropriate or medically unnecessary care among physicians, pharmacists and Members associated with specific drugs.

f. The PH-MCO must send data files, via the Department's file transfer protocol (FTP), containing records of detailed outpatient drug services as provided to individual enrollees of the BH-MCOs contracted with the Department. The PH-MCO must adhere to the file delivery schedule established at the implementation of the data exchange process, or notify the Department in advance of schedule changes. Files must be sent directly to the Department for distribution by the Department

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EXHIBIT BBB(3)

PHARMACY DENIAL NOTICE – COMPLETE DENIAL

[DATE] [This MUST be the date the notice is MAILED]

RE: [**Member's name and DOB**]

Dear **[Member Name]:**

[PH-MCO Name] has reviewed the request to approve the prescription for [**identify SPECIFIC medication including dosage and number of refills requested**], a **new/ongoing** [**circle one**] medication submitted by [**prescriber's name**] on behalf of [**patient name**] on [**date**]. After physician review, the request is:

Denied completely because: **[Explain in detail every reason for denial. In addition to explanation for decision, include specific references to approved criteria, rules or protocols on which decision is based. If denied because of insufficient information, identify all additional information needed to render decision.]**

This decision will take effect on [date].

> **To continue getting services**
> If you have been receiving the medicine that is being reduced, changed, or denied and you file a complaint, grievance, or request for a Fair Hearing (see instructions below) that is postmarked or hand-delivered **within 10 days of the date on this notice**, the prescription will continue until a decision is made. (You may use the attached tear-off forms.)

IF YOU DO NOT AGREE WITH THIS DECISION, YOU MAY DO ONE OR ALL OF THE FOLLOWING:

1) Request Criteria

You may request a copy of the medical necessity criteria or other rules on which the decision was based by sending a written request to:

PH-MCO Name and Address

2) File a Complaint or Grievance

You may file a complaint or grievance with **[PH-MCO Name] within 45 days from the date you get this notice**. Your complaint or grievance will be decided no later than ( ) days *[PH-MCO: Insert 30 unless PH-MCO will be using a shorter timeframe.]* from when we receive it.

To file a complaint or grievance:

- Call **[PH-MCO Name]** at **[Phone #/Toll-free TTY #]**; or
- Send your complaint or grievance to **[PH-MCO Name]** at the following address:

PH-MCO Address for filing complaint or grievance

To ask for an early decision

If your doctor or dentist believes that waiting ( ) days *[PH-MCO: Insert 30 unless PH-MCO will be using a shorter timeframe.]* to get a decision could harm your health, you may ask that your complaint or grievance be decided more quickly. To do this:

- Call **[PH-MCO Name]** at **[Phone #/Toll-free TTY #];**

AND

- Your doctor or dentist must fax a signed letter to **[PH-MCO fax #]** explaining why taking 30 days to decide your complaint or grievance could harm your health.

[PH-MCO Name] will notify you of the decision within 48 hours from when we receive your doctor's or dentist's letter, or within 3 business days from when we receive your request for an early decision, whichever is sooner.

3) Request a Fair Hearing

You may ask for a Fair Hearing from the Department of Public Welfare. Your request for a Fair Hearing must be in writing and must be postmarked **within 30 days from the date on this notice**. Your request should include the following information:

- Your (the Member's) name, social security number, and date of birth;
- A telephone number where you can be reached during the day;
- Whether you want to have a hearing in person or by telephone;
- A copy of this notice.

Your request for a Fair Hearing must be sent to the following address:

Department of Public Welfare
Office of Medical Assistance Programs
HealthChoices Program/Complaint, Grievance and Fair Hearing
P.O. Box 2675
Harrisburg, PA 17105-2675

The Department will issue a decision between 60 and 90 days from when it receives your request (see Member handbook for more details).

To ask for an early decision

If your doctor or dentist believes that the usual time frame for deciding your request for a Fair Hearing could harm your health, you may ask that the Fair Hearing take place more quickly. To do this:

- Call the Department at 1-800-798-2339, or fax your request to the Department at 1-717-772-6328.
- Your doctor or dentist must fax a signed letter to 717-772-6328 explaining why taking the usual amount of time to decide your request for a Fair Hearing could harm your health. If your doctor or dentist does not send a written letter, your doctor or dentist must testify at the Fair Hearing to explain why taking the usual amount of time to decide your request for a Fair Hearing could harm your health.

