

CITATION/SPECIFIC EXCLUSION	REGULATORY LANGUAGE DESCRIPTION
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
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)

MCO PAY FOR PERFORMANCE

This Exhibit B(1) defines a potential payment obligation by the Department to the PH-MCO for Quality Performance Measures achieved per HEDIS® 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 2021. If the PH-MCO does not operate a HealthChoices program in this HealthChoices zone under this Agreement in the month of December 2021 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 II. below.

I. Quality Performance Measures

The Department selected eleven (11) HEDIS® 2021 and one (1) 2021 Pennsylvania Performance Measure (PAPM) as quality indicators (representing CY 2020 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 twelve (12) quality indicators are:

HEDIS®

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. Prenatal Care in the First Trimester
6. Postpartum Care
7. Well-Child Visits in the First 15 Months of Life, 6 or more
8. Well Child Visits in the Third, Fourth, Fifth and Sixth Years of Life
9. Asthma Medication Ratio
10. Lead Screening in Children
11. Plan All Cause Readmissions – Count of Observed 30-Day Readmissions

PAPM

1. Developmental Screening First Three Years of Life

The MCO P4P Program measures Benchmark Performance and Improvement Performance. The PAPM measure, Developmental Screening First Three Years of Life, will be eligible for the Improvement Performance component. In addition, the Department has set a performance goal for Developmental Screening First Three Years of Life. While this measure does not have a national benchmark, the

measure value will be calculated the same as HEDIS measures in the benchmark performance, Section I. A., below.

The PH-MCO will be eligible for a Health Equity Improvement Performance payout for Prenatal Care in the First Trimester and Well-Child Visits in the First 15 Months of Life, 6 or more for their African American population. The Department will be using the PH-MCO's administrative rate for Prenatal Care in the First Trimester and Well-Child Visits in the First 15 Months of Life, 6 or more for their African American population to calculate the Improvement Performance payout.

NOTE: The MCO P4P measures are subject to change due to NCQA specifications.

NOTE: The Department intends to develop a PAPM related to the Home Visiting Program that will be added to the MCO P4P Program.

A. Benchmark Performance: The Department will award a Benchmark Performance payout amount for each measure in Section I. that will range from 0% up to and including 125% of the measure's value, defined as half of the PH-MCO's Maximum Program Payout amount (equivalent to 1.0% of the sum of the amounts defined in Section II. below) divided by thirteen (13) (consisting of twelve (12) quality indicators with Annual Dental Visit counted twice). The Department will make Benchmark Performance payouts for performance relative to the HEDIS® 2021(CY 2020) benchmarks, for all measures excluding Developmental Screening First Three Years of Life. A goal of 57 percent (57.00%) has been set for Developmental Screening First Three Years of Life (see Section I.A.3.) If the PH-MCO's HEDIS 2021(CY 2020) performance rate is below the 50th Percentile Benchmark, the Department will implement a 75% off-set. The Department will distribute the payouts according to the following criteria:

1. All HEDIS® Measures

- HEDIS® 2021 rate at or above the 90th percentile benchmark: 125 percent of the measure value.
- HEDIS® 2021 rate at or above the 75th percentile and below the 90th percentile benchmark: 100 percent of the measure value.
- HEDIS® 2021 rate at or above the 50th percentile and below the 75th percentile benchmark: No payout.
- HEDIS® 2021 rate below the 50th percentile benchmark: -75 percent offset

2. Annual Dental Visit Performance Only

- The Benchmark Performance measure value applicable to Annual Dental Visit Performance is equal to double the Benchmark Performance measure value (as identified in Section I.A.).

- The -50% off-set will be applied to double the Benchmark Performance measure value (as identified in Section I. A.).

3. Developmental Screening First Three Years of Life

- Performance goal at or above 57.00 percent (57.00%): 100 percent of the measure value.
- Performance goal below 57.00 percent (57.00%): No payout

B. Benchmark Bonus Bundles: The Department will award a Benchmark Bonus Bundle payment for two groups of measures in the current MCO P4P model. If a bundle payment is earned this payment method will apply in addition to I.A.

The first bundle is the Perinatal and Infant Bundle. The measures in this bundle are:

- Prenatal Care in the First Trimester
- Postpartum Care, and
- Well-Child Visits in the First 15 Months of Life, 6 or more

The second bundle is the Child and Adolescent Well Care Bundle. The measures in this bundle are:

- Well-Child Visits in the Third, Fourth, Fifth and Sixth Years of Life,
- Adolescent Well-Care Visits, and
- Lead Screening in Children

1. Perinatal and Infant Bundle:

- If the rate for Prenatal Care in the First Trimester, Postpartum Care and Well-Child Visits in the First 15 Months of Life, 6 or more is $\geq 75^{\text{th}}$ percentile benchmark: 115% of the measure value payout for each measure.
- If the rate for Prenatal Care in the First Trimester, Postpartum Care and Well-Child Visits in the First 15 Months of Life, 6 or more is $\geq 90^{\text{th}}$ percentile benchmark: 130% of the measure value payout for each measure.
- If a rate achieved is $\geq 50^{\text{th}}$ percentile benchmark or below: No bonus payout will be issued.

NOTE: If one or more of the measures in the bundle achieves a $\geq 75^{\text{th}}$ percentile benchmark and another measure(s) achieves a $\geq 90^{\text{th}}$ percentile benchmark, the measure(s) that achieved the $\geq 75^{\text{th}}$ percentile benchmark will receive 115% of the measure value payout, while the measure(s) that achieved a $\geq 90^{\text{th}}$ percentile benchmark will receive 130% of the measure value payout.

2. Child and Adolescent Well Care Bundle:

- If the rate for Well-Child Visits in the Third, Fourth, Fifth and Sixth Years of Life, Adolescent Well-Care Visits and Lead Screening in Children are $\geq 75^{\text{th}}$ percentile benchmark: 115% of the measure value payout will be issued for each measure.
- If the rate for each of the measures is $\geq 90^{\text{th}}$ percentile benchmark: 130% of the measure value payout will be issued for each measure.
- If the rate achieved for any of the measures is $\geq 50^{\text{th}}$ percentile benchmark or below: No bonus payout will be issued.

NOTE: If one or more of the measures in the bundle achieves a $\geq 75^{\text{th}}$ percentile benchmark and another measure(s) achieves a $\geq 90^{\text{th}}$ percentile benchmark, the measure (s) that achieved the $\geq 75^{\text{th}}$ percentile benchmark will receive 115% of the measure value payout, while the other measure(s) that achieved a $\geq 90^{\text{th}}$ percentile benchmark will receive 130% of the measure value payout.

C. Improvement Performance: The Department will award an Improvement Performance payout amount for each measure in Section I. that will range from 0% up to and including 100% of the measure's value, defined as half of the PH-MCO's Maximum Program Payout amount (equivalent to 1.0% of the sum of the amounts defined in Section II. below) divided by thirteen (13) (consisting of twelve (12) 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 2021 measure (see Section I.C.1. and I.C.2.).

- If improvement is achieved and the benchmark performance for that measure is $\leq 50^{\text{th}}$ percentile, Scale 1 will be applied.
- If improvement is achieved and the benchmark performance for that measure is $> 50^{\text{th}}$ percentile and $< 75^{\text{th}}$ percentile, Scale 1 will be applied.
- If improvement is achieved and the benchmark performance $\geq 75^{\text{th}}$ percentile (see Section I.C.2.), Scale 2 will be applied.

Scale 2 applies to improvement performance for the PAPM Developmental Screening the First Three Years of Life. Receiving the Improvement Performance payout is not contingent on meeting the goal of 57 percent (57.00%) for Developmental Screening First Three Years of Life.

Scale 2 applies to improvement performance for the Health Equity quality measures Prenatal Care in the First Trimester and Well-Child Visits in the First 15 Months of Life, 6 or more.

1. 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® 2020 (CY 2019) to HEDIS® 2021 (CY 2020).

- ≥ 5 Percentage Point Improvement: 100 percent of the measure value.
- ≥ 4 and < 5 Percentage Point Improvement: 80 percent of the measure value.
- ≥ 3 and < 4 Percentage Point Improvement: 70 percent of the measure value.
- < 3 Percentage Point Improvement: No payout

2. 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® 2020 (CY 2019) to HEDIS® 2021 (CY 2020) and PAPM 2020 (CY 2019) to PAPM 2021(CY 2020).

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

3. Annual Dental Visit Performance Only

The Improvement Performance measure value available for Annual Dental Visit Performance is equal to double the Improvement Performance measure value (identified in Section I.C.).

4. Limitation on Payout Amounts

The total awarded payout amount to a PH-MCO, which includes Benchmark Performance (I.A.) and Improvement Performance (I.C.),

cannot exceed the Maximum Program Payout amount, as identified in Section II. below.

II. Payment for MCO Pay for Performance

The Department will inform the PH-MCO of the Maximum Program Payout amount by November 30, 2021.

The Maximum Program Payout amount will be equivalent to two (2.0) percent of the sum of the amounts defined below:

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 or another HealthChoices Agreement, Appendix 3b and Appendix 3f, for the program period July 2020 through June 2021 inclusive of allowance amounts for the risk sharing and risk pool arrangements. Any settlements for the risk sharing and risk pool arrangements will not be considered in the Capitation Revenue.

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 2020 through June 2021.

If the PH-MCO has purchased the assets or liabilities of a PH-MCO that previously contracted with the Department to operate a HealthChoices program in the same zone ("Previous PH-MCO"); or if the Department transferred the Members enrolled in the Previous PH-MCO, who did not make a different choice, to the current PH-MCO; then the Department will allow the PH-MCO to include Capitation Revenue and Maternity Care Revenue paid to the Previous PH-MCO for the program period July 2020 through June 2021, provided the Previous PH-MCO relinquishes any claims to payment under the terms of this Exhibit B(1).

Capitation Revenues or Maternity Care Revenue paid or payable by the Department can be included in only one Maximum Program Payout amount provided by the Department. Transition in HealthChoices Agreements or in PH-MCOs will not lead to double counting of any set of revenue when the Department calculates Maximum Program Payout amounts.

Per 42 C.F.R. 438.6(b)(2)(ii) –(iii), this incentive arrangement does not automatically renew and is made available to both public and private PH-MCOs under the same terms of performance.

NOTE: The Department may change the payout methodology based on reporting restrictions due to a natural disaster, pandemic or other unforeseen events. The payout methodology will be shared with the PH-MCOs prior to finalizing.

If the Department has a payment obligation to the PH-MCO pursuant to this Exhibit B(1), the Department will issue the payment by August 31, 2022. If the PH-MCO

has a payment obligation to the Department pursuant to this Exhibit B(1), the Department will reduce a subsequent payment to the PH-MCO by this amount.

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® 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 2021. If the PH-MCO does not operate a HealthChoices program in this HealthChoices zone under this Agreement in the month of December 2021, 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.

A. **In order to be eligible for payments under the ICP**, the PH-MCO must submit Operations Report 17 for Calendar Year (CY) 2021 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** - Re-stratification shall be conducted on all members in the targeted SPMI population from the previous calendar year in January. New members shall have an initial stratification level established within sixty (60) days of the date of 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 **1200 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. The ICP must be reviewed and

updated at least annually. An ICP will not count towards the required amount if the member has disenrolled from the PH-MCO prior to the calendar year. An ICP will count towards the required amount if a member has an ICP and disenrolls from the PH-MCO during the calendar year.

3. **Hospitalization Notification and Coordination** - Each PH-MCO and BH-MCO will jointly share responsibility for notification of all inpatient hospital admissions and will coordinate discharge and follow-up. This includes at a minimum the individual's member identification, the date of inpatient admission and name of the acute care hospital. Additional information sharing is encouraged 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.

For CY 2021 the PH-MCO is to share the ICP with both the Member and the member's Primary Care Provider (PCP). Beginning in CY 2022 sharing the ICP with both the Member and member's PCP will become an eligibility requirement for an incentive payout. The Operations Report 17 will be reviewed to verify the accuracy of the stratification, integrated care plan and hospital notification information.

B. Performance Measures

The performance measures for the 2021 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)**
6. Diabetes Screening for People with Schizophrenia or Bipolar Disorder who are using Antipsychotic Medications (SSD)*

7. Diabetes Care for People with Serious Mental Illness: Hemoglobin A1c (HbA1c) Poor Control (>9/0%) (HPCMI)**
8. Cardiovascular Monitoring for People with Cardiovascular Disease and Schizophrenia (SMC)*

NOTE: The ICP P4P measures are subject to change due to NCQA specifications.

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

C. Payment for MCO Performance

Ten million dollars (\$10M) will be allocated for the ICP Program in RY 2021 for the PH-MCO. The funding will be allocated to each PH-MCO according to its overall percent of HealthChoices member months for CY 2020.

The ICP P4P Program measures Benchmark Performance and Improvement Performance. Payments will be based on meeting a Benchmark/Goal and an incremental improvement calculated from the previous HEDIS®/PAPM 2020 (measurement year of 2019) to the current HEDIS®/PAPM 2021 (measurement year of 2020).

1. **Benchmark Performance:** The Department will make a Benchmark Performance payout for performance relative to the HEDIS® (RY) 2021 (MY 2020) benchmarks, for all measures excluding Initiation and Engagement of Alcohol and Other Drug Dependence Treatment – Engagement rate, Emergency Room Utilization for Individuals with SPMI, Combined BH-PH Inpatient 30 Day Readmission Rate for Individuals with SPMI, Combined BH-PH Inpatient Admission Utilization for Individuals with SPMI, Diabetes Screening for People with Schizophrenia or Bipolar Disorder who are using Antipsychotic Medications, Diabetes Care for People with Serious Mental Illness: Hemoglobin A1c (HbA1c) Poor Control (>9/0%), Cardiovascular Monitoring for People with Cardiovascular Disease and Schizophrenia. For Initiation and Engagement of Alcohol and Other Drug Dependence Treatment – Engagement rate, Emergency Room Utilization for Individuals with SPMI, Combined BH-PH Inpatient 30 Day Readmission Rate for Individuals with SPMI and Combined BH-PH Inpatient Admission Utilization for Individuals with SPMI a goal has been set.

A goal of 32.00% has been set for Initiation and Engagement of Alcohol and Other Drug Dependence Treatment – Engagement rate, a goal of 142.00 has been set for Emergency Department Utilization for Individuals with SPMI, a goal of 22.00 has been set for Combined BH-PH Inpatient Admission Utilization Rate for Individuals with SPMI and a goal of 15.00% has been set

for Combined BH-PH Inpatient 30 Day Readmission Rate for Individuals with SPMI.

The Department will award a Benchmark Performance payout amount for each measure that will range from 0% up to and including 125% of the measure's value, defined as half of the PH-MCO's Maximum Program Payout amount divided by eight (8) quality indicators.

The Department will distribute the payouts according to the following criteria:

- a. All HEDIS® Measures
 - HEDIS® 2021 rate at or above the 90th percentile benchmark: 125 percent of the measure value.
 - HEDIS® 2021 rate at or above the 75th percentile and below the 90th percentile benchmark: 100 percent of the measure value.
 - HEDIS® 2021 rate at or above the 50th percentile and below the 75th percentile benchmark: 75 percent of the measure value.
 - b. Emergency Department Utilization for Individuals with SPMI
 - Performance goal at or below 142.00: 100 Percent of the measure value.
 - Performance goal above 142.00: No payout.
 - c. Combined BH-PH Inpatient 30 Day Readmission Rate for Individuals with SPMI
 - Performance goal at or below 15.00%: 100 Percent of the measure value.
 - Performance goal above 15.00%: No payout.
 - d. Combined BH-PH Inpatient Admission Rate for Individuals with SPMI
 - Performance goal at or below 22.00: 100 percent of the measure value.
 - Performance goal above 22.00: No payout.
 - e. Initiation and Engagement of Alcohol and Other Drug Dependence Treatment – Engagement rate
 - Performance goal at or above 32.00%: 100 percent of the measure value.
 - Performance goal below 32.00%: No payout.
2. **Improvement Performance:** The Department will award an Improvement Performance payout amount for each measure that will range from 0% up to and including 100% of the measure's value, defined as half of the PH-MCO's Maximum Program Payout amount divided by eight (8) quality indicators.

The Improvement Performance payout scales will be applied contingent on benchmark percentile performance for each HEDIS® 2021 measure.

- If improvement is achieved and the benchmark performance for that measure is <50th percentile, Scale 1 will be applied.
- If improvement is achieved and the benchmark performance for that measure is ≥50th percentile and <75th percentile, Scale 1 will be applied.
- If improvement is achieved and the benchmark performance ≥75th percentile Scale 2 will be applied.

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® (RY) 2020 (MY 2019) to HEDIS® (RY) 2021 (MY 2020).

- ≥ 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 Reporting Year (RY) 2020 (MY 2019) to Reporting Year 2021 (MY 2020) and PAPM (RY) 2020 (MY 2019) to PAPM (RY) 2021(MY 2020).

Scale 2 applies to Initiation and Engagement of Alcohol and Other Drug Dependence (Engagement rate), Emergency Department Utilization for Individuals with SPMI, Combined BH-PH Inpatient Admission Utilization Rate for Individuals with SPMI, Combined BH-PH Inpatient 30 Day Readmission Rate for Individuals with SPMI, Diabetes Screening for People with Schizophrenia or Bipolar Disorder who are using Antipsychotic Medications, Diabetes Care for People with SPMI: Hemoglobin A1c (HbA1c) Poor Control (>9.0%) and Cardiovascular Monitoring for People with Cardiovascular Disease and Schizophrenia.

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

NOTE: The payout structure is subject to change based on reporting restriction due to a natural disaster, pandemic and other unforeseen events. We will share those changes with the MCO prior to making the changes.

If the Department has a payment obligation to the PH-MCO and BH-MCO pursuant to this Exhibit B(2), the Department will issue the payment by August 31, 2022.

Exhibit B(3)

PROVIDER PAY FOR PERFORMANCE PROGRAM

The Provider Pay-for-Performance (Provider P4P) program described in this Exhibit B(3) is for services rendered by providers during a Calendar Year (CY) and defined in Section I 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.

- A. The PH-MCO is required to develop a Provider P4P program using the following **mandatory** twelve (12) HEDIS[®] Quality Measures (per HEDIS[®] 2021 Technical Specifications, Vol. 2), one (1) PA Performance Measures (PAPM) and one (1) Electronic Quality Measure:

HEDIS[®]

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 that must be based on preventive dental services. The incentives must be structured to pay defined minimal amounts to dentists for performing episodes of preventive care for new and established recipients in at least two age bands- (0-5 years and 6-20 years). The specific incentive model will be relatively uniform across the HealthChoices program. The incentive model will be determined by the Department in cooperation with all HealthChoices PH-MCOs.
3. Controlling High Blood Pressure
4. Comprehensive Diabetes Care: HbA1c Poorly Controlled (>9%)
5. Prenatal Care in the First Trimester
6. Postpartum Care
7. Well-Child Visits in the First 15 Months of Life, 6 or more
8. Well-Child Visits in the Third, Fourth, Fifth and Sixth Years of Life
9. Asthma Medication Ratio
10. Ambulatory Care – ED Visits
11. Lead Screening for Children
12. Plan All Cause Readmissions

PAPM

1. Developmental Screening in the First Three (3) Years of Life

Electronic Quality Measure

Payment for electronic submission of any mandatory 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

NOTE: The Provider P4P program measures are subject to change due to NCQA specifications.

- B. The PH-MCO is required to develop and submit a proposal to the Department using the Provider P4P Submission Template on DocuShare. The proposal must be reviewed by the Department prior to implementing its Provider P4P program.
- C. A PH-MCO's approved Provider P4P program will remain in effect until December 31 of each calendar year. The PH-MCO may submit one (1) revision per quarter only to the provider payout amounts for the Department's review and approval. The PH-MCO must complete and submit the 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 Provider P4P Change Forms will be accepted in the fourth quarter. No other revisions to the Provider P4P program will be accepted.
- D. The PH-MCO must provide a quarterly analysis of its approved Provider P4P program through updates at the Quarterly Quality Review Meetings (QQRM).
- E. The PH-MCO must annually evaluate and provide an analysis to the Department of the effectiveness of its approved Provider P4P.
- F. The Department may request that PH-MCOs share Provider P4P program findings with other HealthChoices PH-MCOs to identify best practices and improve the overall HealthChoices Program.