The Department will schedule a telephone hearing and notify you of its decision within three business days from when it receives your request.

You have the right to be present either in person or by telephone at the complaint review, grievance review, or Fair Hearing and to bring a family member, friend, lawyer or other person to help you.

If you file a complaint, grievance, or request for a Fair Hearing, you may request all documents relevant to this decision by sending a written request for the information to the following address:

PH-MCO Address for records information

4) Get a second opinion

You may get a second opinion from a provider in the **[PH-MCO Name]** network. Call your PCP or **[PH-MCO Name]** at **[Phone #/Toll-free TTY #]** to get a referral for a second opinion. Asking for a second opinion will not extend the time for filing a complaint, grievance, or request for a Fair Hearing, and it will not continue any service or item that you have been receiving.

5) Get Help with Grievances, Complaints, or Fair Hearings

If you need help filing a grievance, complaint, or request a Fair Hearing, you can call:

- [PH MCO Name] at [Phone #/Toll-freeTTY#]

To ask for free legal help with your grievance, complaint, or Fair Hearing, or with filing your grievance, complaint or request for Fair Hearing, you can call:

- Pennsylvania Health Law Project at 1-800-274-3258 (www.phlp.org) <OR>

- Pennsylvania Legal Aid Network at 1-800-322-7572 (www.palegalaid.net)

cc: Prescribing Provider

PH-MCO, the following statement must appear in English, Russian, Cambodian, Vietnamese, Spanish, Chinese, and any other language as required by the contract:]

The information in this notice is available in other languages and formats by calling [PH-MCO Name] at [Phone #/ Toll-free TTY #].

If this is a medicine that you have been getting until now, to be able to continue to get your prescription filled, you should fill out and tear off one or both of the slips below and send it to either **[name of PH-MCO]** (if you are filing a complaint or grievance) or DPW (if you are asking for a Fair Hearing), at the address listed above, **within 10 days of the date on the notice**.

REQUEST TO PH-MCO FOR COMPLAINT OR GRIEVANCE

_____ _____ or _____
Name **Med Assist. ID#** **Social Security #**

I disagree with **[name of PH-MCO's]** decision to reduce or terminate my prescription for

_____ on _____.
Name of Medicine Date of Notice

Please consider this a complaint or grievance unless, after further consideration, my HMO decides to authorize my full prescription. Please continue my medication.

Date:_____ Signature:_____

REQUEST TO DPW FOR FAIR HEARING

_____ _____ or _____
Name **Med. Assist. ID#** **Social Security #**

I disagree with **[name of PH-MCO's]** decision to reduce or terminate my prescription for

_____ on _____.

Name of Medicine Date of Notice

Please consider this a request for a Fair Hearing unless, after further consideration, my HMO decides to authorize my full prescription. Please continue my medication.

Date:_____ Signature:_____

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EXHIBIT BBB(4)

PHARMACY DENIAL NOTICE – PARTIAL APPROVAL OF MEDICATION

[DATE] [This MUST be the date the notice is MAILED]

RE: [**Member's name and DOB**]

Dear **[Member Name]:**

[PH-MCO Name] has reviewed the request to approve the prescription for [**identify SPECIFIC medication including dosage and number of refills requested**], a **new/ongoing** [**circle one**] medication submitted by [**prescriber's name**] on behalf of [**patient name**] on [**date**]. After physician review, the request is:

> Approved at a lesser dosage for a shorter time period or with fewer refills:
> **[Describe the specific dosage, duration, and number of refills approved and the specific dosage, duration and number of refills denied.]**

The dosage, time period or number of refills is not approved as requested because:
[Explain in detail every reason for denial. In addition to explanation for decision, include specific references to approved criteria, rules or protocols on which decision is based. If denied because of insufficient information, identify all additional information needed to render decision.]

The decision will take effect on [date].

> **To continue getting services**
> If you have been receiving the medicine that is being reduced, changed, or denied and you file a complaint, grievance, or request for a Fair Hearing (see instructions below) that is postmarked or hand-delivered **within 10 days of the date on this notice**, the prescription will continue until a decision is made. (You may use the attached tear-off forms.)