II. Payments to the PH-MCO

- A. The Department will make payments for Provider P4P based on a per member per month (PMPM) rate, noted in Appendix 3f. The Provider P4P payments are part of the monthly capitation process, as identified in Appendix 3b. Coverage for Members in a freestanding IMD is specified in Section VII. E. 13.
 - 1. If the PH-MCO has unspent Provider P4P funds, as determined by the Department, upon receipt and review of Report #40, the Department may reduce a future payment to the PH-MCO by the unspent amount or the

Department may direct unspent Provider P4P funds provided to the PH-MCO per this Exhibit for the current or a prior program year.

2. If at any time the Department determines Provider P4P funds were not disbursed in accordance with the approved Provider P4P plan, upon advanced written notice to the PH-MCO, the Department may elect to reduce a future payment to the PH-MCO by the amount identified.
- B. Payments made to the PH-MCO under the Provider P4P program are intended to fund all mandatory measures

III. Payments to Providers

- A. All Provider P4P funds received from the Department for this HealthChoices Agreement should be paid to network providers in accordance with the approved Provider P4P program above.
- B. The PH-MCO is required to develop and maintain a separate accounting process of the receipts and disbursements of all Provider P4P funds. The PH-MCO must be able to separately identify and track each payment to a provider for each specific mandatory HEDIS[®] Quality Measure identified in the Provider P4P program.
- C. 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.

IV. Reporting

- A. Clinical Reporting
The PH-MCO is required to meet the Department's reporting requirements for the submissions of quarterly analyses of its approved Provider P4P Program through updates at the QQRMs and an annual analysis of the effectiveness of its approved Provider P4P program.
- B. Financial Reporting
Expenditures for this program are reported on annual Report #40 as required by the annual Financial Reporting Requirements. Reported disbursements should only reflect disbursements for the specified program year.

V. Clinical Review

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

Exhibit B(4)

HOSPITAL QUALITY INCENTIVE PROGRAM (HQIP)

The Department is administering a HQIP. This program is designed to incentivize acute care general hospitals, and potentially other hospitals, enrolled in HealthChoices to improve the quality of healthcare services. The Department developed this initiative as part of its commitment to promote cost-effective, quality healthcare through an outcome and value-based payment structure. The Department makes an annual determination of Hospital Quality measures.

The Department will measure performance by hospital statewide across HealthChoices. The performance measurements will not be PH-MCO specific. The Department will make one HQIP payment to the PH-MCO on or before October 31, 2021 per this Agreement if the PH-MCO is responsible to operate a HealthChoices program per this Agreement on October 1, 2021, respectively.

The Department's obligation for this program across all PH-MCOs that are responsible to operate a HealthChoices program in any or all zones on October 1, 2021, is \$80 million for the 2020 performance year. The Department will divide the \$80 million, respectively, across all PH-MCOs participating in HealthChoices in any or all zones based on each PH-MCO's monthly enrollment, as determined by the Department.

The Department will calculate the HQIP payments by hospital and will provide a schedule of HQIP payment(s) and instructions to each PH-MCO. The PH-MCO will make HQIP payments to hospitals per the instructions within ten business days of the later of the receipt of this payment or the PH-MCO's receipt of payment instructions from the Department. The PH-MCO will not be required to make HQIP payments that exceed, in total, the amount paid by the Department for this purpose.

The Department will continue this HQIP for subsequent calendar years' performance. The Department will share hospital quality data prepared per this program with all PH-MCOs.

Exhibit B(5)

COMMUNITY BASED CARE MANAGEMENT PROGRAM

The Community Based Care Management (CBCM) Program requirements described in this Exhibit B(5) are for care rendered during a CY and defined in the PH-MCO specific CBCM Program approved by the Department. The PH-MCO shall submit CBCM proposals that increase the partnership with Community-Based Organizations (CBOs), encourage the use of preventive services, mitigate Social Determinates of Health barriers, reduce healthcare disparities and improve maternal and child health. The PH-MCO may submit proposals that include collaborations with Behavioral Health Primary Contractors and BH-MCOs.

I. CBCM Program Requirements

A. The PH-MCO must propose CBCM activities and funding focused on partnerships with CBOs and providers, integrating a holistic approach to patient care and education to:

1. Assess, refer and mitigate Social Determinants of Health;
2. Promote maternal, infant and early childhood assessment, education and referral including expansion and capacity building of existing home visiting programs;
3. Localize efforts to promote health education and wellness and encourage the use of preventive health services;
4. Promote education on the appropriate management of chronic health conditions;
5. Enhance behavioral and physical health coordination of services; and
6. Reduce healthcare disparities.

The PH-MCO shall only use funding for CBCM services that have been approved by the Department in writing.

B. The PH-MCO must implement a minimum of one rapid cycle quality improvement pilot program per year. To qualify as a rapid cycle quality improvement program, the PH-MCO must make and test changes over a period of three months or less. The PH-MCO must implement at least one rapid cycle quality improvement pilot program by the end of the second calendar quarter. If a rapid cycle quality improvement pilot program is demonstrating success, the PH-MCO must progressively expand the program.

C. The PH-MCO must include in it CBCM agreements with CBOs and providers the requirements that:

1. Interventions conducted are carried out by appropriately trained/qualified personnel.
2. CBOs and providers participate in collaborative learning sessions.

3. CBOs and providers have systems to document services and interventions provided to Members and communities. Where feasible, systems include the use of electronic health records.
 4. CBOs and providers must exchange program and outcome data with the PH-MCO.
- D.** If the PH-MCO does business in multiple HealthChoices Zones, the PH-MCO may allocate CBCM Program funds across any Zone in which it provides Physical Health HealthChoices services.
- E.** The PH-MCO shall develop and submit a proposal to the Department prior to implementing its 2021 CBCM Program, which 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 **October 1, 2020** and must be submitted to the appropriate folder in DocuShare using the CBCM Proposal template. The PH-MCO must include in each CBCM proposal:
1. A program description that lists targeted CBOs and providers, a twelve- month budget and operations timeline that outlines the startup of the program from January 1, 2021 through December 31, 2021.
 2. For rapid cycle quality improvement pilot programs, the budget for the pilot phase of the program. If the program is expanded, a revised budget for the expanded program must be submitted.
 3. Clearly defined goals, objectives and outcome measures that include benchmarks for success.
 4. An outline of interventions performed for each of the targeted CBOs and providers that increases face to face interactions with recipients in clinical and non-clinical settings for the purposes of assessment, education, and/or referral.
 5. Outline of payment mechanisms and time frames to providers for CBCM.
- F.** A PH-MCO's approved CBCM program will remain in effect until December 31 of each calendar year. The PH-MCO may only submit one revision per quarter no later than the last business day of each calendar quarter for the Department's review and approval. The PH-MCO must complete and submit the CBCM Proposal Change Form, that is available on DocuShare. The Department will not accept changes for the fourth calendar quarter.
- G.** The PH-MCO must implement an evidenced informed, outcomes-based home visit program as per Exhibit B(5)A. PH-MCOs should , where feasible, contract with existing home visiting providers.

II. Payments to the PH-MCO

- A.** The Department will make payments for CBCM based on a per member per month (PMPM) rate. The Department will not include in the CBCM PMPM those Members that have been determined by the Department to have coverage in an IMD as referenced in Section VII. E. 13.
1. Determined by the Department, if the PH-MCO has unspent CBCM funds as of June 30 of the subsequent calendar year, the Department may reduce a future payment to the PH-MCO by the unspent amount or may direct unspent CBCM funds to be used for the current or a prior program year. The PH-MCO must use CBCM funds only to support of a program to improve access to care or quality outcomes for Members.
 2. If the Department determines CBCM funds were not expended in accordance with the approved PH-MCO CBCM plan, upon advanced written notice to the PH-MCO, the Department may elect to reduce a future payment to the PH-MCO by the amount identified.
 3. The Department will not reimburse the PH-MCO for CBCM related expenses in excess of payments made by the Department. Any excess related expenses would be the PH-MCO's responsibility.

III. Payments to Providers

The PH-MCO must make payment to CBOs and providers within the approved time period for the approved CBCM program, as identified above.

IV. Reporting

A. Clinical Reporting

1. The PH-MCO must submit an analysis of their Comprehensive Care Management in addition to submitting a sub-analysis of the CBCM program, which details each CBO and provider involved as well as the CBCM interventions utilized during Member interactions.
2. The PH-MCO shall report on the clinical and financial outcomes of the program, including return on investment (ROI).

B. Financial Reporting

The PH-MCO must submit the financial report in a format approved by the Department. The final annual financial report is due by June 30 of the subsequent calendar year. If requested by the Department, the PH-MCO must submit additional financial reports in the format and by the date requested.

Exhibit B(5a)

HOME VISITING PROGRAM

The Home Visiting Program requirements described in this Exhibit B(5a) are for maternal and infant care coordination activities rendered during a CY and defined in the PH-MCO specific Home Visiting Program approved by the Department per Section II below. Proposals submitted for the Home Visiting program must encourage the use of preventive services, identify and resolve barriers to care, and mitigate social determinants of health barriers.

I. Home Visiting Program Requirements and Goals

- A.** The PH-MCO must implement a home visiting program that is available to all first-time parents and parents/caregivers of children who have been identified as having additional risk factors which may include social, clinical, racial, economic or environmental factors. The home visiting program is also available to any infant and the infant's parent/caregiver who requests home visiting services. Services must be available from the prenatal period through the child's first 18 months of life.
- B.** The home visiting program must be designed to provide support to parents/caregivers, children, and families. The program must be individualized, strengths-based and family-focused to ensure that all needs are addressed, and families are active partners in their care.
- C.** Home visiting activities must be primarily be focused on:
 - 1. Maternal and Infant Health promotion and prevention
 - 2. Parent/caregiver education and support
 - 3. Healthy child development
 - 4. Child safety (Infant sleep safety, car seat safety, crib and changing table safety, environmental lead, accident prevention, environmental safety, etc.)
 - 5. Identification and mitigation of social determinants of health (SDOH)
 - 6. Increasing screenings and referrals to community resources for SDOH (food insecurity, health care access/affordability, housing, education transportation, childcare, employment, utilities, clothing, financial strain)
 - 7. Prevention of intimate partner violence
 - 8. Reducing disparities in perinatal health
 - 9. Strengthening family economic self-sufficiency
 - 10. Family planning, which includes access to counseling for available contraceptive options, childbirth-spacing education, and support to attain contraceptives if requested by mother
 - 11. Increasing postpartum health care visits
 - 12. Increasing screenings for Maternal/Caregiver depression and anxiety
 - 13. Increasing screenings for substance use disorder (SUD)

14. Increasing follow up care on positive postpartum depression screenings and/or other behavioral healthcare needs
 15. Increasing rates of well-child visits and follow up on Early and Periodic Screening, Diagnostic and Treatment (EPSDT) appointments
 16. Increasing plans of safe care for all infants born affected by substance abuse, NAS and FASD.
- D.** The objective of the Home Visiting program is to improve maternal and infant health outcomes and reduce maternal and infant morbidity and mortality, especially in individuals identified to be at risk.
- E.** Home Visiting programs will include licensed and/or non-licensed staff with an emphasis on expanding the use of non-licensed providers.
1. Home visitors must meet the requirements of nationally recognized home visiting programs. Home visitors must be provided initial and ongoing training, supervision and professional development. High-quality supervision, including reflective supervision, must be implemented for all home visitors.
 2. The home visitor must have knowledge about resources in the family's community and be able to link the family to needed services and local health care organizations.
- F.** The PH-MCO maternity case manager must offer to initiate a warm handoff to a home visiting vendor or to the PH-MCO internal Home Visiting program.
- G.** Families who decline home visiting services at initial outreach must receive follow up outreaches by the PH-MCO to the parent/caregiver every 90 days until the child has reached age 18 months to ensure the family does not need home visiting support. The PH-MCO must reach out to parents/caregivers who did not participate in the PH-MCO's Maternity Care Management program to inform and offer the Home Visiting program.
- H.** If the family has risks identified that are already being met by an evidence-based home visiting program, the PH-MCO case manager will follow up with the evidence-based program with the caregiver/parental consent to avoid duplication of services and to ensure that there are no unmet needs.
- I.** The PH-MCO must educate their network providers on their Home Visiting program and services offered.
- J.** The PH-MCO maternity case manager must discuss and offer home visiting services to the parent/caregiver during the first postpartum contact. Home visiting services must be initiated, either by a home visiting vendor or the PH-MCO Home Visiting program, as soon as the parent/caregiver agrees to the first visit, but no more than fourteen (14) calendar days after first contact. If services cannot be provided during this time frame, the member must be

- contacted by the PH-MCO case manager to assess and address any immediate needs and refer to needed resources or services.
- K.** Home visiting services must be delivered appropriate to the family's level of knowledge and must be culturally and linguistically competent. Bilingual services must be provided or arranged for when necessary and any health care records must be accessible in the beneficiary's primary language. There must be no barriers to services for families with limited English proficiency, partial/full vision and/or auditory loss. Necessary supportive aids and services, such as sign language, interpretation, translation, and alternative formats must be available to beneficiaries.
 - L.** All first-time parents, parents/caregivers of children who have been identified as having additional risk factors, any infant and the infant's parent/caregiver who requests home visiting services are to be offered home visits. The time and location of the visit must be scheduled to accommodate the parent/caregiver. Visits should be at the home unless the parent/caregiver requests services at another location frequented by the parent/caregiver or if the parent/caregiver requests a telemedicine visit as per N below.
 - M.** All postpartum visits must include the parent/caregiver and child as appropriate. Health promotion must begin at the first visit. Services will be individualized and will focus on the parent/caregiver-child dyad and family supports. The needs and risks identified in the family's plan of care must be addressed at every visit. Subsequent home visits must be tailored to the family and must follow the objectives, interventions and goals outlined in the plan of care.
 - N.** In-person home visits are preferred but the use of telemedicine visits are allowed in situations where in-person visits are not possible, such as during a public health emergency. Telemedicine visits must provide the same level of care and achieve the same outcomes as an in-person home visit. Telephone calls are acceptable in situations where the family does not possess or have access to video technology. Text messages may be used to provide supplemental communication between visits but are not considered a telemedicine visit. The PH-MCO or contracted Home Visiting agency must obtain and document informed consent for the use of telemedicine technology for the initial telemedicine visit.
 - O.** The PH-MCO or the contracted Home Visiting agency must work to identify the family's risks and needs and provide referrals to needed resources and services. Parental/caregiver, infant and family risk levels must be assigned based on the needs and risk assessments. The duration and frequency of Home Visiting services and referrals will be managed according to risk level.
 - P.** The PH-MCO or contracted Home Visiting agency must follow-up with all provided referrals to ensure risks and needs are addressed. All families must receive information on child development, well child visits/EPSTD screenings and their importance, lead exposure during pregnancy through infancy and

during childhood, infant safety, safe sleep practices, family planning, positive parenting techniques, health promotion, preventative health care and decision making around accessing safe child care, if needed. Families must also be offered a referral to Women Infants and Children (WIC) services if they are not already involved. Referrals must be made to Early Intervention Services as appropriate.

- Q.** The home visitor must complete maternal, infant and family needs and risk assessments starting at the first visit. The home visitor must evaluate the home and environment during the first visit to ensure there are no safety concerns that need addressed. The PH-MCO maternity case manager must coordinate with the home visitor to develop a parent/caregiver, infant, and family focused plan of care based on the home visitor's assessment. The plan of care addresses the family's needs, applies the family's strengths and is outcome focused. The plan of care includes family-specific objectives, interventions and goals based on identified needs and risks. If any safety concerns are identified for the parent/caregiver or child, a safety plan must be included.
- R.** The PH-MCO maternity case manager must monitor the plan of care implementation throughout the Home Visiting program duration and ensure all needs are met and referrals are followed up and completed.
- S.** The Maternal Needs and Risk Assessment must include at a minimum the following: demographic information, pregnancy health history, chronic disease health history, other health history (sexually transmitted infections, prescription drugs, oral health), family planning, prenatal care, nutrition, breastfeeding, tobacco, alcohol and drug use, stressors, social support, mental health (depression, anxiety), intimate partner violence and social determinants of health (food insecurity, health care access/affordability, housing, education, transportation, childcare, employment, utilities, clothing, financial strain), and parenting.
- T.** Infant Needs and Risk Assessment must include at a minimum the following: infant and caregiver demographics, parental family planning, parental/caregiver tobacco, alcohol and drug use, parental/caregiver stress, parental/caregiver mental health (depression, anxiety), intimate partner violence, social determinants of health (food insecurity, health care/medical access/affordability, housing, education, transportation, childcare, employment, utilities, clothing, financial strain), infant family support, parenting and childcare, infant birth health status, infant health care, infant safety, safe sleep practices, infant feeding and nutrition, infant development and infant needs (clothing, car seat, crib, diapers, formula, etc.).

For families of multiples (for example: twins, triplets), an Infant Needs and Risk Assessment must be completed for each infant.

- U.** The following domains must be addressed in assessments for all families:

Socio-Economic Status: Examples of factors that indicate risks under this domain include family living below the poverty level, parent/caregiver employment status, highest education level attained by parent/caregiver, age of parent/caregiver, family participation in assistance benefits (SSI, Cash assistance, SNAP, WIC, etc.) and current or past food insecurity.

Substance Use: Examples of factors that indicate risks under this domain include parent/caregiver/household member current opioid prescription, current or past substance abuse treatment, history of impaired driving, history of opioid overdose hospitalization, substance use disorder, binge alcohol use, marijuana use, illicit drug use, pain medication use, maternal smoking during pregnancy and child born with neonatal abstinence syndrome.

Perinatal and Child Health Outcomes: Examples of factors that indicate risks under this domain include mother's utilization of adequate and timely prenatal care, was the mother counseled about family planning options, is the mother breastfeeding, current or past maternal postpartum depression, infant preterm birth, low birth weight, NICU admission and status of well child visit utilization.

Child Maltreatment: Examples of factors that indicate risks under this domain include reported child abuse and neglect, substantiated child abuse and neglect, current or past child maltreatment and current or past intimate partner violence for parent/caregiver/household member.

Environment and Community: Examples of factors that indicate risks under this domain include family access to SNAP and WIC authorized stores, adequate access to affordable health care, does the family feel safe in their neighborhood, lead, air and/or water pollution concerns in the home environment, family access to transportation, adequate housing, family sharing the home with others, and current or recent homelessness.

Child Care: Examples of factors that indicate risks under this domain include family access to affordable and quality child care.

Note: The Office of Child Development and Early Learning (OCDEL) funded Evidence-based home visiting programs use Maternal Infant Early Childhood Home Visiting (MIECHV) approved screening tools for Intimate Partner Violence, Parent-Child Interaction, Depression and Child Development. A list of the screening tools will be made available to the PH-MCOs via DocuShare.

V. The Home Visiting program must minimally address the following:

1. Maternal Physical Assessment
2. Infant Physical Assessment
3. Maternal Depression and Anxiety Screening
4. Childbirth Preparation including obtaining prenatal care if needed
5. Substance Use Assessment and Referral (Drug, Opioid and Alcohol)

6. Tobacco Use Assessment
7. Lactation Care
8. Parent/Caregiver-Infant Care and interaction
9. Well Child Screening and Visits Assessment
10. Family Planning
11. Home Assessment
12. Intimate Partner/Interpersonal Violence Risk Assessment
13. Parent/Caregiver Skills Education
14. Positive Parenting Practices
15. Nutrition Counseling
16. Physical recovery from birth
17. Chronic disease management
18. Health promotion
19. Postpartum health
20. Safe Sleep practices
21. Assessment and Development of Home Visiting Plan
22. Social Determinants of Health (food insecurity, health care access/affordability, housing, education, transportation, childcare, employment, utilities, clothing, financial strain)
23. Referral to support programs (Home visiting Programs, Health coverage, SNAP, housing, employment, transportation, WIC)
24. Child Safety Education
25. Child Development Screening
26. Age Appropriate Immunizations
27. EPSDT scheduling and education
28. Early language and literacy activities
29. Maternal and Infant Lead Screening and education

II. Reporting

- A. The PH-MCO is required to develop and submit a proposal to the Department prior to implementing its Home Visiting Program. The Home Visiting Program may include multiple programs. If multiple programs are identified, each one must follow the requirements below. Proposals are due no later than **October 1, 2020** and must be submitted to the appropriate folder in DocuShare using the Home Visiting Program proposal template. Each Home Visiting Program proposal must include:
 1. An initial Home Visiting program description that lists targeted providers/organizations, a twelve (12) month budget, and operations timeline that outlines the startup of the program from January 1, 2021 through December 31, 2021.
 2. The targeted providers/organizations involved with the Home Visiting program. The PH-MCO will be responsible for reporting the targeted providers/organizations, targeted recipients, and define the financial spending for each arrangement.