IF YOU DO NOT AGREE WITH THIS DECISION, YOU MAY DO ONE OR ALL OF THE FOLLOWING:

1) Request Criteria

You may request a copy of the medical necessity criteria or other rules on which the decision was based by sending a written request to:

PH-MCO Name and Address

2) File a Complaint or Grievance

You may file a complaint or grievance with **[PH-MCO Name] within 45 days from the date you get this notice**. Your complaint or grievance will be decided no later than ( ) days *[PH-MCO: Insert 30 unless PH-MCO will be using a shorter timeframe.]* from when we receive it.

To file a complaint or grievance:

- Call **[PH-MCO Name]** at **[Phone #/Toll-free TTY #]**; or
- Send your complaint or grievance to **[PH-MCO Name]** at the following address:

PH-MCO Address for filing complaint or grievance

To ask for an early decision

If your doctor or dentist believes that waiting ( ) days *[PH-MCO: Insert 30 unless PH-MCO will be using a shorter timeframe.]* to get a decision could harm your health, you may ask that your complaint or grievance be decided more quickly. To do this:

- Call **[PH-MCO Name]** at **[Phone #/Toll-free TTY #];**

AND

- Your doctor or dentist must fax a signed letter to **[PH-MCO fax #]** explaining why taking 30 days to decide your complaint or grievance could harm your health.

[PH-MCO Name] will notify you of the decision within 48 hours from when we receive your doctor's or dentist's letter, or within 3 business days from when we receive your request for an early decision, whichever is sooner.

3) Request a Fair Hearing

You may ask for a Fair Hearing from the Department of Public Welfare. Your request for a Fair Hearing must be in writing and must be postmarked **within 30 days from the date on this notice**. Your request should include the following information:

- Your (the Member's) name, social security number, and date of birth;
- A telephone number where you can be reached during the day;
- Whether you want to have a hearing in person or by telephone;
- A copy of this notice.

Your request for a Fair Hearing must be sent to the following address:

Department of Public Welfare
Office of Medical Assistance Programs
HealthChoices Program/Complaint, Grievance and Fair Hearing
P.O. Box 2675
Harrisburg, PA 17105-2675

The Department will issue a decision between 60 and 90 days from when it receives your request (see Member handbook for more details).

To ask for an early decision

If your doctor or dentist believes that the usual time frame for deciding your request for a Fair Hearing could harm your health, you may ask that the Fair Hearing take place more quickly. To do this:

- Call the Department at 1-800-798-2339, or fax your request to the Department at 1-717-772-6328.
- Your doctor or dentist must fax a signed letter to 717-772-6328 explaining why taking the usual amount of time to decide your request for a Fair Hearing could harm your health. If your doctor or dentist does not send a written letter, your doctor or dentist must testify at the Fair Hearing to explain why taking the usual amount of time to decide your request for a Fair Hearing could harm your health.

The Department will schedule a telephone hearing and notify you of its decision within three business days from when it receives your request.

You have the right to be present either in person or by telephone at the complaint review, grievance review, or Fair Hearing and to bring a family member, friend, lawyer or other person to help you.

You may receive the approved medication while your complaint, grievance, or request for a Fair Hearing is being decided.

If you file a complaint, grievance, or request for a Fair Hearing, you may request all documents relevant to this decision by sending a written request for the information to the following address:

PH-MCO Address for records information

4) Get a second opinion

You may get a second opinion from a provider in the **[PH-MCO Name]** network. Call your PCP or **[PH-MCO Name]** at **[Phone #/Toll-free TTY #]** to get a referral for a second opinion. Asking for a second opinion will not extend the time for filing a complaint, grievance, or request for a Fair Hearing, and it will not continue any service or item that you have been receiving.