3. Clearly defined goals, objectives and outcome measures that include benchmarks for success.
 4. An outline of interventions that the Home Visiting worker will be performing for each of the targeted providers.
 5. Outline payment mechanisms and time frames to providers for Home Visiting.
 6. Program Budget, which should include the payment terms.
- B. The PH-MCO must submit an analysis of their Home Visiting program. This analysis must be submitted as part of Operations Report #15 to the Department on the scheduled reporting due date(s).

III. Clinical Review

- A. The Department may choose to perform a review of the Home Visiting program. The PH-MCO must reasonably cooperate with Department staff during the review process.

Exhibit B(6)

MEDICATION ADHERENCE PAY-FOR-PERFORMANCE

This Exhibit is effective January 1, 2020.

This Exhibit B(6) defines a potential payment obligation by the Department to the PH-MCO for managing Members with a diagnosis of Hepatitis C to cure through adherence to their medication regimen as verified through point of sale claims for Hepatitis C medication dispensed and by the Member's subsequent laboratory test post medication regimen for viral load.

The Department will make a one-time payment in the amount of \$1,000 to the PH-MCO for each Member with a diagnosis of Hepatitis C that has received Hepatitis C medication(s), as identified on the Department's Specialty Drug List, within the given calendar year and received a subsequent laboratory test that confirms the Member has achieved cure. Example: A Member's last Hepatitis C medication was dispensed on October 1, 2020 and a Sustained Viral Response (SVR) was administered on February 15, 2021 with cure. The Member will be considered for the second semi-annual period.

A Member who completed their Hepatitis C medication regimen on or after July 1, 2019 and has achieved cure between January 1, 2020 and July 31, 2020 as documented on a subsequent laboratory test will be subject to inclusion for the first semi-annual period if the SVR was not included in the CY 2019 Appendix 5 Quality Risk Pool. The Department will not allow inclusion of an SVR dated prior to January 1, 2020 in this Pay-for-Performance arrangement.

The Department will verify eligible Members for this incentive payment through encounter data for pharmacy services that have dates of service during the given calendar year and for which the PH-MCO submits an SVR that confirms the Member achieved cure. The PH-MCO will notify the Department of SVRs it has obtained that document undetectable Hepatitis C Ribonucleic Acid (RNA) twelve to twenty-four weeks following completion of the medication therapy. The Department will not utilize an SVR if it utilized an SVR for the same Member that is dated less than 24 months prior, or if the MCO has not followed procedures specified by the Department.

The Department will accept an SVR from the PH-MCO if at least one of the following criteria is met, along with other requirements:

- A. The PH-MCO has paid for a Hepatitis C drug for the recipient during the given calendar year; OR
- B. The recipient is currently enrolled with the PH-MCO.

If the Member changes PH-MCOs during the course of medication therapy, the Department will make a proportional payment to the PH-MCO for a Member that has switched prior to receiving the SVR confirming cure. If the PH-MCO did not make a payment for any days of the medication regimen received by the switching Member, the one-time payment will be multiplied by 10 percent (10.0%); If the PH-MCO paid for 1 to 30 days of the medication regimen received by the switching Member, the one-time payment will be multiplied by 50

percent (50.0%); If the PH-MCO paid for 31 days or more of medication regimen received by the switching Member, the PH-MCO will receive the one-time payment in full. The difference between the one-time payment less the proportional payment, will be paid to the PH-MCO from which the Member switched.

The Department will process one payment to the PH-MCO for each semi-annual period for the given calendar year. Each payment will total the sum of the one-time payments earned plus any proportional payments earned by the PH-MCO during that period. The Department will determine the inclusion of Members in each semi-annual period based on the date of service for that Member's last Hepatitis C medication claim as identified through encounter data. The Department will not process each semi-annual payment until, at the earliest, nine months after the end of the semi-annual period. Members that have been determined cured will be included in only one of the two semi-annual periods during the given calendar year.

If the PH-MCO has purchased the assets or liabilities of a PH-MCO that previously had an Agreement with the Department to operate a HealthChoices program ("Previous PH-MCO"); or if the Department transferred the Members enrolled in the Previous PH-MCO, who did not make a different choice, to the current PH-MCO; then the Department will include claims paid by the Previous PH-MCO.

EXHIBIT B(7)

MATERNITY CARE BUNDELED PAYMENT

1. Maternity Care Bundle: As part of VBP, the MCO must utilize a Maternity Care Bundled Payment for Network Providers that elect to take part in the model, use a maternity care team, and have at least twenty (20) births annually attributed to the maternity care team. An MCO utilizing a Maternity Care Bundled Payment must require that the Network Provider use a maternity care team that:
 - a. Includes at least one (1) clinician (physician, CRNP, CNW, or other) who is qualified and licensed to provide prenatal care to pregnant women.
 - b. Includes at least one (1) clinician (physician, CRNP, CNW, or other) who is qualified and licensed to assist in vaginal delivery of babies.
 - c. Includes at least one (1) clinician (physician, CRNP, CNW, or other) who is qualified and licensed to provide newborn services.
 - d. Provides access to at least one (1) physician who is qualified to treat women with high-risk pregnancies, to treat complications experienced during pregnancy or childbirth, and to perform cesarean sections.
 - e. Provides access to at least one (1) hospital that has the capability to perform cesarean sections and treat common complications of labor and delivery.
 - f. Provides access to at least one (1) physician practice, hospital, clinical laboratory, or other entity that has the ability to perform laboratory tests or imaging studies needed as part of prenatal care, labor and delivery, and postpartum care.
 - g. Includes at least one (1) individual, such as a doula, community health worker, social worker, or peer recovery specialist, to coordinate the care of the pregnant woman to address other needs, including behavioral health, substance use disorder, and Social Determinants of Health.

2. Payment to the Maternity Care Team: The target price of the bundle shall be prospectively developed with the maternity care team. The MCO shall pay the maternity care team the applicable fee-for-service payments and perform a retrospective review to compare the fee-for-service payments to the target price. If the fee-for-service payments made for the services included in the bundle are less than the target price, the MCO shall include the difference in a pool of shared savings. On an annual basis, the MCO shall determine the amount of shared savings to be paid to a Network Provider using a maternity care team as specified in section 9.

The MCO must base the prospectively developed target price on:

- a. The trimester in which the pregnant woman engaged in care;
- b. Historical spending, with factors taken into consideration that reflect patient acuity;

- c. Blended regional prices of vaginal births, cesarean section rates, including prenatal, postpartum, and newborn services for up to sixty (60) days postpartum, with a proportion of cesarean sections set for 2021 at:
 - i. 27.25% cesarean sections in the Southeast and Southwest Zone
 - ii. 29.25% cesarean sections in the Lehigh/Capital Zone
 - iii. 30.75% cesarean sections in the Northeast Zone
 - iv. 31.50% cesarean sections in the Northwest zone

- 3. Services included in the bundle: The MCO must develop a target payment that includes all services provided during pregnancy episode: prenatal care, labor and delivery, care coordination services, and up to sixty (60) days postpartum for the mother and newborn, other than contraceptive care.

- 4. Services excluded from the bundle: Contraceptive care, including placement of long-acting reversible contraception.

- 5. Pregnancies excluded from the bundle: Non-singleton pregnancies.

- 6. Stop loss mechanism: If the cost of the maternity care episode (including services provided during pregnancy, labor and delivery, and postpartum) for a member exceeds 300% of the target price of the maternity care bundle, then no costs over 300% of the target price of the bundle will be attributed to the Maternity Care Team.

- 7. Quality Measures: The MCO shall use the following quality measures to determine its incentive payments:
 - a. Social Determinants of Health Screening: One Social Determinants of Health screening during the episode duration with G9919 or G9920 Procedure Code claims, including ICD-10 Z-codes when relevant those determinant areas as defined by Social Determinants Health.
 - b. Initiation of Alcohol and Other Drug Abuse or Dependence Treatment (HEDIS®)
 - c. Timeliness of Prenatal Care (HEDIS®)
 - d. Postpartum Care (HEDIS®)
 - e. Prenatal Depression Screening and Follow Up (HEDIS®)
 - f. Postpartum Depression Screening and Follow Up (HEDIS®)
 - g. Prenatal immunization status (HEDIS®)
 - h. Well child visits (Modified HEDIS®): Children who receive two (2) or more well-child visits with a primary care physician within the first sixty (60) days after birth.

- 8. Scoring of Quality Measures: Point totals for each quality measures are listed below. Virtual or telehealth visits should count for calculation of quality scores.
 - a. Social Determinants of Health

- i. 0.5 points for screening 50% of Members
 - ii. 1 point for screening 75% of Members
 - iii. 1.5 points for screening 90% of Members
- b. Initiation of Alcohol and Other Drug Abuse or Dependence Treatment (HEDIS®)
 - i. 0.5 points for reaching NCQA 50th percentile
 - ii. 1 point for reaching NCQA 75th percentile
 - iii. 1.5 points for reaching NCQA 90th percentile
- c. Timeliness of Prenatal Care (HEDIS®):
 - i. 0.5 points for reaching NCQA 50th percentile
 - ii. 1 point for reaching NCQA 75th percentile
 - iii. 1.5 points for reaching NCQA 90th percentile
- d. Postpartum Care (HEDIS®):
 - i. 0.5 points for reaching NCQA 50th percentile
 - ii. 1 point for reaching NCQA 75th percentile
 - iii. 1.5 points for reaching NCQA 90th percentile
- e. Prenatal depression screening and follow up (HEDIS®):
 - i. 0.5 points for reaching NCQA 50th percentile
 - ii. 1 point for reaching NCQA 75th percentile
 - iii. 1.5 points for reaching NCQA 90th percentile
- f. Postpartum depression screening and follow up (HEDIS®):
 - i. 0.5 points for reaching NCQA 50th percentile
 - ii. 1 point for reaching NCQA 75th percentile
 - iii. 1.5 points for reaching NCQA 90th percentile
- g. Prenatal immunization status (HEDIS®):
 - i. 0.5 points for reaching NCQA 50th percentile
 - ii. 1 point for reaching NCQA 75th percentile
 - iii. 1.5 points for reaching NCQA 90th percentile
- h. Well child visits (Modified HEDIS®): Benchmarks are based on HEDIS® W15, two (2) visits in the first fifteen (15) months of life (even though the quality measurement in the bundle is in first sixty (60) days of life)
 - i. 0.5 points for reaching NCQA 50th percentile
 - ii. 1 point for reaching NCQA 75th percentile
 - iii. 1.5 points for reaching NCQA 90th percentile
- i. Health Equity score:
 - i. 0.5 points for reaching NCQA 75th percentile for four (4) out of the seven (7) HEDIS® measures within the Black/ African American community

The Department of Revenue regulations provide that exemption certificates are not required for sales made to governmental entities and none will be issued. Nothing in this paragraph is meant to exempt a construction contractor from the payment of any of these taxes or fees that are required to be paid with respect to the purchase, use, rental, or lease of tangible personal property or taxable services used or transferred in connection with the performance of a construction contract.

8. WARRANTY

The PH-MCO warrants that all services performed by the PH-MCO, its agents and subcontractor shall be performed in a professional and workmanlike manner and in accordance with prevailing professional and industry standards using the utmost care and skill. Unless otherwise stated in the Agreement, all services are warranted for a period of one year following completion of performance by the PH-MCO and acceptance by the Commonwealth. The PH-MCO shall correct any problem with the service without any additional cost to the Commonwealth.

9. PATENT, COPYRIGHT, AND TRADEMARK INDEMNITY

The PH-MCO warrants that it is the sole owner or author of, or has entered into a suitable legal agreement for: a) the design of any product or process provided or used in the performance of the Agreement that is covered by a patent, copyright, or trademark registration or other right duly authorized by state or federal law and b) any copyrighted matter provided to the Commonwealth. The PH-MCO shall defend any suit or proceeding brought by a third party against the Commonwealth, its departments, offices and employees for the alleged infringement of United States or foreign patents, copyrights, trademarks or misappropriation of trade secrets arising out of the performance of the Agreement. The Commonwealth will 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 PH-MCO's written request, it shall be at the PH-MCO's expense, but the responsibility for such expense shall be only that within the PH-MCO's written authorization. The PH-MCO shall indemnify and hold the Commonwealth harmless from all damages, costs, and expenses, including attorney's fees that the PH-MCO or the Commonwealth may pay or incur by reason of any infringement or violation of the rights occurring to any holder of copyright, trademark, or patent interests and rights. If any of the products provided by the PH-MCO in such suit or proceeding are held to constitute infringement and the use is enjoined, the PH-MCO shall, at its own expense and at its option, either procure the right to continue use of such products, replace them with non-infringing equal performance products or modify them so that they are no longer infringing. If the PH-MCO is unable to do any of the preceding, the PH-MCO shall 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 that 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 PH-MCO under this paragraph continue without time limit. No costs or expenses shall be incurred for the account of the PH-MCO without its written consent.

10. OWNERSHIP RIGHTS

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

11. ASSIGNMENT OF ANTITRUST CLAIMS

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

12. HOLD HARMLESS PROVISION

The PH-MCO shall indemnify the Commonwealth against any and all third party claims, demands and actions based upon or arising out of any activities performed by the PH-MCO and its employees and agents under this Agreement provided the Commonwealth gives the PH-MCO prompt notice of any such claim of which it learns. The Office of Attorney General ("OAG") has the sole authority to represent the Commonwealth in actions brought against the Commonwealth. The OAG may, however, in its sole discretion and under such

Section – 2

Rights and Responsibilities

HealthChoices Model Member Handbook

Member Rights and Responsibilities

[MCO Name] and its network of providers do not discriminate against members based on race, sex, religion, national origin, disability, age, sexual orientation, gender identity, or any other basis prohibited by law.

As a **[MCO Name]** member, you have the following rights and responsibilities.

Member Rights

You have the right:

1. To be treated with respect, recognizing your dignity and need for privacy, by **[MCO Name]** staff and network providers.
2. To get information in a way that you can easily understand and find help when you need it.
3. To get information that you can easily understand about **[MCO Name]**, its services, and the doctors and other providers that treat you.
4. To pick the network health care providers that you want to treat you.
5. To get emergency services when you need them from any provider without **[MCO Name]**'s approval.
6. To get information that you can easily understand and talk to your providers about your treatment options, risks of treatment, and tests that may be self-administered without any interference from **[MCO Name]**.
7. To make all decisions about your health care, including the right to refuse treatment. If you cannot make treatment decisions by yourself, you have the right to have someone else help you make decisions or make decisions for you.
8. To talk with providers in confidence and to have your health care information and records kept confidential.
9. To see and get a copy of your medical records and to ask for changes or corrections to your records.
10. To ask for a second opinion.
11. To file a Grievance if you disagree with **[MCO Name]**'s decision that a service is not medically necessary for you.
12. To file a Complaint if you are unhappy about the care or treatment you have received.

HealthChoices Model Member Handbook

13. To ask for a DHS Fair Hearing.
14. To be free from any form of restraint or seclusion used to force you to do something, to discipline you, to make it easier for the provider, or to punish you.
15. To get information about services that **[MCO Name]** or a provider does not cover because of moral or religious objections and about how to get those services.
16. To exercise your rights without it negatively affecting the way DHS, **[MCO Name]**, and network providers treat you.
17. To create an advance directive. See Section 6 on page **[MCO to add page number]** for more information.
18. To make recommendations about the rights and responsibilities of **[MCO name]**'s members.

Member Responsibilities

Members need to work with their health care service providers. **[MCO Name]** needs your help so that you get the services and supports you need.

These are the things you should do:

1. Provide, to the extent you can, information needed by your providers.
2. Follow instructions and guidelines given by your providers.
3. Be involved in decisions about your health care and treatment.
4. Work with your providers to create and carry out your treatment plans.
5. Tell your providers what you want and need.
6. Learn about **[MCO Name]** coverage, including all covered and non-covered benefits and limits.
7. Use only network providers unless **[MCO Name]** approves an out-of-network provider or you have Medicare.
8. Get a referral from your PCP to see a specialist.
9. Respect other patients, provider staff, and provider workers.
10. Make a good-faith effort to pay your co-payments.
11. Report fraud and abuse to the DHS Fraud and Abuse Reporting Hotline.

HealthChoices Model Member Handbook

Privacy and Confidentiality

[MCO Name] must protect the privacy of your protected health information (PHI). **[MCO Name]** must tell you how your PHI may be used or shared with others. This includes sharing your PHI with providers who are treating you or so that **[MCO Name]** can pay your providers. It also includes sharing your PHI with DHS. This information is included in **[MCO Name]**'s Notice of Privacy Practices. To get a copy of **[MCO Name]**'s Notice of Privacy Practices, please call **[MCO Privacy Contact]** or visit **[MCO Website]**.

Co-payments

A co-payment is the amount you pay for some covered services. It is usually only a small amount. You will be asked to pay your co-payment when you get the service, but you cannot be denied a service if you are not able to pay a co-payment at that time. If you did not pay your co-payment at the time of the service, you may receive a bill from your provider for the co-payment.

Co-payment amounts can be found in the Covered Services chart starting on page **[MCO to insert page number]** of this Handbook.

The following members do not have to pay co-payments:

- Members under age 18
- Pregnant women (including 60 days after the child is born (the post-partum period))
- Members who live in a long-term care facility, including Intermediate Care Facilities for the Intellectually Disabled and Other Related Conditions or other medical institution
- Members who live in a personal care home or domiciliary care home
- Members eligible for benefits under the Breast and Cervical Cancer Prevention and Treatment Program
- Members eligible for benefits under Title IV-B Foster Care and Title IV-E Foster Care and Adoption Assistance

The following services do not require a co-payment:

- Emergency services
- Laboratory services
- Family planning services, including supplies
- Hospice services
- Home health services

HealthChoices Model Member Handbook

- Tobacco cessation services
- **[MCO to identify any additional services exempt from co-payment]**

What if I Am Charged a Co-payment and I Disagree?

If you believe that a provider charged you the wrong amount for a co-payment or a co-payment you believe you should not have had to pay, you can file a Complaint with **[MCO Name]**. Please see Section 8, Complaints, Grievances, and Fair Hearings for information on how to file a Complaint, or call Member Services at **[MCO Member Services Phone Number and TTY]**.

Billing Information

Providers in **[MCO Name]**'s network may not bill you for medically necessary services that **[MCO Name]** covers. Even if your provider has not received payment or the full amount of his or her charge from **[MCO Name]**, the provider may not bill you. This is called balance billing.

When Can a Provider Bill Me?

Providers may bill you if:

- You did not pay your co-payment.
- You received services from an out-of-network provider without approval from **[MCO Name]** and the provider told you before you received the service that the service would not be covered, and you agreed to pay for the service.
- You received services that are not covered by **[MCO Name]** and the provider told you before you received the service that the service would not be covered, and you agreed to pay for the service.
- You received a service from a provider that is not enrolled in the Medical Assistance Program.

What Do I Do if I Get a Bill?

If you get a bill from a **[MCO Name]** network provider and you think the provider should not have billed you, you can call Member Services at **[MCO Member Services Phone Number and TTY]**.

[MCO may add additional steps it would like members to take (call provider, return bill with MCO ID number)]

HealthChoices Model Member Handbook

If you get a bill from a provider for one of the above reasons that a provider is allowed to bill you, you should pay the bill or call the provider.

Third-Party Liability

You may have Medicare or other health insurance. Medicare or your other health insurance is your primary insurance. This other insurance is known as “third party liability” or TPL. Having other insurance does not affect your Medical Assistance eligibility. In most cases, your Medicare or other insurance will pay your PCP or other provider before **[MCO Name]** pays. **[MCO Name]** can only be billed for the amount that your Medicare or other health insurance does not pay.

You must tell both your CAO and Member Services at **[Member Services Phone Number and TTY]** if you have Medicare or other health insurance. When you go to a provider or to a pharmacy you must tell the provider or pharmacy about all forms of medical insurance you have and show the provider or pharmacy your Medicare card or other insurance card, ACCESS or EBT card, and your **[MCO Name]** ID card. This helps make sure your health care bills are paid timely and correctly.

Coordination of Benefits

If you have Medicare and the service or other care you need is covered by Medicare, you can get care from any Medicare provider you pick. The provider does not have to be in **[MCO Name]**'s network. You also do not have to get prior authorization from **[MCO Name]** or referrals from your Medicare PCP to see a specialist. **[MCO Name]** will work with Medicare to decide if it needs to pay the provider after Medicare pays first, if the provider is enrolled in the Medical Assistance Program.

If you need a service that is not covered by Medicare but is covered by **[MCO Name]**, you must get the service from a **[MCO Name]** network provider. All **[MCO Name]** rules, such as prior authorization and specialist referrals, apply to these services.

If you do not have Medicare but you have other health insurance and you need a service or other care that is covered by your other insurance, you must get the service from a provider that is in both the network of your other insurance and **[MCO Name]**'s network. You need to follow the rules of your other insurance and **[MCO Name]**, such as prior authorization and specialist referrals. **[MCO Name]** will work with your other insurance to decide if it needs to pay for the services after your other insurance pays the provider first.

If you need a service that is not covered by your other insurance, you must get the services from a **[MCO Name]** network provider. All **[MCO Name]** rules, such as prior authorization and specialist referrals, apply to these services.

HealthChoices Model Member Handbook

Recipient Restriction/Lock-in Program

The Recipient Restriction/Member Lock-In Program requires a member to use specific providers if the member has abused or overused his or her health care or prescription drug benefits. **[MCO Name]** works with DHS to decide whether to limit a member to a doctor, pharmacy, hospital, dentist, or other provider.

How Does it Work?

[MCO Name] reviews the health care and prescription drug services you have used. If **[MCO Name]** finds overuse or abuse of health care or prescription services, **[MCO Name]** asks DHS to approve putting a limit on the providers you can use. If approved by DHS, **[MCO Name]** will send you a written notice that explains the limit.

You can pick the providers, or **[MCO Name]** will pick them for you. If you want a different provider than the one **[MCO Name]** picked for you, call Member Services at **[Member Services Phone Number and TTY]**. The limit will last for 5 years even if you change HealthChoices plans.

If you disagree with the decision to limit your providers, you may appeal the decision by asking for a DHS Fair Hearing, within 30 days of the date of the letter telling you that **[MCO Name]** has limited your providers.

You must sign the **written** request for a Fair Hearing and send it to:

Department of Human Services
Office of Administration
Bureau of Program Integrity - DPPC
Recipient Restriction Section
P.O. Box 2675
Harrisburg, Pennsylvania 17105-2675

If you need help asking for a Fair Hearing, please call Member Services at **[MCO Member Services Phone Number and TTY]** or contact your local legal aid office.

If your appeal is postmarked within 10 days of the date on **[MCO Name]**'s notice, the limits will not apply until your appeal is decided. If your appeal is postmarked more than 10 days but within 30 days from the date on the notice, the limits will be in effect until your appeal is decided. The Bureau of Hearings and Appeals will let you know, in writing, of the date, time, and place of your hearing. You may not file a Grievance or Complaint through **[MCO Name]** about the decision to limit your providers.

HealthChoices Model Member Handbook

After 5 years, **[MCO Name]** will review your services again to decide if the limits should be removed or continued and will send the results of its review to DHS. **[MCO Name]** will tell you the results of the review in writing.

Reporting Fraud or Abuse

How Do I Report Member Fraud or Abuse?

If you think that someone is using your or another member's **[MCO Name]** card to get services, equipment, or medicines, is forging or changing their prescriptions, or is getting services they do not need, you can call the **[MCO Name]** Fraud and Abuse Hotline at **[Insert Phone Number and TTY]** to give **[MCO Name]** this information. You may also report this information to the DHS Fraud and Abuse Reporting Hotline at 1-844-DHS-TIPS (1-844-347-8477).

How Do I Report Provider Fraud or Abuse?

Provider fraud is when a provider bills for services, equipment, or medicines you did not get or bills for a different service than the service you received. Billing for the same service more than once or changing the date of the service are also examples of provider fraud. To report provider fraud you can call the **[MCO Name]**'s Fraud and Abuse Hotline at **[Insert Phone Number]**. You may also report this information to the DHS Fraud and Abuse Reporting Hotline at 1-844-DHS-TIPS (1-844-347-8477).

Section 3 – Physical Health Services

HealthChoices Model Member Handbook

Covered Services

The chart below lists the services that are covered by **[MCO Name]** when the services are medically necessary. Some of the services have limits or co-payments, or need a referral from your PCP or require prior authorization by **[MCO Name]**. If you need services beyond the limits listed below, your provider can ask for an exception, as explained later in this section. Limits do not apply if you are under age 21 or pregnant.

[MCO to complete table, including additional services that MCO covers]

Service		Children	Adults
Primary Care Provider	Limit		
	Co-payment		
	Prior Authorization / Referral		
Specialist	Limit		
	Co-payment		
	Prior Authorization / Referral		
Certified Registered Nurse Practitioner	Limit		
	Co-payment		
	Prior Authorization / Referral		
Federally Qualified Health Center / Rural Health Center	Limit		
	Co-payment		
	Prior Authorization / Referral		
Outpatient Non-Hospital Clinic	Limit		
	Co-payment		
	Prior Authorization / Referral		
Outpatient Hospital Clinic	Limit		
	Co-payment		
	Prior Authorization / Referral		
Podiatrist Services	Limit		
	Co-payment		
	Prior Authorization / Referral		
Chiropractor Services	Limit		
	Co-payment		
	Prior Authorization / Referral		
Optometrist Services	Limit		
	Co-payment		
	Prior Authorization / Referral		
Hospice Care	Limit		
	Co-payment		
	Prior Authorization / Referral		
Dental Care Services	Limit		
	Co-payment		
	Prior Authorization / Referral		

HealthChoices Model Member Handbook

Service		Children	Adults
Radiology (ex. X-rays, MRIs, CTs)	Limit		
	Co-payment		
	Prior Authorization / Referral		
Outpatient Hospital Short Procedure Unit	Limit		
	Co-payment		
	Prior Authorization / Referral		
Outpatient Ambulatory Surgical Center	Limit		
	Co-payment		
	Prior Authorization / Referral		
Non-Emergency Medical Transport	Limit		
	Co-payment		
	Prior Authorization / Referral		
Family Planning Services	Limit		
	Co-payment		
	Prior Authorization / Referral		
Renal Dialysis	Limit		
	Co-payment		
	Prior Authorization / Referral		
Emergency Services	Limit		
	Co-payment		
	Prior Authorization / Referral		
Urgent Care Services	Limit		
	Co-payment		
	Prior Authorization / Referral		
Ambulance Services	Limit		
	Co-payment		
	Prior Authorization / Referral		
Inpatient Hospital	Limit		
	Co-payment		
	Prior Authorization / Referral		
Inpatient Rehab Hospital	Limit		
	Co-payment		
	Prior Authorization / Referral		
Maternity Care	Limit		
	Co-payment		
	Prior Authorization / Referral		
Prescription Drugs	Limit		
	Co-payment		
	Prior Authorization / Referral		
Enteral/Parenteral Nutritional Supplements	Limit		
	Co-payment		
	Prior Authorization / Referral		
	Limit		

HealthChoices Model Member Handbook

Service		Children	Adults
Nursing Facility Services	Co-payment		
	Prior Authorization / Referral		
Home Health Care including Nursing, Aide, and Therapy Services	Limit		
	Co-payment		
	Prior Authorization / Referral		
Durable Medical Equipment	Limit		
	Co-payment		
	Prior Authorization / Referral		
Prosthetics and Orthotics	Limit		
	Co-payment		
	Prior Authorization / Referral		
Eyeglass Lenses	Limit		
	Co-payment		
	Prior Authorization / Referral		
Eyeglass Frames	Limit		
	Co-payment		
	Prior Authorization / Referral		
Contact Lenses	Limit		
	Co-payment		
	Prior Authorization / Referral		
Medical Supplies	Limit		
	Co-payment		
	Prior Authorization / Referral		
Therapy (Physical, Occupational, Speech)	Limit		
	Co-payment		
	Prior Authorization / Referral		
Laboratory	Limit		
	Co-payment		
	Prior Authorization / Referral		
Tobacco Cessation	Limit		
	Co-payment		
	Prior Authorization / Referral		

[MCO to add any additional information regarding covered services as necessary]

Services That Are Not Covered

There are physical health services that **[MCO Name]** does not cover. If you have any questions about whether or not **[MCO Name]** covers a service for you, please call Member Services at **[MCO Member Services Phone Number and TTY]**.

HealthChoices Model Member Handbook

MCOs may not cover experimental medical procedures, medicines, and equipment.

Second Opinions

You have the right to ask for a second opinion if you are not sure about any medical treatment, service, or non-emergency surgery that is suggested for you. A second opinion may give you more information that can help you make important decisions about your treatment. A second opinion is available to you at no cost other than a co-pay.

Call your PCP to ask for the name of another **[MCO Name]** network provider to get a second opinion. If there are not any other providers in **[MCO Name]**'s network, you may ask **[MCO Name]** for approval to get a second opinion from an out-of-network provider.

What is Prior Authorization?

Some services or items need approval from **[MCO Name]** before you can get the service. This is called Prior Authorization. For services that need prior authorization, **[MCO Name]** decides whether a requested service is medically necessary before you get the service. You or your provider must make a request to **[MCO Name]** for approval before you get the service.

What Does Medically Necessary Mean?

Medically necessary means that a service, item, or medicine does one of the following:

- It will, or is reasonably expected to, prevent an illness, condition, or disability;
- It will, or is reasonably expected to, reduce or improve the physical, mental, or developmental effects of an illness, condition, injury or disability;
- It will help you to get or keep the ability to perform daily tasks, taking into consideration both your abilities and the abilities or someone of the same age.

If you need any help understanding when a service, item, or medicine is medically necessary or would like more information, please call Member Services at **[MCO Member Services Phone Number and TTY]**.

[MCO to add additional prior authorization information as necessary]

HealthChoices Model Member Handbook

How to Ask for Prior Authorization

[Insert detailed steps that MCO requires for prior authorization here, including all contact information.]

If you need help to better understand the prior authorization process, talk to your PCP or specialist or call Member Services at **[MCO Member Services Phone Number and TTY]**.

If you or your provider would like a copy of the medical necessity guidelines or other rules that were used to decide your prior authorization request, **[Insert MCO information here on how to obtain the information.]**

What Services, Items, or Medicines Need Prior Authorization?

The following chart identifies some, but not all services, items, and medicines that require prior authorization.

[Insert chart of covered services, items, and medicines that require prior authorization]

[TO BE ADDED IF MCO DOES NOT HAVE SEPARATE PA AND PE PROCESSES:]

For those services that have limits, if you or your provider believes that you need more services than the limit on the service allows, you or your provider can ask for more services through the prior authorization process.

If you are or your provider is unsure about whether a service, item, or medicine requires prior authorization, call Member Services at **[MCO Member Services Phone Number and TTY]**.

Prior Authorization of a Service or Item

[MCO Name] will review the prior authorization request and the information you or your provider submitted. **[MCO Name]** will tell you of its decision within 2 business days of the date **[MCO Name]** received the request if **[MCO Name]** has enough information to decide if the service or item is medically necessary.

If **[MCO Name]** does not have enough information to decide the request, we must tell your provider within 48 hours of receiving the request that we need more information to decide the request and allow 14 days for the provider to give us more information.

HealthChoices Model Member Handbook

[MCO Name] will tell you of our decision within 2 business days after **[MCO Name]** receives the additional information.

You and your provider will get a written notice telling you if the request is approved or denied and, if it was denied, the reason it was denied.

Prior Authorization of Outpatient Drugs

[MCO Name] will review a prior authorization request for outpatient drugs, which are drugs that you do not get in the hospital, within 24 hours from when **[MCO Name]** gets the request. You and your provider will get a written notice telling you if the request is approved or denied and, if it was denied, the reason it was denied.

If you go to a pharmacy to fill a prescription and the prescription cannot be filled because it needs prior authorization, the pharmacist will give you a temporary supply unless the pharmacist thinks the medicine will harm you. If you have not already been taking the medicine, you will get a 72-hour supply. If you have already been taking the medicine, you will get a 15-day supply. Your provider will still need to ask **[MCO Name]** for prior authorization as soon as possible

The pharmacist will not give you the 15-day supply for a medicine that you have been taking if you get a denial notice from **[MCO Name]** 10 days before your prescription ends telling you that the medicine will not be approved again and you have not filed a Grievance.

What if I Receive a Denial Notice?

If **[MCO Name]** denies a request for a service, item, or drug or does not approve it as requested, you can file a Grievance or a Complaint. If you file a Complaint or a Grievance for denial of an ongoing medication, **[MCO Name]** must authorize the medication until the Complaint or Grievance is resolved. See Section 8, Complaints, Grievances, and Fair Hearings, starting on page **[MCO to add page number]** of this Handbook for detailed information on Complaints and Grievances.

Program Exception Process

For those services that have limits, if you or your provider believes that you need more services than the limits on the service allows, you or your provider can ask for a program exception (PE). The PE process is different from the Dental Benefit Limit Exception process described on page **[MCO to insert page number]**.

To ask for a PE, **[MCO to add information on how to request a PE]**

HealthChoices Model Member Handbook

[MCO to add additional Program Exception information as necessary]

Service Descriptions

Emergency Services

Emergency services are services needed to treat or evaluate an emergency medical condition. An emergency medical condition is an injury or illness that is so severe that a reasonable person with no medical training would believe that there is an immediate risk to a person's life or long-term health. If you have an emergency medical condition, go to the nearest emergency room, dial 911, or call your local ambulance provider. You do **not** have to get approval from **[MCO Name]** to get emergency services and you may use any hospital or other setting for emergency care.

Below are some examples of emergency medical conditions and non-emergency medical conditions:

Emergency medical conditions

- Heart attack
- Chest pain
- Severe bleeding
- Intense pain
- Unconsciousness
- Poisoning

Non-emergency medical conditions

- Sore throat
- Vomiting
- Cold or flu
- Backache
- Earache
- Bruises, swelling, or small cuts

HealthChoices Model Member Handbook

If you are unsure if your condition requires emergency services, call your PCP or the **[MCO Name]** Nurse Hotline at **[MCO Nurse Hotline Phone Number]** 24 hours a day, 7 days a week.

[MCO to add any additional information about emergency services as necessary]

Emergency Medical Transportation

[MCO Name] covers emergency medical transportation by an ambulance for emergency medical conditions. If you need an ambulance, call 911 or your local ambulance provider. Do not call MATP (described on page **[MCO to insert page number]** of this Handbook) for emergency medical transportation.

Urgent Care

[MCO Name] covers urgent care for an illness, injury, or condition which if not treated within 24 hours, could rapidly become a crisis or an emergency medical condition. This is when you need attention from a doctor, but not in the emergency room.

If you need urgent care, but you are not sure if it is an emergency, call your PCP or the **[MCO Name]** Nurse Hotline at **[MCO Nurse Hotline phone number]** first. Your PCP or the hotline nurse will help you decide if you need to go to the emergency room, the PCP's office, or an urgent care center near you. In most cases if you need urgent care, your PCP will give you an appointment within 24 hours. If you are not able to reach your PCP or your PCP cannot see you within 24 hours and your medical condition is not an emergency, you may also visit an urgent care center or walk-in clinic within **[MCO Name]**'s network. Prior authorization is not required for services at an Urgent Care center.

Some examples of medical conditions that may need urgent care include:

- Vomiting
- Coughs and fever
- Sprains
- Rashes
- Earaches
- Diarrhea
- Sore throats
- Stomach aches

HealthChoices Model Member Handbook

If you have any questions, please call Member Services at **[MCO Member Services Phone Number and TTY]**.

[MCO to add any additional information about urgent care services as necessary]

Dental Care Services

[MCO to provide information on DBM if applicable]

Members Under 21 Years of Age

[MCO Name] provides all medically necessary dental services for children under 21 years of age. Children may go to a participating dentist within the **[DBM / MCO Name]** network.

Dental visits for children do not require a referral. If your child is 1 year old or older and does not have a dentist, you can ask your child's PCP to refer your child to a dentist for regular dental checkups. For more information on dental services, contact **[MCO Name]** Member Services at **[MCO Member Services Phone Number and TTY]**.

[MCO to include further details and specifics including covered service, co-payments, and prior authorization requirement]

Members 21 Years of Age and Older

[MCO Name] covers some dental benefits for members 21 years of age and older through dentists in the **[DBM / MCO Name]** network. Some dental services have limits.

[MCO to include further details and specifics including process for choosing and changing a dentist, covered services, co-payments, and prior authorization and BLE requirements]

Dental Benefit Limit Exception

Some dental services are only covered with a Benefit Limit Exception (BLE). You or your dentist can also ask for a BLE if you or your dentist believes that you need more dental services than the limits allow.

[MCO Name] will approve a BLE if:

- You have a serious or chronic illness or health condition and without the additional service your life would be in danger; OR

HealthChoices Model Member Handbook

- You have a serious or chronic illness or health condition and without the additional service your health would get much worse; OR
- You would need more expensive treatment if you do not get the requested service; OR
- It would be against federal law for **[MCO Name]** to deny the exception.

To ask for a BLE before you receive the service, you or your dentist can call **[MCO/DBM Name]** Member Services at **[MCO/DBM Member Services Phone Number and TTY]** or send the request to:

[MCO/DBM Contact Address].

BLE requests must include the following information:

- Your name
- Your address
- Your phone number
- The service you need
- The reason you need the service
- Your provider's name
- Your provider's phone number

Time Frames for Deciding a Benefit Limit Exception

If you or your provider asks for an exception before you get the service, **[MCO Name]** will let you know whether or not the BLE is approved within the same time frame as the time frame for prior authorization requests, described on page **[MCO to insert page number]**. **[or MCO can repeat the time frame]**.

If your dentist asks for an exception after you got the service, **[MCO Name]** will let you know whether or not the BLE request is approved within 30 days of the date **[MCO Name]** gets the request.

If you disagree with or are unhappy with **[MCO Name]**'s decision, you may file a Complaint or Grievance with **[MCO Name]**. For more information on the Complaint and

HealthChoices Model Member Handbook

Grievance process, please see Section 8 of this Handbook, Complaints, Grievances, and Fair Hearings on page [MCO to insert page number].

Vision Care Services

[MCO to provide information on Vision Benefit Manager if applicable]

Members Under 21 Years of Age

[MCO Name] covers all medically necessary vision services for children under 21 years of age. Children may go to a participating vision provider within the [MCO/VBM Name] network.

[MCO to include further details and specifics including covered service, co-payments, and prior authorization requirement]

Members 21 Years of Age and Older

[MCO Name] covers some vision services for members 21 years of age and older through providers within the [MCO/VBM Name] network.

[MCO to include further details and specifics including covered service, co-payments, and prior authorization requirement]

Pharmacy Benefits

[MCO Name] covers pharmacy benefits that include prescription medicines and over-the-counter medicines and vitamins with a doctor's prescription.

Prescriptions

When a provider prescribes a medication for you, you can take it to any pharmacy that is in [MCO Name]'s network. You will need to have your [MCO Name] prescription ID card with you and you may have a co-payment if you are over the age of 18. [MCO Name] will pay for any medicine listed on the Statewide PDL and [MCO Name]'s supplemental formulary and may pay for other medicines if they are prior authorized. Either your prescription or the label on your medicine will tell you if your doctor ordered refills of the prescription and how many refills you may get. If your doctor ordered refills, you may only get 1 refill at a time. If you have questions about whether a prescription medicine is covered, need help finding a pharmacy in [MCO Name]'s network, or have any other questions, please call Member Services at [MCO Member Services Phone Number and TTY].

HealthChoices Model Member Handbook

[MCO to add additional information on prescriptions as necessary]

Statewide Preferred Drug List (PDL) and [MCO Name] Supplemental Formulary

[MCO Name] covers medicines listed on the Statewide Preferred Drug List (PDL) and the **[MCO Name]** supplemental formulary. This is what your PCP or other doctor should use when deciding what medicines you should take. Both the Statewide PDL and **[MCO Name]** supplemental formulary cover both brand name and generic drugs. . Generic drugs contain the same active ingredients as brand name drugs. Any medicine prescribed by your doctor that is not on the Statewide PDL and **[MCO Name]**'s supplemental formulary needs prior authorization. The Statewide PDL and **[MCO Name]**'s supplemental formulary can change from time to time, so you should make sure that your provider has the latest information when prescribing a medicine for you.