5) Get Help with Grievances, Complaints, or Fair Hearings

If you need help filing a grievance, complaint, or request a Fair Hearing, you can call:

- [PH MCO Name] at [Phone #/Toll-free TTY#]

To ask for free legal help with your grievance, complaint, or Fair Hearing, or with filing your grievance, complaint or request for Fair Hearing, you can call:

- Pennsylvania Health Law Project at 1-800-274-3258 (www.phlp.org) <OR>
- Pennsylvania Legal Aid Network at 1-800-322-7572 (www.palegalaid.net)

cc: Prescribing Provider

PH-MCO, the following statement must appear in English, Russian, Cambodian, Vietnamese, Spanish, Chinese, and any other language as required by the contract:]

The information in this notice is available in other languages and formats by calling [PH-MCO Name] at [Phone #/Toll-free TTY #].

If this is a medicine that you have been getting until now, to be able to continue to get your prescription filled, you should fill out and tear off one or both of the slips below and send it to either **[name of PH-MCO]** (if you are filing a complaint or grievance) or DPW (if you are asking for a Fair Hearing), at the address listed above, **within 10 days of the date on the notice**.

REQUEST TO PH-MCO FOR COMPLAINT OR GRIEVANCE

_____ _____ or _____

Name **Med Assist. ID#** **Social Security #**

I disagree with [**name of PH-MCO's**] decision to reduce or terminate my prescription for

_____ on _____.

Name of Medicine Date of Notice

Please consider this a complaint or grievance unless, after further consideration, my HMO decides to authorize my full prescription. Please continue my medication.

Date:_____ Signature:_____

REQUEST TO DPW FOR FAIR HEARING

_____ _____ or _____

Name **Med. Assist. ID#** **Social Security #**

I disagree with [**name of PH-MCO's**] decision to reduce or terminate my prescription for

_____ on _____.
Name of Medicine Date of Notice

Please consider this a request for a Fair Hearing unless, after further consideration, my HMO decides to authorize my full prescription. Please continue my medication.

Date:_____ Signature:_____

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EXHIBIT BBB(5)

PHARMACY DENIAL NOTICE – APPROVAL OF DIFFERENT MEDICATION

[DATE] [This MUST be the date the notice is MAILED]

RE: [**Member's name and DOB**]

Dear **[Member Name]:**

[PH-MCO Name] has reviewed the request to approve the prescription for [**identify SPECIFIC medication including dosage and number of refills requested**], a **new/ongoing** [**circle one**] medication submitted by [**prescriber's name**] on behalf of [**patient name**] on [**date**]. After physician review, the request is:

> Denied as requested, but the following medication is approved: **[Describe the medication, dosage, duration and number of refills approved.]**

The prescription is not approved as requested because: **[Explain in detail every reason for denial. In addition to explanation for decision, include specific references to approved criteria, rules or protocols on which decision is based. If denied because of insufficient information, identify all additional information needed to render decision.]**

This decision will take effect on [date].

> **To continue getting services**
> If you have been receiving the medicine that is being reduced, changed, or denied and you file a complaint, grievance, or request for a Fair Hearing (see instructions below) that is postmarked or hand-delivered **within 10 days of the date on this notice**, the prescription will continue until a decision is made. (You may use the attached tear-off forms.)

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2) File a Complaint or Grievance

You may file a complaint or grievance with **[PH-MCO Name] within 45 days from the date you get this notice**. Your complaint or grievance will be decided no later than ( ) days *[PH-MCO: Insert 30 unless PH-MCO will be using a shorter timeframe.]* from when we receive it.

To file a complaint or grievance:

- Call **[PH-MCO Name]** at **[Phone #/Toll-free TTY #]**; or
- Send your complaint or grievance to **[PH-MCO Name]** at the following address:

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To ask for an early decision

If your doctor or dentist believes that waiting ( ) days *[PH-MCO: Insert 30 unless PH-MCO will be using a shorter timeframe.]* to get a decision could harm your health, you may ask that your complaint or grievance be decided more quickly. To do this:

- Call **[PH-MCO Name]** at **[Phone #/Toll-free TTY #];**

AND

- Your doctor or dentist must fax a signed letter to **[PH-MCO fax #]** explaining why taking 30 days to decide your complaint or grievance could harm your health.

[PH-MCO Name] will notify you of the decision within 48 hours from when we receive your doctor's or dentist's letter, or within 3 business days from when we receive your request for an early decision, whichever is sooner.

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The Department will schedule a telephone hearing and notify you of its decision within three business days from when it receives your request.