If you have any questions or to get a copy of the the Statewide PDL and **[MCO Name]**'s supplemental formulary, call Member Services at **[MCO Member Services Phone Number and TTY]** or visit **[MCO Name]**'s website at **[MCO to insert link to formulary on website]**.

[MCO to add any additional information on the drug formulary as necessary]

Reimbursement for Medication

[MCO to provide description of any potential reimbursement for medication]

Specialty Medicines

The Statewide PDL and **[MCO Name]**'s supplemental formulary includes medicines that are called specialty medicines. A prescription for these medicines needs to be prior authorized **[MCO may remove sentence if prior authorization is not required]**. You may have a co-payment for your medicine. To see the Statewide Preferred Drug List, the **[MCO Name]**'s supplemental formulary and a complete list of specialty medicines, call Member Services at **[MCO Member Services Phone Number and TTY]** or visit **[MCO Name]**'s website at **[MCO to insert link to formulary on website]**.

You will need to get these medicines from a specialty pharmacy. A specialty pharmacy can mail your medicines directly to you and will not charge you for sending you your medicines. The specialty pharmacy will contact you before sending your medicine. The pharmacy can also answer any questions you have about the process. You can pick any specialty pharmacy that is in **[MCO Name]**'s network. For the list of network

HealthChoices Model Member Handbook

specialty pharmacies, please call Member Services at **[MCO Member Services Phone Number and TTY]** or see the provider directory on **[MCO Name]**'s website at **[MCO to insert link to provider directory on website]**. For any other questions or more information please call Member Services at **[MCO Member Services Phone Number and TTY]**.

Over-the-Counter Medicines

[MCO Name] covers over-the-counter medicines when you have a prescription from your provider. You will need to have your **[MCO Name]** prescription ID card with you and you may have a co-payment. The following are some examples of covered over-the-counter medicines:

- Sinus and allergy medicine
- Tylenol or aspirin
- Vitamins
- Cough medicine
- Heartburn medicine
- **[MCO may add additional items]**

You can find more information about covered over-the-counter medicines by visiting **[MCO Name]**'s website at **[MCO website]** or by calling Member Services at **[Member Services phone number and TTY]**.

Tobacco Cessation

Do you want to quit smoking? [MCO Name] wants to help you quit!

If you are ready to be smoke free, no matter how many times you have tried to quit smoking, we are here to help you.

Medicines

The Statewide PDL covers the following medicines to help you quit smoking.

[MCO to insert chart of tobacco medicines covered and whether they require prior authorization]

HealthChoices Model Member Handbook

Contact your PCP for an appointment to get a prescription for a tobacco cessation medicine.

Counseling Services

Counseling support may also help you to quit smoking. **[MCO Name]** covers the following counseling services: **[MCO to insert specific information on what is covered & how to receive counseling services here.]**

Behavioral Health Treatment

Some people may be stressed, anxious, or depressed when they are trying to become smoke-free. **[MCO Name]** members are eligible for services to address these side effects, but these services are covered by your BH-MCO. You can find the BH-MCO in your county and its contact information on page **[xx]** in this Handbook. You can also call **[MCO Name]** Member Services at **[MCO Member Services Phone Number and TTY]** for help in contacting your BH-MCO.

[MCO to provide additional behavioral health treatment for tobacco cessation information as necessary]

Case Management Programs [If Applicable]

[If the MCO offers tobacco cessation as part of any case management programs insert that specific information here.]

Other Tobacco Cessation Resources

[Insert information on services provided by and contact information for tobacco cessation services offered by the PA Free Quit line, PA Cancer Society, and the American Heart Association and the American Lung Association.]

Remember **[MCO Name]** is here to help support you in becoming healthier by becoming smoke-free. Do not wait! Please call Member Services at **[MCO Member Services Phone Number and TTY]** so we can help to get you started.

Family Planning

[MCO Name] covers family planning services. You do not need a referral from your PCP for family planning services. These services include pregnancy testing, testing and treatment of sexually transmitted diseases, birth control supplies, and family

HealthChoices Model Member Handbook

Parents who have questions about their child's development may contact the CONNECT Helpline at 1-800-692-7288 or visit www.papromiseforchildren.org. The CONNECT Helpline assists families in locating resources and providing information regarding child development for children from birth to age 5. In addition, CONNECT can help parents with contacting their county Early Intervention Program or local preschool Early Intervention Program.

HealthChoices 2020 Model Member Handbook

members under the age of 21

[MCO Name], unless you are already being treated by a PCP or specialist.

with PCP for an EPSDT exam no later than 45 days after you become a member in **[MCO Name]**, unless you are already being treated by a PCP or specialist.

all other members

Members who are pregnant:

pregnant women in their first trimester

with PCP no later than 3 weeks after you become a member in **[MCO Name]**.

pregnant women in their second trimester

We will make an appointment for you

...
with OB/GYN provider within 10 business days of **[MCO Name]** learning you are pregnant.

pregnant women in their third trimester

with OB/GYN provider within 5 business days of **[MCO Name]** learning you are pregnant.

pregnant women with high-risk pregnancies

with OB/GYN provider within 4 business days of **[MCO Name]** learning you are pregnant.

Appointment with...

with OB/GYN provider within 24 hours of **[MCO Name]** learning you are pregnant.

PCP

urgent medical condition
routine appointment
health assessment/general
physical examination

An appointment must be scheduled

within 24 hours.
within 10 business days.

Specialists (when referred by PCP)

urgent medical condition

within 3 weeks.

routine appointment with one of the following specialists:

within 24 hours of referral.

HealthChoices 2020 Model Member Handbook

- Otolaryngology within 15 business days of referral
- Dermatology
- Pediatric Endocrinology
- Pediatric General Surgery
- Pediatric Infectious Disease
- Pediatric Neurology
- Pediatric Pulmonology
- Pediatric Rheumatology
- Dentist
- Orthopedic Surgery
- Pediatric Allergy & Immunology
- Pediatric Gastroenterology
- Pediatric Hematology
- Pediatric Nephrology
- Pediatric Oncology
- Pediatric Rehab Medicine
- Pediatric Urology
- Pediatric Dentistry

routine appointment with all other
specialists

within 10 business days of referral

You may file **all other Complaints at any time.**

What Happens After I File a First Level Complaint?

HealthChoices 2020 Model Member Handbook

After you file your Complaint, you will get a letter from **[MCO Name]** telling you that **[MCO Name]** has received your Complaint, and about the First Level Complaint review process.

You may ask **[MCO Name]** to see any information **[MCO Name]** has about the issue you filed your Complaint about at no cost to you. You may also send information that you have about your Complaint to **[MCO Name]**.

You may attend the Complaint review if you want to attend it. **[MCO Name]** will tell you the location, date, and time of the Complaint review at least 10 days before the day of the Complaint review. You may appear at the Complaint review in person, by phone, or by videoconference **[MCO to include videoconferencing only if available]**. If you decide that you do not want to attend the Complaint review, it will not affect the decision.

A committee of 1 or more **[MCO Name]** staff who were not involved in and do not work for someone who was involved in the issue you filed your Complaint about will meet to make a decision about your Complaint. If the Complaint is about a clinical issue, a licensed doctor will be on the committee. **[MCO Name]** will mail you a notice within **[date that is no more than 30 days from receipt of the Complaint]** days from the date you filed your First Level Complaint to tell you the decision on your First Level Complaint. The notice will also tell you what you can do if you do not like the decision.

If you need more information about help during the Complaint process, see page _____
[MCO to insert page number of help section].

What to do to continue getting services:

If you have been getting the services or items that are being reduced, changed or denied and you file a Complaint verbally, or that is faxed, postmarked, or hand-delivered within 10 days of the date on the notice telling you that the services or items you have been receiving are not covered services or items for you, the services or items will continue until a decision is made.

What if I Do Not Like **[MCO Name]**'s Decision?

You may ask for an external Complaint review, a Fair Hearing, or an external Complaint review and a Fair Hearing if the Complaint is about one of the following:

- **[MCO Name]**'s decision that you cannot get a service or item you want because it is not a covered service or item.
- **[MCO Name]**'s decision to not pay a provider for a service or item you got.

HealthChoices 2020 Model Member Handbook

- **[MCO Name]**'s failure to decide a Complaint or Grievance you told **[MCO Name]** about within **[number that is 30 or fewer days]** days from when **[MCO Name]** got your Complaint or Grievance.
- You not getting a service or item within the time by which you should have received it
- **[MCO Name]**'s decision to deny your request to disagree with **[MCO Name]**'s decision that you have to pay your provider.

You must ask for an external Complaint review within **15 days of the date you got the First Level Complaint decision notice.**

You must ask for a Fair Hearing within **120 days from the mail date on the notice** telling you the Complaint decision.

For all other Complaints, you may file a Second Level Complaint within **45 days of the date you got the Complaint decision notice.**

For information about Fair Hearings, see page _____
For information about external Complaint review, see page ____
If you need more information about help during the Complaint process, see page _____
[MCO to insert page number].

Second Level Complaint

What Should I Do if I Want to File a Second Level Complaint?

To file a Second Level Complaint:

- Call **[MCO Name]** at **[Member Services Phone Number and TTY]** and tell **[MCO Name]** your Second Level Complaint, or
- Write down your Second Level Complaint and send it to **[MCO Name]** by mail or fax, or
- Fill out the Complaint Request Form included in your Complaint decision notice and send it to **[MCO Name]** by mail or fax.

[MCO Name]'s address and fax number for Second Level Complaints
[MCO address]
[MCO fax number]

HealthChoices 2020 Model Member Handbook

What Happens After I File a Second Level Complaint?

After you file your Second Level Complaint, you will get a letter from **[MCO Name]** telling you that **[MCO Name]** has received your Complaint, and about the Second Level Complaint review process.

You may ask **[MCO Name]** to see any information **[MCO Name]** has about the issue you filed your Complaint about at no cost to you. You may also send information that you have about your Complaint to **[MCO Name]**.

You may attend the Complaint review if you want to attend it. **[MCO Name]** will tell you the location, date, and time of the Complaint review at least 15 days before the Complaint review. You may appear at the Complaint review in person, by phone, or by videoconference **[MCO to include videoconferencing only if available]**. If you decide that you do not want to attend the Complaint review, it will not affect the decision.

A committee of 3 or more people, including at least 1 person who does not work for **[MCO Name]**, will meet to decide your Second Level Complaint. The **[MCO Name]** staff on the committee will not have been involved in and will not have worked for someone who was involved in the issue you filed your Complaint about. If the Complaint is about a clinical issue, a licensed doctor will be on the committee. **[MCO Name]** will mail you a notice within **[date that is no more than 45 days from receipt of the Second Level Complaint]** days from the date your Second Level Complaint was received to tell you the decision on your Second Level Complaint. The letter will also tell you what you can do if you do not like the decision.

If you need more information about help during the Complaint process, see page _____
[MCO to insert page number of help section].

What if I Do Not Like [MCO Name]'s Decision on My Second Level Complaint?

You may ask for an external review by either the Department of Health or the Insurance Department.

You must ask for an external review **within 15 days of the date you got the Second Level Complaint decision notice**.

External Complaint Review

How Do I Ask for an External Complaint Review?

You must send your request for an external review of your Complaint in writing to either:

HealthChoices 2020 Model Member Handbook

Pennsylvania Department of Health
Bureau of Managed Care
Health and Welfare Building, Room 912
625 Forster Street
Harrisburg, PA 17120-0701
Telephone Number: 1-888-466-2787

or

Pennsylvania Insurance Department
Bureau of Consumer Services
Room 1209, Strawberry Square
Harrisburg, PA 17120
Telephone Number: 1-877-881-6388

If you ask, the Department of Health will help you put your Complaint in writing.

The Department of Health handles Complaints that involve the way a provider gives care or services. The Insurance Department reviews Complaints that involve **[MCO Name]**'s policies and procedures. If you send your request for an external review to the wrong Department, it will be sent to the correct Department.

What Happens After I Ask for an External Complaint Review?

The Department of Health or the Insurance Department will get your file from **[MCO Name]**. You may also send them any other information that may help with the external review of your Complaint.

You may be represented by an attorney or another person such as your representative during the external review.

A decision letter will be sent to you after the decision is made. This letter will tell you all the reason(s) for the decision and what you can do if you do not like the decision.

What to do to continue getting services:

If you have been getting the services or items that are being reduced, changed or denied and your request for an external Complaint review is postmarked or hand-delivered within 10 days of the date on the notice telling you **[MCO Name]**'s First Level Complaint decision that you cannot get services or items you have been receiving because they are not covered services or items for you, the services or items will continue until a decision is made.

GRIEVANCES

What is a Grievance?

When **[MCO Name]** denies, decreases, or approves a service or item different than the service or item you requested because it is not medically necessary, you will get a notice telling you **[MCO Name]**'s decision.

HealthChoices 2020 Model Member Handbook

A Grievance is when you tell **[MCO Name]** you disagree with **[MCO Name]**'s decision.

What Should I Do if I Have a Grievance?

To file a Grievance:

- Call **[MCO Name]** at **[Member Services Phone Number and TTY]** and tell **[MCO Name]** your Grievance, or
- Write down your Grievance and send it to **[MCO Name]** by mail or fax, or
- Fill out the Complaint/Grievance Request Form included in the denial notice you got from **[MCO Name]** and send it to **[MCO Name]** by mail or fax.

[MCO Name]'s address and fax number for Grievances:

[MCO address]
[MCO fax number]

Your provider can file a Grievance for you if you give the provider your consent in writing to do so. If your provider files a Grievance for you, you cannot file a separate Grievance on your own.

When Should I File a Grievance?

You must file a Grievance within **60 days from the date you get the notice** telling you about the denial, decrease, or approval of a different service or item for you.

What Happens After I File a Grievance?

After you file your Grievance, you will get a letter from **[MCO Name]** telling you that **[MCO Name]** has received your Grievance, and about the Grievance review process.

You may ask **[MCO Name]** to see any information that **[MCO Name]** used to make the decision you filed your Grievance about at no cost to you. You may also send information that you have about your Grievance to **[MCO Name]**.

You may attend the Grievance review if you want to attend it. **[MCO Name]** will tell you the location, date, and time of the Grievance review at least 10 days before the day of the Grievance review. You may appear at the Grievance review in person, by phone, or by videoconference **[MCO to include videoconferencing only if available]**. If you decide that you do not want to attend the Grievance review, it will not affect the decision.

HealthChoices 2020 Model Member Handbook

A committee of 3 or more people, including a licensed doctor, will meet to decide your Grievance. The **[MCO Name]** staff on the committee will not have been involved in and will not have worked for someone who was involved in the issue you filed your Grievance about. **[MCO Name]** will mail you a notice within **[date that is no more than 30 days from receipt of the Grievance]** days from the date your Grievance was received to tell you the decision on your Grievance. The notice will also tell you what you can do if you do not like the decision.

If you need more information about help during the Grievance process, see page _____
[MCO to insert page number of help section].

What to do to continue getting services:

If you have been getting services or items that are being reduced, changed, or denied and you file a Grievance verbally, or that is faxed, postmarked, or hand-delivered within 10 days of the date on the notice telling you that the services or items you have been receiving are being reduced, changed, or denied, the services or items will continue until a decision is made.

What if I Do Not Like [MCO Name]'s Decision?

You may ask for an external Grievance review or a Fair Hearing or you may ask for both an external Grievance review and a Fair Hearing. An external Grievance review is a review by a doctor who does not work for **[MCO Name]**.

You must ask for an external Grievance review within **15 days of the date you got the Grievance decision notice**.

You must ask for a Fair Hearing from the Department of Human Services **within 120 days from the date on the notice** telling you the Grievance decision.

For information about Fair Hearings, see page _____
For information about external Grievance reviews, see below
If you need more information about help during the Grievance process, see page _____
[MCO to insert page number].

External Grievance Review

How Do I Ask for External Grievance Review?

To ask for an external Grievance review:

- Call **[MCO Name]** at **[Member Services Phone Number and TTY]** and tell **[MCO Name]** your Grievance, or

HealthChoices 2020 Model Member Handbook

- Write down your Grievance and send it to **[MCO Name]** by mail to: **[MCO address]**.

[MCO Name] will send your request for external Grievance review to the Department of Health.

What Happens After I Ask for an External Grievance Review?

The Department of Health will notify you of the external Grievance reviewer's name, address and phone number. You will also be given information about the external Grievance review process.

[MCO Name] will send your Grievance file to the reviewer. You may provide additional information that may help with the external review of your Grievance to the reviewer within 15 days of filing the request for an external Grievance review.

You will receive a decision letter within 60 days of the date you asked for an external Grievance review. This letter will tell you all the reason(s) for the decision and what you can do if you do not like the decision.

What to do to continue getting services:

If you have been getting the services or items that are being reduced, changed, or denied and you ask for an external Grievance review verbally or in a letter that is postmarked or hand-delivered within 10 days of the date on the notice telling you **[MCO Name]**'s Grievance decision, the services or items will continue until a decision is made.

Expedited Complaints and Grievances

What Can I Do if My Health Is at Immediate Risk?

If your doctor or dentist believes that waiting **[30, unless the MCO will be using a shorter time frame to provide notice of 1st Level Complaint or Grievance decisions or 45, unless the MCO will be using a shorter time frame to provide notice of 2nd Level Complaint decisions]** days to get a decision about your Complaint or Grievance, could harm your health, you or your doctor or dentist may ask that your Complaint or Grievance be decided more quickly. For your Complaint or Grievance to be decided more quickly:

- You must ask **[MCO Name]** for an early decision by calling **[MCO Name]** at **[Member Services Phone Number and TTY]**, faxing a letter or the Complaint/Grievance Request Form to **[MCO fax number]**, or sending an email to **[PH-MCO e-mail]**.

HealthChoices 2020 Model Member Handbook

- Your doctor or dentist should fax a signed letter to **[MCO fax number]** within 72 hours of your request for an early decision that explains why **[MCO Name]** taking **[30, unless the MCO will be using a shorter time frame for 1st Level Complaint or Grievance decisions or 45, unless the MCOS will be issuing a shorter time frame for 2nd level Complaint decisions]** days to tell you the decision about your Complaint or Grievance could harm your health.

If **[MCO Name]** does not receive a letter from your doctor or dentist and the information provided does not show that taking the usual amount of time to decide your Complaint or Grievance could harm your health, **[MCO Name]** will decide your Complaint or Grievance in the usual time frame of **[45, unless the MCO will be using a shorter time frame to provide notice of 1st Level Complaint or Grievance decisions]** days from when **[MCO Name]** first got your Complaint or Grievance.

Expedited Complaint and Expedited External Complaint

Your expedited Complaint will be reviewed by a committee that includes a licensed doctor. Members of the committee will not have been involved in and will not have worked for someone who was involved in the issue you filed your Complaint about.

You may attend the expedited Complaint review if you want to attend it. You can attend the Complaint review in person, but may have to appear by phone or by videoconference **[MCO to include videoconferencing only if available]** because **[MCO Name]** has a short amount of time to decide an expedited Complaint. If you decide that you do not want to attend the Complaint review, it will not affect the decision.

[MCO Name] will tell you the decision about your Complaint within 48 hours of when **[MCO Name]** gets your doctor's or dentist's letter explaining why the usual time frame for deciding your Complaint will harm your health or within 72 hours from when **[MCO Name]** gets your request for an early decision, whichever is sooner, unless you ask **[MCO Name]** to take more time to decide your Complaint. You can ask **[MCO Name]** to take up to 14 more days to decide your Complaint. You will also get a notice telling you the reason(s) for the decision and how to ask for expedited external Complaint review, if you do not like the decision.

If you did not like the expedited Complaint decision, you may ask for an expedited external Complaint review from the Department of Health within **2 business days from the date you get the expedited Complaint decision notice**. To ask for expedited external review of a Complaint:

- Call **[MCO Name]** at **[Member Services Phone Number and TTY]** and tell **[MCO Name]** your Complaint, or

HealthChoices 2020 Model Member Handbook

- Send an email to **[MCO Name]** at **[MCO email address]**, or
- Write down your Complaint and send it to **[MCO Name]** by mail or fax: **[MCO Address and fax number for requesting expedited external review of a Complaint]**.

Expedited Grievance and Expedited External Grievance

A committee of 3 or more people, including a licensed doctor, will meet to decide your Grievance. The **[MCO Name]** staff on the committee will not have been involved in and will not have worked for someone who was involved in the issue you filed your Grievance about.

You may attend the expedited Grievance review if you want to attend it. You can attend the Grievance review in person, but may have to appear by phone or by videoconference **[MCO to include videoconferencing only if available]** because **[MCO Name]** has a short amount of time to decide the expedited Grievance. If you decide that you do not want to attend the Grievance review, it will not affect our decision.

[MCO Name] will tell you the decision about your Grievance within 48 hours of when **[MCO Name]** gets your doctor's or dentist's letter explaining why the usual time frame for deciding your Grievance will harm your health or within 72 hours from when **[MCO Name]** gets your request for an early decision, whichever is sooner, unless you ask **[MCO Name]** to take more time to decide your Grievance. You can ask **[MCO Name]** to take up to 14 more days to decide your Grievance. You will also get a notice telling you the reason(s) for the decision and what to do if you do not like the decision.

If you do not like the expedited Grievance decision, you may ask for an expedited external Grievance review or an expedited Fair Hearing by the Department of Human Services or both an expedited external Grievance review and an expedited Fair Hearing.

You must ask for expedited external Grievance review by the Department of Health within **2 business days from the date you get the expedited Grievance decision notice**. To ask for expedited external review of a Grievance:

- Call **[MCO Name]** at **[Member Services Phone Number and TTY]** and tell **[MCO Name]** your Grievance, or
- Send an email to **[MCO Name]** at **[MCO email address]**, or
- Write down your Grievance and send it to **[MCO Name]** by mail or fax: **[MCO address and fax number for requesting expedited external review of a Grievance]**.

HealthChoices 2020 Model Member Handbook

[MCO Name] will send your request to the Department of Health within 24 hours after receiving it.

You must ask for a Fair Hearing within **120 days from the date on the notice** telling you the expedited Grievance decision.

What Kind of Help Can I Have with the Complaint and Grievance Processes?

If you need help filing your Complaint or Grievance, a staff member of **[MCO Name]** will help you. This person can also represent you during the Complaint or Grievance process. You do not have to pay for the help of a staff member. This staff member will not have been involved in any decision about your Complaint or Grievance.

You may also have a family member, friend, lawyer or other person help you file your Complaint or Grievance. This person can also help you if you decide you want to appear at the Complaint or Grievance review.

At any time during the Complaint or Grievance process, you can have someone you know represent you or act for you. If you decide to have someone represent or act for you, tell **[MCO Name]**, in writing, the name of that person and how **[MCO Name]** can reach him or her.

You or the person you choose to represent you may ask **[MCO Name]** to see any information **[MCO Name]** has about the issue you filed your Complaint or Grievance about at no cost to you.

You may call **[MCO Name]**'s toll-free telephone number at **[Member Services Phone Number and TTY]** if you need help or have questions about Complaints and Grievances, you can contact your local legal aid office at **[MCO insert Phone Number]** or call the Pennsylvania Health Law Project at 1-800-274-3258.

Persons Whose Primary Language Is Not English

If you ask for language services, **[MCO Name]** will provide the services at no cost to you.

Persons with Disabilities

[MCO Name] will provide persons with disabilities with the following help in presenting Complaints or Grievances at no cost, if needed. This help includes:

- Providing sign language interpreters;

HealthChoices 2020 Model Member Handbook

- Providing information submitted by **[MCO Name]** at the Complaint or Grievance review in an alternative format. The alternative format version will be given to you before the review; and
- Providing someone to help copy and present information.

DEPARTMENT OF HUMAN SERVICES FAIR HEARINGS

In some cases you can ask the Department of Human Services to hold a hearing because you are unhappy about or do not agree with something **[MCO Name]** did or did not do. These hearings are called “Fair Hearings.” You can ask for a Fair Hearing after **[MCO Name]** decides your First Level Complaint or decides your Grievance.

What Can I Request a Fair Hearing About and By When Do I Have to Ask for a Fair Hearing?

Your request for a Fair Hearing must be postmarked within **120 days from the date on the notice** telling you **[MCO Name]**'s decision on your First Level Complaint or Grievance about the following:

- The denial of a service or item you want because it is not a covered service or item.
- The denial of payment to a provider for a service or item you got and the provider can bill you for the service or item.
- **[MCO Name]**'s failure to decide a First Level Complaint or Grievance you told **[MCO Name]** about within **[number that is 30 or fewer days]** days from when **[MCO Name]** got your Complaint or Grievance.
- The denial of your request to disagree with **[MCO Name]**'s decision that you have to pay your provider.
- The denial of a service or item, decrease of a service or item, or approval of a service or item different from the service or item you requested because it was not medically necessary.
- You're not getting a service or item within the time by which you should have received a service or item.

You can also request a Fair Hearing within 120 days from the date on the notice telling you that **[MCO Name]** failed to decide a First Level Complaint or Grievance you told

HealthChoices 2020 Model Member Handbook

[MCO Name] about within **[number that is 30 or fewer days]** days from when **[MCO Name]** got your Complaint or Grievance.

How Do I Ask for a Fair Hearing?

Your request for a Fair Hearing must be in writing. You can either fill out and sign the Fair Hearing Request Form included in the Complaint or the Grievance decision notice or write and sign a letter.

If you write a letter, it needs to include the following information:

- Your (the member's) name and date of birth;
- A telephone number where you can be reached during the day;
- Whether you want to have the Fair Hearing in person or by telephone;
- The reason(s) you are asking for a Fair Hearing; and
- A copy of any letter you received about the issue you are asking for a Fair Hearing about.

You must send your request for a Fair Hearing to the following address:

Department of Human Services
Office of Medical Assistance Programs – HealthChoices Program
Complaint, Grievance and Fair hearings
PO Box 2675
Harrisburg, PA 17105-2675

What Happens After I Ask for a Fair Hearing?

You will get a letter from the Department of Human Services' Bureau of Hearings and Appeals telling you where the hearing will be held and the date and time for the hearing. You will receive this letter at least 10 days before the date of the hearing.

You may come to where the Fair Hearing will be held or be included by phone. A family member, friend, lawyer or other person may help you during the Fair Hearing. You **MUST** participate in the Fair Hearing.

[MCO Name] will also go to your Fair Hearing to explain why **[MCO Name]** made the decision or explain what happened.

HealthChoices 2020 Model Member Handbook

You may ask **[MCO Name]** to give you any records, reports and other information about the issue you requested your Fair Hearing about at no cost to you.

When Will the Fair Hearing Be Decided?

The Fair Hearing will be decided within 90 days from when you filed your Complaint or Grievance with **[MCO Name]**, not including the number of days between the date on the written notice of the **[MCO Name]**'s First Level Complaint decision or Grievance decision and the date you asked for a Fair Hearing.

If you requested a Fair Hearing because **[MCO Name]** did not tell you its decision about a Complaint or Grievance you told **[MCO Name]** about within **[number that is 30 or fewer]** days from when **[MCO Name]** got your Complaint or Grievance, your Fair Hearing will be decided within 90 days from when you filed your Complaint or Grievance with **[MCO Name]**, not including the number of days between the date on the notice telling you that **[MCO Name]** failed to timely decide your Complaint or Grievance and the date you asked for a Fair Hearing.

The Department of Human Services will send you the decision in writing and tell you what to do if you do not like the decision.

If your Fair Hearing is not decided within 90 days from the date the Department of Human Services receives your request, you may be able to get your services until your Fair Hearing is decided. You can call the Department of Human Services at 1-800-798-2339 to ask for your services.

What to do to continue getting services:

If you have been getting the services or items that are being reduced, changed or denied and you ask for a Fair Hearing and your request is postmarked or hand-delivered within 10 days of the date on the notice telling you **[MCO Name]**'s First Level Complaint or Grievance decision, the services or items will continue until a decision is made.

Expedited Fair Hearing

What Can I Do if My Health Is at Immediate Risk?

If your doctor or dentist believes that waiting the usual time frame for deciding a Fair Hearing could harm your health, you may ask that the Fair Hearing take place more quickly. This is called an expedited Fair Hearing. You can ask for an early decision by calling the Department at 1-800-798-2339 or by faxing a letter or the Fair Hearing Request Form to 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 Fair Hearing

HealthChoices 2020 Model Member Handbook

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 Fair Hearing could harm your health.

The Bureau of Hearings and Appeals will schedule a telephone hearing and will tell you its decision within 3 business days after you asked for a Fair Hearing.

If your doctor does not send a written statement and does not testify at the Fair Hearing, the Fair Hearing decision will not be expedited. Another hearing will be scheduled and the Fair Hearing will be decided using the usual time frame for deciding a Fair Hearing.

You may call **[MCO Name]**'s toll-free telephone number at **[MCO Number]** if you need help or have questions about Fair Hearings, you can contact your local legal aid office at **[MCO insert Phone Number]** or call the Pennsylvania Health Law Project at 1-800-274-3258.

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 FAIR HEARING PROCESSES

A. General Requirements

1. The PH-MCO must obtain the Department's prior written approval of its Complaint, Grievance, and Fair Hearing policies and procedures.
2. The PH-MCO must have written policies and procedures for registering, responding to, and resolving Complaints and Grievances as they relate to the MA population and must make these policies and procedures available to Members upon request.
3. The PH-MCO policies and procedures resolving Complaints and Grievances as they relate to the MA population should outline expectations that providers secure and submit all documentation available at the time of request for service or item.
4. The PH-MCO must maintain an accurate written record of each Complaint and Grievance and the actions taken by the PH-MCO to resolve each Complaint and Grievance. The record must include at least the following:
 - a. The name of the Member on whose behalf the Complaint or Grievance was filed;
 - b. The date the Complaint or Grievance was received;
 - c. A description of the reason for the Complaint or Grievance;
 - d. The date of each review or review meeting;
 - e. The date of resolution of the Complaint or Grievance and how the Complaint or Grievance was resolved; and
 - f. A copy of any documents or records reviewed.
 - g. Documentation the member was asked if they were in need of an interpreter and that one was provided for them.

The PH-MCO must provide the record of each Complaint and Grievance and the actions taken by the PH-MCO to resolve each Complaint and Grievance to the Department and CMS upon request.

5. The PH-MCO must submit a log of all Complaint and Grievance decisions in a format specified by the Department and must include review of the Complaint and Grievance processes in its QM and UM programs as outlined in Exhibit M(1) Quality Management and Utilization Management Program Requirements.

6. The PH-MCO must have a data system to process, track, and trend all Complaints and Grievances. This system must be updated and maintained to assure accurate accountability.
7. The PH-MCO must designate and train sufficient staff as reported in the Operating Procedures Report (OPS) 11 Provider Education, to be responsible for receiving, processing, and responding to Member Complaints and Grievances in accordance with the requirements specified in this Exhibit. To ensure a seamless transference of information, the PH-MCO will notify and update all changes to correspondence upon receipt of change by email and phone call.
8. PH-MCO staff performing Complaint and Grievance reviews must have the necessary orientation, clinical training, and experience to make an informed, accurate and impartial determination regarding issues assigned to them.
9. The PH-MCO must provide information about the Complaint and Grievance process to all Providers and Subcontractors when the PH-MCO enters into a contract or agreement with the Provider or Subcontractor. The PH-MCO is held accountable for the actions and outcomes from their Providers and Subcontractors. Accountability measures must be submitted to these partners in writing annually and will be reviewed and validated upon request by the Complaints, Grievances and Fair Hearings supervisor or designee.
10. The PH-MCO may not use the time frames or procedures of the Complaint or Grievance process to avoid the medical decision process or to discourage or prevent a Member from receiving Medically Necessary care in a timely manner.
11. The PH-MCO must require that anyone who participates in making the decision on a Complaint or Grievance was not involved in and is not a subordinate of an individual who was involved in any previous level of review or decision-making on the issue that is the subject of the Complaint or Grievance.
12. The PH-MCO may not charge Members a fee for filing a Complaint or a Grievance.
13. The PH-MCO must allow the Member and the Member's representative to have access to all relevant documentation, available in alternative formats if requested, pertaining to the subject of the Complaint or Grievance free of charge and sufficiently in advance of the time frame for resolution of the Complaint or Grievance outlined in this Exhibit.
14. The PH-MCO must maintain the following information in the Member's case file:
 - a. Medical records;
 - b. Any documents or records relied upon or generated by the PH-MCO in connection with the Complaint or Grievance, including any Medical Necessity guidelines used to make a decision or information on coverage limits relied upon to make a decision; and

- c. Any new or additional evidence considered, relied upon, or generated by the PH-MCO in connection with the Complaint or Grievance.
15. The PH-MCO must provide language interpreter services at no cost when requested by a Member.
16. 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 deaf or hearing impaired; Braille; tape; computer disk; and other commonly accepted alternative forms of communication. The PH-MCO must make its employees who receive telephone Complaints and Grievances aware of the speech limitations of Members with disabilities or language barriers, so they treat these individuals with patience, understanding, and respect.
17. 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 but is not limited to:
 - a. Providing qualified sign language interpreters for Members who are deaf or hearing impaired;
 - b. Providing information submitted on behalf of the PH-MCO at the Complaint or Grievance review in an alternative format accessible to the Member or Member's representative, filing the Complaint or Grievance. The alternative format version must be supplied to the Member at or before the review, so the Member can discuss and/or refute the content during the review; and
 - c. Providing personal assistance to a Member filing the Complaint or Grievance who has other physical limitations in copying and presenting documents and other evidence.
18. The PH-MCO must offer Members the assistance of a PH-MCO staff member trained and updated in the Complaints and Grievances process throughout the Complaint and Grievance processes at no cost to the Member.
19. The PH-MCO must provide Members with a toll-free number to file a Complaint or Grievance, request information about the Complaint or Grievance process, and ask any questions the Member may have about the status of a Complaint or Grievance.
20. The PH-MCO must, at a minimum, hold in-person reviews of Complaints and Grievances 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 specified by the Department.
21. The PH-MCO must ensure that any location where it will hold in-person reviews is physically accessible for persons with disabilities.

22. The PH-MCO must notify the Member when the PH-MCO fails to decide a first level Complaint or a Grievance within the time frames specified in this Exhibit, using the template specified by the Department. The PH-MCO must mail this notice to the Member one (1) day following the date the decision was to be made not to exceed 30 calendar days.
23. The PH-MCO must notify the Member when it denies payment after a service or item has been delivered because the service or item was provided without authorization by a Provider not enrolled in the MA Program, using the template specified by the Department. The PH-MCO must mail this notice to the Member on the day the decision is made to deny payment.
24. The PH-MCO must notify the Member when it denies payment after a service or item has been delivered because the service or item provided is not a covered service for the Member, using the template specified by the Department. The PH-MCO must mail this notice to the Member on the day the decision is made to deny payment.
25. The PH-MCO must notify the Member when it denies payment after a service or item has been delivered because the PH-MCO determined that the service or item was not Medically Necessary, using the template specified by the Department. The PH-MCO must mail this notice to the Member on the day the decision is made to deny payment.
26. The PH-MCO must notify the Member when it denies the Member's request to dispute a financial liability, including cost sharing, copayments, premiums, deductibles, coinsurance, and other enrollee financial liabilities, using the template specified by the Department. The PH-MCO must mail this notice to the Member on the day the decision is made to deny payment.
27. The PH-MCO must use all templates specified by the Department, which are available in DocuShare.

B. Complaint Requirements

Complaint: A dispute or objection regarding:

- a denial because the requested service or item is not a covered service; this does not include BLE.
- the failure of the PH-MCO to provide a service or item in a timely manner, as defined by the Department;
- the failure of the PH-MCO to decide a Complaint within the specified time frames;
- a denial of payment by the PH-MCO after a service or item has been delivered because the service or item was provided without authorization by a Provider not enrolled in the MA Program;

- a denial of payment by the PH-MCO after a service or item has been delivered because the service or item provided is not a covered service for the Member; or
- a denial of a Member's request to dispute a financial liability, including cost sharing, copayments, premiums, deductibles, coinsurance, and other Member financial liabilities.

These types of complaints must be filed within sixty (60) calendar days from the date of the incident complained of or the date the Member receives written notice of a decision.

A Complaint **without** an adverse benefit determination: is an expression of dissatisfaction about any matter other than an adverse benefit determination. Complaints may include, but are not limited to, the quality of care of services provided, and aspect of interpersonal relationships such as rudeness of a provider or employee, or failure to respect the enrollee's right regardless of whether remedial actions is requested. Complaint includes an enrollee's right to dispute an extension of time proposed by the MCO to make an authorization decision. These types of complaints do not have a filing timeframe.

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 first level Complaint either in writing or verbally. The PH-MCO must commit oral requests to writing if not confirmed in writing by the Member and should provide the written Complaint to the Member or Member's representative for signature.
 - i. If the requestor is the Member's representative, the signature may be obtained at any point in the process, and failure to obtain a signed consent may not delay the Complaint process.
 - ii. If the requestor is the Member's Provider, the written consent must be obtained prior to the onset of this process. If written consent from the member or Member's representative has not been obtained by the Provider, the Provider should proceed using the Provider Appeal Process.
- b. If the first level Complaint disputes one of the following, the Member must file a Complaint within sixty (60) calendar days from the date of the incident complained of or the date the Member receives written notice of a decision:
 - i. a denial because the service or item is not a covered service;

- ii. the failure of the PH-MCO to provide a service or item in a timely manner, as defined by the Department;
- iii. the failure of the PH-MCO to decide a Complaint within the specified time frames;
- iv. a denial of payment after the service or item has been delivered because the service or item was provided without authorization by a Provider not enrolled in the MA Program;
- v. a denial of payment after the service or item has been delivered because the service or item provided is not a covered service for the Member; or
- vi. a denial of a Member's request to dispute a financial liability, including cost sharing, copayments, premiums, deductibles, coinsurance, and other Member financial liabilities,

For all other Complaints, there is no time limit for filing a first level Complaint.

- c. A Member who files a first level Complaint to dispute a decision to discontinue, reduce, or change a service or item that the Member has been receiving on the basis that the service or item is not a covered service must continue to receive the disputed service or item at the previously authorized level pending resolution of the first level Complaint, if the first level Complaint is made verbally, hand delivered, or post-marked within ten (10) calendar days from the mail date on the written notice of decision.
- d. Upon receipt of the Complaint, the PH-MCO must send the Member and Member's representative, if the Member has designated one in writing, a first level Complaint acknowledgment letter by the next business day, using the template specified by the Department.
- e. The first level Complaint review for all complaints must be conducted by a first level Complaint review committee, which must include one or more employees of the PH-MCO who were not involved in and are not the subordinates of an individual involved in any previous level of review or decision-making on the issue that is the subject of the Complaint. For a first level complaint with an adverse benefit determination involving a clinical issue, a licensed physician or dentist, in the same or similar specialty must participate on the committee panel.
- f. A committee member who does not personally attend the first level Complaint review meeting may not be part of the decision-making process unless that committee member actively participates in the review by telephone or videoconference and has the opportunity to review all information presented during the review.

- g. The PH-MCO must afford the Member or Member's representative, a reasonable opportunity to present evidence and testimony and make legal and factual arguments, in person as well as in writing.
- h. The PH-MCO must give the Member at least ten (10) calendar days advance written notice of the first level Complaint review date, using the template specified by the Department. The PH-MCO must be flexible when scheduling the review to facilitate the Member's attendance. If the Member cannot appear in person at the review, the PH-MCO must provide an opportunity for the Member to communicate with the first level Complaint review committee by telephone or videoconference.
- i. The Member may elect not to attend the first level Complaint review 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 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 is held and the other members of the first level Complaint review committee must participate in the review through the use of videoconferencing.
- k. The decision of the first level Complaint review committee must take into account all comments, documents, records, and other information submitted by the Member or the Member's representative without regard to whether such information was submitted or considered in the initial determination of the issue.
- l. The testimony taken by the Complaint review committee (including the Member's comments) must be tape-recorded, transcribed verbatim and maintained as part of the Complaint record.
- m. The first level Complaint review committee must complete its review of the Complaint as expeditiously as the Member's health condition requires.
- n. 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.
- o. The PH-MCO must send a written notice of the first level Complaint decision, using the template specified by the Department, to the Member, Member's representative, if the Member has designated one in writing, service Provider and prescribing Provider, if applicable, within thirty (30) calendar days from the date the PH-MCO received the Complaint unless the time frame for deciding the Complaint has been extended by up to fourteen (14) calendar days at the request of the Member.