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- [PH MCO Name] at [Phone #/Toll-free TTY#]

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REQUEST TO PH-MCO FOR COMPLAINT OR GRIEVANCE

_____ _____ or _____

Name **Med Assist. ID#** **Social Security #**

I disagree with [**name of PH-MCO's**] decision to reduce or terminate my prescription for

_____ on _____.

Name of Medicine Date of Notice

Please consider this a complaint or grievance unless, after further consideration, my HMO decides to authorize my full prescription. Please continue my medication.

Date:_____ Signature:_____

REQUEST TO DPW FOR A FAIR HEARING

_____ _____ or _____

Name **Med Assist. ID#** **Social Security #**

I disagree with [**name of PH-MCO's**] decision to reduce or terminate my prescription for

_____ on _____.

Name of Medicine Date of Notice

Please consider this a request for a Fair Hearing unless, after further consideration, my HMO decides to authorize my full prescription. Please continue my medication.

Date:_____ Signature:_____

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EXHIBIT CCC

PHYSICAL HEALTH MCO (PH-MCO) PROVIDER AGREEMENTS

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

The PH-MCO's Provider Agreements must include the following provisions:

a. A requirement that the PH-MCO must not exclude or terminate a Provider from participation in the PH-MCO's Provider Network due to the fact that the Provider has a practice that includes a substantial number of patients with expensive medical conditions.

b. A requirement that the PH-MCO must not exclude a Provider from the PH-MCO's Provider Network because the Provider advocated on behalf of a Member for Medically Necessary and appropriate health care consistent with the degree of learning and skill ordinarily possessed by a reputable Health Care Provider practicing according to the applicable legal standard of care.

c. A provision that prohibits the Provider from denying services to an Recipient during the MA FFS eligibility window prior to the effective date of the PH-MCO Enrollment.

d. Notification of the prohibition and sanctions for submission of false Claims and statements.

e. The definition of Medically Necessary as defined in Section II of this Agreement, Definitions.

f. A requirement that the PH-MCO cannot prohibit or restrict a Health Care Provider acting within the lawful scope of practice from discussing Medically Necessary care and advising or advocating appropriate medical care with or on behalf of a Member including; information regarding the nature of treatment options; risks of treatment; alternative treatments; or the availability of alternative therapies, consultation or tests that may be self-administered.

g. A requirement that the PH-MCO cannot prohibit or restrict a Health Care Provider acting within the lawful scope of practice from providing information the Member needs in order to decide among all relevant treatment options and the risks, benefits, and consequences of treatment or nontreatment.

h. A requirement that the PH-MCO cannot terminate a contract or employment with a Health Care Provider for filing a Grievance on a Member's behalf.

i. A clause which specifies that the agreement will not be construed as requiring the PH-MCO to provide, reimburse for, or provide coverage of, a counseling or referral service if the Provider objects to the provision of such services on moral or religious grounds.

j. A requirement securing cooperation with the QM/UM Program standards outlined in Exhibit M(1) of this Agreement, Quality Management and Utilization Management Program Requirements.

k. A requirement for cooperation for the submission of Encounter Data for all services provided within the time frames required in Section VIII of this Agreement, Reporting Requirements, no matter whether reimbursement for these services is made by the PH-MCO either directly or indirectly through capitation.

l. A continuation of benefits provision which states that the Provider agrees that in the event of the PH-MCO's insolvency or other cessation of operations, the Provider must continue to provide benefits to the PH-MCO's Members, including Members in an inpatient setting, through the period for which the Capitation has been paid.

m. A requirement that the PCPs who serve Members under the age of twenty-one (21) are responsible for conducting all EPSDT screens for individuals on their panel under the age of twenty-one (21). Should the PCP be unable to conduct the necessary EPSDT screens, the PCP is responsible for arranging to have the necessary EPSDT screens conducted by another Network Provider and ensure that all relevant medical information, including the results of the EPSDT screens, are incorporated into the Member's PCP medical record. For details on access requirements, see Exhibit AAA(1), AAA(2) or AAA(3) of this Agreement, Provider Network Composition/Service Access, as applicable.

n. A requirement that PCPs who serve Members under the age of twenty-one (21) report Encounter Data associated with EPSDT screens, using a format approved by the Department, to the PH-MCO within ninety (90) days from the date of service.