- p. If the Complaint disputes one of the following, the Member may file a request for a Fair Hearing, a request for an external review, or both a request for a Fair Hearing and a request for an external review:
 - i. a denial because the service or item is not a covered service;
 - ii. the failure of the PH-MCO to provide a service or item in a timely manner, as defined by the Department;
 - iii. the failure of the PH-MCO to decide the Complaint or Grievance within the specified time frames;
 - iv. a denial of payment by the PH-MCO after the service or item has been delivered because the service or item was provided by a Provider not enrolled in the MA Program;
 - v. a denial of payment by the PH-MCO after the service or item has been delivered because the service or item provided is not a covered service for the Member; or
 - vi. a denial of a Member's request to dispute a financial liability, including cost sharing, copayments, premiums, deductibles, coinsurance, and other Member financial liabilities.

The Member or Member's representative may file a request for a Fair Hearing within one hundred and twenty (120) calendar days from the mail date on the written notice of the PH-MCO's first level Complaint decision.

The 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, may file a request for an external review in writing with either DOH or PID within fifteen (15) calendar days from the date the Member receives written notice of the PH-MCO's first level Complaint decision.

For all other Complaints, the 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, may file a second level Complaint either in writing or verbally within forty-five (45) calendar days from the date the Member receives written notice of the PH-MCO's first level Complaint decision.

2. Second 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 second level Complaint either in writing or verbally

for any Complaint unless it is one of the following as they are eligible for a Fair Hearing and/or an external review with the Department of Health.

- i. a denial because the service or item is not a covered service;
 - ii. the failure of the PH-MCO to provide a service or item in a timely manner, as defined by the Department;
 - iii. the failure of the PH-MCO to decide the Complaint within the specified time frames;
 - iv. a denial of payment by the PH-MCO after the service or item has been delivered because the service or item was provided by a Provider not enrolled in the MA Program;
 - v. a denial of payment by the PH-MCO after the service or item has been delivered because the service or item provided is not a covered service for the Member; or
 - vi. a denial of a Member's request to dispute a financial liability, including cost sharing, copayments, premiums, deductibles, coinsurance, and other Member financial liabilities.
- b. Upon receipt of the second level Complaint, the PH-MCO must send the Member and Member's representative, if the Member has designated one in writing, a second level Complaint acknowledgment letter by the next business day, using the template specified by the Department.
- c. The second level Complaint review for all other complaints not eligible for a Fair Hearing must be conducted by a second level Complaint review committee made up of three (3) or more individuals who were not involved in and are not the subordinates of an individual involved in any previous level of review or decision-making on the issue that is the subject of the Complaint.
- d. At least one-third of the second level Complaint review committee members 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 meeting may not be part of the decision-making process unless that committee member actively participates in the review by telephone or videoconference and has the opportunity to review all information presented during the review.
- f. The PH-MCO must afford the Member a reasonable opportunity to present evidence and testimony and make legal and factual arguments, in person as well as in writing.
- g. The PH-MCO must give the Member at least fifteen (15) calendar days advance written notice of the second level Complaint review date, using the

template specified by the Department. The PH-MCO must be flexible when scheduling the review to facilitate the Member's attendance. If the Member cannot appear in person at the review, the PH-MCO must provide an opportunity for the Member to communicate with the second level Complaint review committee by telephone or videoconference.

- h. The Member may elect not to attend the second level Complaint review meeting, but the meeting must be conducted with the same protocols as if the Member was present.
- i. 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 is held and the other members of the second level Complaint review committee must participate in the review through the use of videoconferencing.
- j. The decision of the second level Complaint review committee must take into account all comments, documents, records, and other information submitted by the Member or the Member's representative without regard to whether such information was submitted or considered previously. The decision of the second level Complaint review committee must be based solely on the information presented at the review.
- k. The testimony taken by the second level Complaint review committee (including the Member's comments) must be tape-recorded, transcribed verbatim and maintained as part of the Complaint record. The Complaint review committee must prepare a verbatim written transcription of the issues presented and decisions made, which must be maintained as part of the Complaint record
- l. The second level Complaint review committee must complete its review of the second level Complaint as expeditiously as the Member's health condition requires.
- m. The PH-MCO must send a written notice of the second level Complaint decision, using the template specified by the Department, to the Member, Member's representative, if the Member has designated one in writing, service Provider, and prescribing Provider, if applicable, within forty-five (45) calendar days from the date the PH-MCO received the second level Complaint.
- n. The Member or the Member's representative, which may include the Member's Provider, with proof of the Member's written authorization of the representative to be involved and/or act of the Member's behalf, may file in writing a request for an external review of the second level Complaint decision with either DOH or PID within fifteen (15) calendar days from the date the Member receives the written notice of the PH-MCO's second level Complaint decision.

3. External Complaint Process

- a. If a Member files a request directly with PID or DOH for an external review of a Complaint decision that disputes a decision to discontinue, reduce, or change a service or item that the Member has been receiving on the basis that the service or item is not a covered service, the Member must continue to receive the disputed service or 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) calendar days from the mail date on the written notice of the PH-MCO's first or second level Complaint decision.
- b. Upon the request of either DOH or PID, the PH-MCO must transmit all records from the PH-MCO's Complaint review to the requesting department within thirty (30) calendar days from the request in the manner prescribed by that department. The Member, the Provider, or the PH-MCO may submit additional materials related to the Complaint.
- c. DOH and PID will determine the appropriate agency for the review.

4. Expedited Complaint Process

- a. The PH-MCO must conduct expedited review of a Complaint if the PH-MCO determines that the Member's life, physical or mental health, or ability to attain, maintain, or regain maximum function would be placed in jeopardy by following the regular Complaint process or 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 the Member's Provider that the Member's life, physical or mental health, or ability to attain, maintain, or regain maximum function would be placed in jeopardy by following the regular Complaint process. The certification is only required if the Managed Care Organization cannot make a determination based on the information provided and must include the Provider's signature.
- b. A request for an expedited review of a Complaint may be filed in writing, by fax, verbally, or by email.
- 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 testimony and make legal and factual arguments 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 and the PH-MCO cannot determine based on the information provided that the Member's life, physical or mental health, or ability to attain, maintain, or regain maximum function would be placed in jeopardy by following the regular Complaint process, 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 seventy-two (72) hours of the Member's request for expedited review, the PH-MCO must decide the Complaint within the standard time frames as set forth in this Exhibit, unless the time frame for deciding the Complaint has been extended by up to fourteen (14) calendar days at the request of the Member. If the PH-MCO decides that expedited consideration within the initial or extended time frame is not warranted, 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 time frame and send a written notice within two (2) business days of the decision to deny expedited review, using the template specified by the Department.

- e. A Member who files a request for expedited review of a Complaint that disputes a decision to discontinue, reduce, or change a service or item that the Member has been receiving on the basis that the service or item is not a covered service must continue to receive the disputed service or item at the previously authorized level pending resolution of the Complaint, if the request for expedited review is made verbally, hand delivered, faxed, emailed, or post-marked within ten (10) calendar days from the mail date on the written notice of decision.
- f. Expedited review of a Complaint must be conducted by a Complaint review committee that includes a licensed physician or dentist in the same or similar specialty that typically manages or consults on the service or item in question. Other appropriate Providers may participate in the review, but the licensed physician must decide the Complaint. The members of the expedited Complaint review committee may not have been involved in and may not be the subordinates of an individual involved in any previous level of review or decision-making on the issue that is the subject of the Complaint.
- g. The testimony taken by the expedited Complaint review committee (including the Member's comments) must be tape-recorded, transcribed verbatim and maintained as part of the expedited Complaint record.
- 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 in writing, service Provider and prescribing Provider, if applicable, within either forty-eight (48) hours of receiving the Provider certification or seventy-two (72) hours of receiving the Member's request for an expedited review, whichever is shorter, unless the time frame for deciding the expedited Complaint has been extended by up to fourteen (14) calendar days at the request of the Member. 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 in writing, the service Provider, and prescribing Provider, if applicable, within two (2) business days of the decision, using the template specified by the Department.

- i. The Member or the Member's representative may file a request for a Fair Hearing within one hundred and twenty (120) calendar days from the mail date on the written notice of the PH-MCO's expedited Complaint decision.
- j. 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 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. A Member who files a request for an expedited Complaint review that disputes a decision to discontinue, reduce, or change a service or item that the Member has been receiving must continue to receive the disputed service or item at the previously authorized level pending resolution of the request for expedited Complaint review.
- k. A request for an expedited external Complaint review may be filed in writing, by fax, verbally, or by email.
- l. The PH-MCO must follow DOH guidelines relating to submission of requests for expedited external Complaint reviews.
- m. The PH-MCO may not take punitive action against a Provider who requests expedited resolution of a Complaint or supports a Member's request for expedited review of a Complaint.

C. Grievance Requirements

Grievance: A request to have a PH-MCO or utilization review entity reconsider a decision concerning the Medical Necessity and appropriateness of a covered service. A Grievance may be filed regarding a PH-MCO's decision to 1) deny, in whole or in part, payment for a service or item; 2) deny or issue a limited authorization of a requested service or item, including a determination based on the type or level of service or item; 3) reduce, suspend, or terminate a previously authorized service or item; 4) deny the requested service or item but approve an alternative service or item 5) deny a request for a BLE and 6) decide a Grievance within the specified time frames.

The term does not include a Complaint.

1. Grievance 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 Grievance either in writing or verbally. The PH-MCO must commit oral requests to writing if not confirmed in writing by the Member and should provide the written Grievance to the Member or the Member's representative for signature.

- i. If the requestor is the Member representative, the signature may be obtained at any point in the process, and the failure to obtain a signed consent may not delay the Grievance process.
 - ii. If the requestor is the Member's Provider, the written consent must be obtained prior to the onset of this process. If written consent from the member or Member's representative has not been obtained by the Provider, the Provider should proceed using the Provider Appeal Process.
- b. A Member must file a Grievance within sixty (60) calendar days from the date the Member receives written notice of decision.
- c. A Member who files a Grievance that disputes a decision to discontinue, reduce, or change a service or item that the Member has been receiving must continue to receive the disputed service or item at the previously authorized level pending resolution of the Grievance, if the Grievance is made verbally, hand delivered, or post-marked within ten (10) calendar days from the mail date on the written notice of decision.
- d. Upon receipt of the Grievance, the PH-MCO must send the Member and Member's representative, if the Member has designated one in writing, a Grievance acknowledgment letter by the next business day, using the template specified by the Department.
- e. A Member who consents to the filing of a Grievance by a Provider may not file a separate Grievance. The Member may rescind consent throughout the 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 and submit the written consent with the Grievance. A Provider may obtain the Member's written permission at the time of treatment. The PH-MCO must assure that a Provider does 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 or item which 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 service or item 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 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 Grievance review must be conducted by a Grievance review committee made up of three (3) or more individuals who were not involved in and are not the subordinates of an individual involved in any previous level of review or decision-making on the issue that is the subject of the Grievance.
 - h. At least one-third of the Grievance review committee may not be employees of the PH-MCO or a related subsidiary or Affiliate.
 - i. The Grievance review committee must include a licensed physician or dentist in the same or similar specialty that typically manages or consults on the service or item in question. Other appropriate Providers may participate in the review, but the licensed physician must decide the Grievance.
 - j. A committee member who does not personally attend the Grievance review may not be part of the decision-making process unless that committee member actively participates in the review by telephone or videoconference and has the opportunity to review all information introduced during the review.
 - k. The PH-MCO must afford the Member or Member’s representative a reasonable opportunity to present evidence and testimony and make legal and factual arguments, in person as well as in writing.
 - l. The PH-MCO must give the Member at least ten (10) calendar days advance written notice of the review date, using the template specified by the

Department. The PH-MCO must be flexible when scheduling the review to facilitate the Member's attendance. If the Member cannot appear in person at the review, the PH-MCO must provide an opportunity for the Member to communicate with the Grievance review committee by telephone or videoconference.

- m. The Member may elect not to attend the Grievance review meeting, but the meeting must be conducted with the same protocols as if the Member was present.
- n. If a Member requests an in-person Grievance review, at a minimum, a member of the Grievance review committee must be physically present at the location where the Grievance review is held and the other members of the Grievance review committee must participate in the review through the use of videoconferencing.
- o. The decision of the Grievance review committee must take into account all comments, documents, records, and other information submitted by the Member or the Member's representative without regard to whether such information was submitted or considered in the initial determination of the issue. The decision of the Grievance review committee must be based solely on the information presented at the review.
- p. The testimony taken by the Grievance review committee (including the Member's comments) must be tape-recorded, transcribed verbatim and a written transcription prepared and maintained as part of the Grievance record.
- q. The Grievance review committee must complete its review of the Grievance as expeditiously as the Member's health condition requires.
- r. The PH-MCO must send a written notice of the Grievance decision, using the template specified by the Department, to the Member, Member's representative, if the Member has designated one in writing, service Provider and prescribing Provider, if applicable, within thirty (30) calendar days from the date the PH-MCO received the Grievance, unless the time frame for deciding the Grievance has been extended by up to fourteen (14) calendar days at the request of the Member.
- s. The Member may file a request for a Fair Hearing, a request for an external review, or both a request for a Fair Hearing and a request for an external review.

The Member or Member's representative may file a request for a Fair Hearing within one hundred and twenty (120) calendar days from the mail date on the written notice of the PH-MCO's Grievance decision.

The Member or Member's 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 of a Grievance decision by a certified review entity (CRE) appointed by DOH. The request must be filed in writing or verbally within fifteen (15) calendar days from the date the Member receives the written notice of the PH-MCO's Grievance decision.

2. External Grievance Process:

- a. The PH-MCO must process all requests for external Grievance review. The PH-MCO must follow the protocols established by DOH 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 in writing, service Provider, and prescribing Provider.
- b. A Member who files a request for an external Grievance review that disputes a decision to discontinue, reduce, or change a service or item that the Member has been receiving must continue to receive the disputed service or item at the previously authorized level pending resolution of the external Grievance review, if the request for external Grievance review is made verbally, hand delivered, or post-marked within ten (10) calendar days from the mail date on the written notice of the PH-MCO's Grievance decision.
- c. Within five (5) business days of receipt of the request for an external Grievance review, the PH-MCO must notify the Member, the Member's representative, if the Member has designated one in writing, the Provider if the Provider filed the request for the external Grievance review, and DOH that the request for external Grievance review has been filed.
- d. The external Grievance review must be conducted by a CRE not affiliated with the PH-MCO.
- e. Within two (2) business days from receipt of the request for an external Grievance review, DOH will randomly assign a CRE to conduct the review and notify the PH-MCO and assigned CRE of the assignment.
- f. If DOH 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 DOH. 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 Grievance decision, including all supporting information, a summary of applicable issues, and the basis and clinical rationale for the Grievance decision, to the CRE conducting the external Grievance review. The PH-MCO must transmit this information within fifteen (15) calendar days from receipt of the Member's request for an external Grievance review.

- h. Within fifteen (15) calendar days from receipt of the request for an external Grievance review by the PH-MCO, the Member or the Member's representative, or the Member's Provider, 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) calendar days from the filing of the request for the external Grievance review, the CRE conducting the external Grievance review must issue a written decision to the 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 must be whether the service or item is Medically Necessary and appropriate under the terms of this Agreement.
- j. The external Grievance decision may be appealed by the Member, the Member's representative, or the Provider to a court of competent jurisdiction (Commonwealth Court) within sixty (60) calendar days from the date the Member receives notice of the external Grievance decision.

3. Expedited Grievance Process

- a. The PH-MCO must conduct expedited review of a Grievance if the PH-MCO determines that the Member's life, physical or mental health, or ability to attain, maintain, or regain maximum function would be placed in jeopardy by following the regular Grievance process or 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 the Member's Provider that the Member's life, physical or mental health, or ability to attain, maintain, or regain maximum function would be placed in jeopardy by following the regular Grievance process. The certification is only required if the Managed Care Organization cannot make a determination based on the information provided and must include the Provider's signature.
- b. A request for expedited review of a Grievance may be filed in writing, by fax, by email, or verbally.
- c. The expedited review process is bound by the same rules and procedures as the 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 testimony and make legal and factual arguments in person as well as in writing and of the limited time available to do so.

- e. If the Provider certification is not included within the request for an expedited review and the PH-MCO cannot determine based on the information provided that the Member's life, physical or mental health, or ability to attain, maintain, or regain maximum function would be placed in jeopardy by following the regular Grievance process, 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 seventy-two (72) hours of the Member's request for expedited review, the PH-MCO must decide the Grievance within the standard time frames as set forth in this Exhibit, unless the time frame for deciding the Grievance has been extended by up to fourteen (14) calendar days at the request of the Member. If the PH-MCO decides that expedited consideration with the initial or extended time frame is not warranted, 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 time frame and send a written notice within two (2) business days of the decision to deny expedited review, using the template specified by the Department.
- f. A Member who files a request for expedited review of a Grievance that disputes a decision to discontinue, reduce, or change a service or item that the Member has been receiving must continue to receive the disputed service or item at the previously authorized level pending resolution of the Grievance, if the request for expedited review of a Grievance is made verbally, hand delivered, or post-marked within ten (10) calendar days from the mail date on the written notice of decision.
- g. Expedited review of a Grievance must be conducted by a Grievance review committee made up of three (3) or more individuals who were not involved in and are not the subordinates of an individual involved in any previous level of review or decision-making on the issue that is the subject of the Grievance.
- h. At least one-third of the expedited Grievance review committee may not be employees of the PH-MCO or a related subsidiary or Affiliate.
- i. The expedited Grievance review committee must include a licensed physician or dentist in the same or similar specialty that typically manages or consults on the service or item in question. Other appropriate Providers may participate in the review, but the licensed physician must decide the Grievance.
- j. The testimony taken by the expedited Grievance review committee (including the Member's comments) must be tape-recorded, transcribed verbatim and maintained as part of the expedited Grievance record.
- k. 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 in writing, service Provider, and prescribing

Provider, if applicable, within either forty-eight (48) hours of receiving the Provider certification or seventy-two (72) hours of receiving the Member's request for an expedited review, whichever is shorter, unless the time frame for deciding the expedited Grievance has been extended by up to fourteen (14) calendar days at the request of the Member. 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 in writing, service Provider, and prescribing Provider, if applicable, within two (2) business days of the decision, using the template specified by the Department.

- i. The Member or the Member's representative may file a request for a Fair Hearing within one hundred and twenty (120) calendar days from the mail date on the written notice of the PH-MCO's expedited Grievance decision.
- m. The 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, 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. A Member who files a request for an expedited external Grievance review that disputes a decision to discontinue, reduce, or change a service or item that the Member has been receiving must continue to receive the disputed service or item at the previously authorized level pending resolution of the request for expedited Grievance review.
- n. A request for an expedited external Grievance review may be filed in writing, by fax, orally, or by email.
- o. The PH-MCO must follow DOH guidelines relating to submission of requests for expedited external Grievance reviews.
- p. The PH-MCO may not take punitive action against a Provider who requests expedited resolution of a Grievance or supports a Member's request for expedited review of a Grievance.

D. Department's Fair Hearing Requirements

Fair Hearing: A hearing conducted by the Department's Bureau of Hearings and Appeals (BHA) or a Department designee.

1. Fair Hearing Process

- a. 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, must file a Complaint or Grievance with the PH-MCO and receive a decision on the Complaint or Grievance before filing a request for a Fair Hearing. If the PH-MCO fails to provide written notice of a Complaint or Grievance decision within the time frames specified in this Exhibit, the

Member is deemed to have exhausted the Complaint or Grievance process and may request a Fair Hearing.