o. A requirement that PCPs contact new Members identified in the quarterly Encounter lists who have not had an Encounter during the first six (6) months of Enrollment, or who have not complied with the scheduling requirements outlined in the RFP and this Agreement. The PH-MCO must require the PCP to contact Members identified in the quarterly Encounter lists as not complying with EPSDT periodicity and immunization schedules for children. The PCP must be required to identify to the PH-MCO any such Members who have not come into compliance with the EPSDT periodicity and immunization schedules within one (1) month of such notification to the site by the PH-MCO. The PCP must also be

required to document the reasons for noncompliance, where possible, and to document its efforts to bring the Member's care into compliance with the standards. PCPs shall be required to contact all Members who have not had an Encounter during the previous twelve (12) months or within the time frames set forth in Exhibit AAA(1), AAA(2), or AAA(3) of this Agreement, Appointment Standards, as applicable, to arrange appointments.

p. A requirement that the PH-MCO include in all capitated Provider Agreements a clause which requires that should the Provider terminate its agreement with the PH-MCO, for any reason, that the Provider provide services to the Members assigned to the Provider under the contract up to the end of the month in which the effective date of termination falls.

q. A requirement that ensures each physician providing services to Members eligible for Medical Assistance under the State Plan to have a unique identifier in accordance with the system established under section 1173(b) of the Social Security Act.

r. Language which requires the Provider to disclose annually any Physician Incentive Plan or risk arrangements it may have with physicians either within its group practice or other physicians not associated with the group practice even if there is no Substantial Financial Risk between the PH-MCO and the physician or physician group.

s. A requirement for cooperation with the PH-MCO's and DHS's Recipient Restriction Program.

t. A requirement that health care facilities and ambulatory surgical facilities develop and implement, in accordance with P.L.154, No. 13 known as the Medical Care Availability and Reduction of Error (Mcare) Act, an internal infection control plan that is established for the purpose of improving the health and safety of patients and health care workers and includes effective measures for the detection, control and prevention of Health Care-Associated Infections.

u. A provision that the PH-MCO's Utilization Management (UM) Departments are mandated by the Department to monitor the progress of a member's inpatient hospital stay. This must be accomplished by the PH-MCO's UM department receiving appropriate clinical information from the hospital that details the member's admission information, progress to date, and any pertinent data within two (2) business days from the time of admission. The PH-MCOs providers must agree to the PH-MCO's UM Department's monitoring of the appropriateness of a continued inpatient stay beyond approved days according to established criteria, under the direction of the PH-MCO's Medical Director. As part of the concurrent review process and in order for the UM Department to coordinate the discharge plan and assist in arranging additional services, special diagnostics, home care and durable medical equipment, the PH-MCO must receive all clinical information

on the inpatient stay in a timely manner which allows for decision and appropriate management of care.

v. Requirements regarding coordination with Behavioral Health Providers (if applicable):

- Comply with all applicable laws and regulations pertaining to the confidentiality of Member medical records, including obtaining any required written member consents to disclose confidential medical records.
- Make referrals for social, vocational, education or human services when a need for such service is identified through assessment.
- Provide health records if requested by the Behavioral Health Provider.
- Notify BH Provider of all prescriptions, and when deemed advisable, check with BH Provider before prescribing medication. Make certain BH clinicians have complete, up-to-date record of medications.
- Be available to the BH Provider on a timely basis for consultations.

w. The PH-MCO must require that participating ER staff and physicians know the procedures for reporting suspected abuse and neglect in addition to performing exams for the county.

The PH-MCO may not enter into a Provider Agreement that prohibits the Provider from contracting with another PH-MCO or that prohibits or penalizes the PH-MCO for contracting with other Providers.

The PH-MCO must make all necessary revisions to its Provider Agreements to be in compliance with the requirements set forth in this section. Revisions may be completed as Provider Agreements become due for renewal provided that all Provider Agreements are amended within one (1) year of the effective date of this Agreement with the exception of the Encounter Data requirements which must be amended immediately, if necessary, to ensure that all Providers are submitting Encounter Data to the PH-MCO within the time frames specified in Section VIII.B.1 of this Agreement, Encounter Data Reporting.