- b. The Member or the Member's representative may request a Fair Hearing in writing, signed by the 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, within one hundred and twenty (120) calendar days from the mail date on the written notice of the PH-MCO's first level Complaint decision or Grievance decision for any of the following:
 - i. the denial, in whole or part, of payment for a requested service or item based on lack of Medical Necessity;
 - ii. the denial of a requested service or item because the service or item is not a covered service;
 - iii. the reduction, suspension, or termination of a previously authorized service or item;
 - iv. the denial of a requested service or item but approval of an alternative service or item;
 - v. the failure of the PH-MCO to provide a service or item in a timely manner, as defined by the Department;
 - vi. the failure of a PH-MCO to decide a Complaint or Grievance within the specified time frame;
 - vii. the denial of payment after a service or item has been delivered because the service or item was provided by a Provider not enrolled in the MA Program;
 - viii. the denial of payment after a service or item has been delivered because the service or item is not a covered service for the Member;
 - ix. the denial of a Member's request to dispute a financial liability, including cost sharing, copayments, premiums, deductibles, coinsurance, and other Member financial liabilities.
- c. The request for a Fair Hearing must include a copy of the written notice of decision that is the subject of the request unless the PH-MCO failed to provide written notice of the Complaint or Grievance decision within the time frames specified in this Exhibit.
- d. A Fair Hearing may be requested as follows:
 - i. Fax: 1-717-772-6328
 - ii. Mail: Department of Human Services

OMAP – HealthChoices Program
Complaint, Grievance and Fair Hearings
P.O. Box 2675
Harrisburg, Pennsylvania 17105-2675

- e. A Member who files a request for a Fair Hearing that disputes a decision to discontinue, reduce, or change a service or item that the Member has been receiving must continue to receive the disputed service or item at the previously authorized level pending resolution of the Fair Hearing, if the request for a Fair Hearing is hand delivered, faxed, or post-marked within ten (10) calendar days from the mail date on the written notice of decision.
- f. Upon receipt of the request for a Fair Hearing, BHA or the Department's designee will schedule a hearing. The Member and the PH-MCO will receive notification of the hearing date by letter at least ten (10) calendar days before the hearing date, 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.
- g. 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. BHA's decision is based solely on the evidence presented at the hearing. The absence of the PH-MCO from the hearing will not be reason to postpone the hearing.
- h. The PH-MCO must provide Members, at no cost, with records, reports, and documents relevant to the subject of the Fair Hearing.
- i. BHA will issue an adjudication within ninety (90) calendar days of the date the Member filed the first level Complaint or the Grievance with the PH-MCO, not including the number of days before the Member requested the Fair Hearing. If BHA fails to issue an adjudication within ninety (90) calendar days of receipt of the initial request of the first level complaint or grievance, less the time it took the member to request a Fair Hearing, the PH-MCO must comply with 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, it will be extended by the length of the delay attributed to the Member.
- j. BHA's 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) calendar days from the date of the adjudication. Only the Member may appeal to Commonwealth Court within thirty (30) calendar days from the date of the BHA adjudication or from the date of 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 Member or the Member's representative may file a request for an expedited Fair Hearing with the Department either in writing or orally.
- b. A Member must exhaust the Complaint or Grievance process prior to filing a request for an expedited Fair Hearing.
- c. BHA will conduct an expedited Fair Hearing if a Member or a Member's representative provides the Department with a signed written certification from the Member's Provider that the Member's life, physical or mental health, or ability to attain, maintain, or regain maximum function would be placed in jeopardy by following the regular Fair Hearing process or if the Provider provides testimony at the Fair Hearing which explains why using the usual time frames would place the Member's life, physical or mental health, or ability to attain, maintain, or regain maximum function in jeopardy.
- d. A Member who files a request for an expedited Fair Hearing that disputes a decision to discontinue, reduce, or change a service or item that the Member has been receiving must continue to receive the disputed service or item at the previously authorized level pending resolution of the Fair Hearing, if the request for an expedited Fair Hearing is made orally, hand delivered, or post-marked within ten (10) calendar days from the mail date on the written notice of decision.
- e. Upon the receipt of the request for an expedited Fair Hearing, BHA or the Department's designee will schedule a 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 absence of the PH-MCO from the hearing will not be reason to postpone the hearing.
- g. The PH-MCO must provide the Member, at no cost, with records, reports, and documents relevant to the subject of the Fair Hearing.
- h. BHA will issue an adjudication within three (3) business days from receipt of the Member's oral or written request for an expedited review.
- i. BHA's 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) calendar days from the date of the adjudication. Only the Member may appeal to Commonwealth Court within thirty (30) calendar days from the date of adjudication or from the date of 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 Service or Item Following Decision

1. If the PH-MCO, BHA, or the Secretary reverses a decision to deny, limit, or delay a service or item that was not furnished during the Complaint, Grievance, or Fair

Hearing process, the PH-MCO must authorize or provide the disputed service or item as expeditiously as the Member's health condition requires but no later than seventy-two (72) hours from the date it receives notice that the decision was reversed. If the PH-MCO requests reconsideration, the PH-MCO must authorize or provide the disputed service or item pending reconsideration unless the PH-MCO requests a stay of the BHA decision and the stay is granted.

2. If the PH-MCO, BHA, or the Secretary reverses a decision to deny authorization of a service or item, and the Member received the disputed service or item during the Complaint, Grievance, or Fair Hearing process, the PH-MCO must pay for the service or item that the Member received.

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 C.F.R. 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 that the subcontractor agrees to comply with all applicable Medicaid, federal and state laws and regulations; including sub-regulatory guidance;

- 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) and the subcontractor's contractor(s) shall, at their own expense, make all books, records, contracts, computers, or other electronic systems available for audit, review, evaluation or inspection by the Commonwealth, its designated representatives, CMS, the HHS Inspector General, the Comptroller General or their designees. Access must be granted either on-site, electronically or through the mail at the discretion of the reviewing entity. The right to audit exists for ten (10) years from the final date of the contract period; or from the date of completion of any audit, whichever is longer. 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 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.

If the Commonwealth, CMS, or the HHS Inspector General or their designees determine that there is a reasonable possibility of fraud or similar risk, the Commonwealth, CMS, or the HHS Inspector General may inspect, evaluate, and audit the subcontractor at any time.

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 HealthChoices Physical Health Agreement effective January 1, 2021

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 ten (10) 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 ten (10) 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.

EXHIBIT KK

REPORTING SUSPECTED FRAUD AND ABUSE TO THE DEPARTMENT

The following requirements are adapted from 55 PA Code §1101, General Provisions 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) and Federal Regulations 42 C.F.R. §§438.608(a)(7-8) and 455.23(a). The basis for Recipient referrals is 55 PA Code §1101.91 and §1101.92, Recipient Misutilization and Abuse and Recipient Prohibited Acts. For information on these regulations, go to the Pennsylvania Code and Bulletin website.

Reporting Requirements:

PH-MCOs are required to report to the Department any act by Providers/Recipients/Caregivers/Employees that may affect the integrity of the HealthChoices Program under the Medical Assistance Program. Specifically, if the PH-MCO suspects that either Fraud, Abuse or Waste (as discussed in Section V.O.4, Fraud and Abuse, of the Agreement) may have occurred, the PH-MCO must report the issue to the Department's Bureau of Program Integrity (BPI). In addition to referrals to the Department, the PH-MCO is required to simultaneously submit fraud referrals to the Pennsylvania Office of Attorney General Medicaid Fraud Control Section in accordance with 42 C.F.R. §438.608(a)(7). The referrals shall be submitted \ using the Department's PH-MCO Referral Form. Fraud referrals submitted to the Department using the PH-MCO Referral Form will be automatically sent to the Pennsylvania Office of Attorney General's Medicaid Fraud Control Section. The PH-MCO must have a process to notify BPI of any adverse actions and/or provider disclosures taken during the credentialing/re-credentialing process. Depending on the nature or extent of the problem, it may also be advisable to place the individual Provider on prepayment review or suspend payments to avoid unnecessary expenditures during the review process.

In addition to referrals to the Department, the PH-MCO is required to simultaneously submit fraud referrals directly to the Pennsylvania Office of Attorney General, Medicaid Fraud Control Section as provided in 42 C.F.R. §438.608(a)(7). Fraud referrals to the Pennsylvania Office of Attorney General, Medicaid Fraud Control Section may be submitted by using the Department's PH-MCO Referral Form. Fraud referrals submitted to the Department using the PH-MCO Referral Form will be automatically forwarded by the Department to the Pennsylvania Office of Attorney General, Medicaid Fraud Control Section. After the referral form is submitted, the PH-MCO is required to upload the supporting documentation to the Department using DocuShare. The PH-MCO is also required to upload the same supporting documentation to the Office of Attorney General, Medicaid Fraud Control Section through ShareFile.

The PH-MCO must also notify the Department if it recovers overpayments or improper payments related to Fraud, Waste or Abuse of Medical Assistance funds from non-administrative overpayments or improper payments made to Network Providers, or

otherwise takes an adverse action against a Provider, e.g. restricting the Members or services of a PCP.

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, Waste or quality referrals must be made within thirty (30) days of the identification of the problem/issue. The PH-MCO must conduct a preliminary investigation to the level of an indication of indicia of fraud. The PH-MCO may informally consult with other state agencies or law enforcement to reach this determination. 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 to indicate the supporting documentation 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.

Failure to comply with the requirements of Exhibit KK will result in sanctions and or corrective action as stated in the HealthChoices Agreement. The Department must suspend all Medicaid payments to a provider after a determination that there is a credible allegation of fraud for which an investigation is pending against an individual or entity unless the Department has good cause not to suspend payments or to suspend payments in part. (42 C.F.R. 455.23 (a)). Upon notification from the Department of the imposition of a payment suspension, the PH-MCO, at a minimum, must also suspend payments to the provider.

The following processes are required for Provider/Caregiver and Employee referrals, unless prior approval is received from BPI. Reports must be submitted online using the PH-MCO Referral Form. Fraud allegations will result in an automatic dual referral to the Office of Attorney General and the Department. The instructions and form templates are located on the HealthChoices extranet website under Managed Care Programs/Fraud and Abuse.

Once completed, the PH-MCO must electronically submit the form to BPI. Additionally, the following information must be submitted to BPI electronically using a DocuShare folder designated by BPI:

- Checklist of Supporting Documentation for Referrals, accessible on the PH-MCO Referral Form,
- A copy of the confirmation page which will appear after the "Submit" button is clicked, submitting the PH-MCO Referral Form, and
- All supporting documentation. Referrals will not be processed but will be returned for

further development if they are received without all supporting documentation.

The same information must be uploaded to the Office of Attorney General, Medicaid Fraud Control Section ShareFile system.

If DocuShare is inaccessible for any reason, the PH MCO will notify the BPI contract monitor, then mail the supporting information above to the below address:

Department of Human Services
Bureau of Program Integrity – DPPC/DPR
P.O. Box 2675
Harrisburg, PA 17105-2675

All suspected member fraud, abuse and/or waste should be reported directly to the Bureau of Program Integrity's Recipient Restriction Section by the PH-MCO's Recipient Restriction Coordinator using the established restriction referral process.

In the event member fraud is suspected but the criteria for restriction is not met, the PH-MCO's Restriction Coordinator should forward all supporting documentation, including a narrative description of the alleged fraud, to the Department's Recipient Restriction Section.

All subsequent information should also be sent to the Recipient Restriction Section at:

Department of Human Services
Bureau of Program Integrity
Recipient Restriction Program
P.O. Box 2675
Harrisburg, PA 17105-2675
717-772-4627 (office)
717- 214-1200 (fax)

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, caregiver or staff person referrals –

- confirmation page from online referral
- FEIN#
- encounter forms (lacking signatures or forged signatures)
- timesheets
- attendance records of recipient
- written statement from parent, provider, caregiver, recipient or other individual that services were not rendered or a signature was forged
- 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, Department of Health certification, Medicare certification)
- copies of complaints filed by members
- admission of guilt 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, WASTE 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 provisions and related state and federal policies, including rules and regulations involving Fraud, Waste and Abuse issues, the Department will impose sanctions on the PH-MCOs as deemed appropriate where there is evidence of violations involving Fraud, Waste and Abuse issues in the HealthChoices Program. To that end, program compliance and improvement assessments, including financial assessments payable to BPI, will be applied by BPI for the PH-MCO's identified program integrity compliance deficiencies. Note that the Department also retains discretion to impose additional remedies available under applicable law and regulations.

FRAUD, WASTE AND ABUSE ISSUES WHICH MAY RESULT IN SANCTIONS

The Department may impose sanctions, for non-compliance with Fraud, Waste and Abuse requirements which include, but are not limited to, the following:

- A. Failure to implement, develop, monitor, continue and/or maintain the required compliance plan and policies and procedures directly related to the detection, prevention, investigation, referral or sanction of Fraud, Waste and Abuse by providers, caregivers, members or employees.
- B. Failure to cooperate with reviews by oversight agencies or their designees, including the Department, Pennsylvania Office of Attorney General Medicaid Fraud Control Unit, Office of Inspector General of the U.S. DHHS, and other state or federal agencies and auditors under contract to CMS or the Department 42 C.F.R. §438.3(h).
- C. Failure to adhere to applicable state and federal laws and regulations.
- D. Failure to adhere to the terms of the HealthChoices Agreement, and the relevant Exhibits which relate to Fraud, Waste and Abuse issues.
- E. If a PH-MCO fails to provide the relevant operating agency, upon its written request, encounter data, claims data and information, payment methodology, policies and/or other data required to document the services and items delivered by or through the PH-MCO to Members 42 C.F.R. §438.604.
- F. PH-MCO engaging in actions that indicate a pattern of wrongful denial of payment for a health-care benefit, service or item that the organization is required to provide under its agreement.

- G. If a PH-MCO or associate fails to furnish services or to provide members a health benefit, service or item that the organization is required to provide under its Agreement 42 C.F.R. § 438.700(b)(1).
- H. PH-MCO engaging in actions that indicate a pattern of wrongful delay of at least for 45 days or a longer period specified in the Agreement (not to exceed 60 days) in making payment for a health-care benefit, service or item that the organization is required to provide under its Agreement.
- I. Discriminating against Members or prospective Members on any basis including without limitation, age, gender, ethnic origin or health status 42 C.F.R. §438.3(d)(3-4)
- J. The PH-MCO must conduct a preliminary investigation and may consult with other state agencies or law enforcement to determine credible allegations of fraud for which an investigation is pending under the Medicaid program against an individual, a provider, or other entity (42 C.F.R. §455.23(a)). Allegations are to be considered credible when there is indicia of reliability and the State Medicaid agency has reviewed all allegations, facts and evidence carefully and acts judiciously on a case by case basis (42 C.F.R. §455.2).
- K. PH-MCO failure to pay overpayments to DHS as identified through network provider audits, reviews, investigations conducted by BPI or its designee and other state and federal agencies.

RANGE OF SANCTIONS

The Department may impose any of the sanctions indicated in Section VIII.H. of the Agreement including, but not limited to, the following:

- A. Preclusion or exclusion of the PH-MCO, its officers, managing employees or other individuals with direct or indirect ownership or control interest in accordance with 42 U.S.C. §1320a-7, 42 C.F.R. Parts 1001 and 1002; 62 P.S. §1407 and 55 Pa. Code §§1101.75 and 1101.77.

These sanctions may, but need not be, progressive. The Department's intends 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

A member with Special Needs is based upon a non-categorical or generic definition of Special Needs. This definition will include but not be limited to key attributes of ongoing physical, developmental, emotional or behavioral conditions or life circumstance which may serve as a barrier to the member's access to care or services. Examples of members with Special Needs will include but not be limited to: Children with Special Health Care Needs including those requiring skilled or unskilled home shift care, Children in Substitute Care, those with limited English Proficiency, or special communication needs due to sensory deficits those with Physical and/or Intellectual/ Developmental Disabilities, those with HIV/AIDS, those with significant behavioral challenges, or members requiring transportation assistance. Examples of factors in the determination of a member with 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 including, but not limited to, housing, food, and employment challenges;
- 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.

- Require assistance in discharge planning from an inpatient or long-term care or pediatric residential setting to ensure the member will receive services in the least restrictive environment possible.
- Any condition, event or life circumstance that as a result inhibits a member's access to any necessary service or support needed to address their medical condition or maintain their current level of functioning.

The PH-MCO will be required to develop, train, and maintain a unit within its organizational structure that will be responsible to provide support and case management services to members with Special Needs in a timely manner. This unit will be headed by a Special Needs Coordinator who must have access to and periodically consult with the Medical Director. The PH-MCO Special Needs Unit case manager must function as the single point of contact to coordinate all health care needs including social determinates of health needs for vulnerable populations. The case management staff must follow the Case Management Society of America standards of practice. Individual case management staff that are eligible should be certified case managers or be working toward certification. The staff members will work in close collaboration with the BMCO SNU 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, including the primary case management and care coordination for members and families receiving special needs services. 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, and the Department of Health District Offices, 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 including behavioral health and substance use disorder services, 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 to support housing, food and employment needs. 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 PH-MCO Special Needs Unit case manager must function as the single point of contact to coordinate all health care needs including social determinates of health needs for vulnerable populations. 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 and assisting in that process as needed or requested. Members with Special Needs determined to have ongoing needs for assistance 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.
- Work towards education and training in the use of LifeCourse™ tools.
- Meet face-to-face at least twice a year with the child and family and/or caregivers for the most complex members receiving shift care services. At least one of the face-to-face visits must be at the time of initial or recertification of shift care services. The PH-MCO staff must be appropriate licensed Special Needs Unit case management staff.
- Ensure coordination between the PH-MCO and other health, education, and human services systems including County Children and Youth Services Offices, County Office of Intellectual Disability Services Offices and Juvenile Justice Offices. For a more inclusive list see Exhibit OO.
- 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 the BMCO SNU staff and the Enrollment Assistance Program contractor's Special Needs contact person. The PH-MCO must 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, case managers, the Office of Medical Assistance Programs, the Enrollment Assistance Program contractor, Members with Special Needs, Providers (Network and Out-of-Network) and other health, education, and human services systems servicing Members with Special Needs and involved agencies.

- The PH-MCO Special Needs Unit must have a resource account email box in place for receipt of transition of care documentation to ensure timely access to all medically necessary services. The Special Needs Unit Coordinator and multiple staff must have access to this resource account.
- Appropriate arrangements must be made to effectively assist Members with Special Needs who speak languages other than English 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) and the Community Support Program (CSP) principles 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, substance use disorder 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.
- Conduct necessary training for all PH-MCO providers to acquaint them with the purpose and function of the Special Needs Unit and identify a contact within the Special Needs Unit as a direct contact for any provider to refer a member with special needs for assistance.
- Provide assistance to any member needing help in filing a Complaint, Grievance, or Fair hearing, and serve in an advocacy role to assist the member in obtaining any information necessary from any PH-MCO provider in support of a Complaint, Grievance or DHS Fair Hearing.
- Provide assistance to any member needing additional help to access the Department's Medical Assistance Transportation Program.
- Provide assistance to any member needing help transitioning from a pediatric to an adult provider. Proactively identify individuals between the ages of 18 and 21 that may be considered to be medically fragile members and provide enhanced assistance to them in transitioning to an adult provider. During this transitioning process ensure that they can receive care from a Pediatrician and adult Primary Care Provider at the same time to facilitate a seamless transition to adult care. These youth should be provided case management, at a minimum, until a successful transition is complete.
- Work in coordination with the Department's Resource Facilitation Team (RFT), other Department of Human Services Program Offices, and Service Coordinators to provide transition assistance to members receiving home shift care services under EPSDT into Home and Community Based Waivers and adult systems of support. This will include functioning as a liaison between the RFT and the member and family.
- For members in inpatient or residential facilities, provide assistance with discharge planning to ensure the member is transitioning not only to the most appropriate and community-based environment for the child as possible, but to ensure that the environment and supports are in place in the new setting prior to any discharge occurring. Provide all necessary oversight including home or site visits with family or other caregivers to ensure adequate supports are in place for a safe discharge. Members in residential facilities will be required to be in active case management by a PH-MCO case manager until the member is successfully discharged home or to another community or other care setting.
- Conduct face-to-face case management activities with members for whom telephonic case management has proven ineffective, and desired goals have not been attained. Utilize and interface with community-based care management staff to maintain a person-centered approach and to ensure that member-specific needs are being met.

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.

The Special Needs Unit will provide data as required for special needs related to existing and new Operations (OPS) Reports and ad hoc requests concerning members with special needs.

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.

- Community HealthChoices Managed Care Organizations (CHC-MCOs)
- HealthChoices Behavioral Health Managed Care Organizations (BH-MCOs)
- County Office of Drug and Alcohol Programs
- Department of Drug and Alcohol Programs (DDAP)
- 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 Helpline
- 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
- Opioid Use Disorder Centers of Excellence
- Career Link
- Office of Vocational Rehabilitation

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 via the Special Needs Unit hotline and listing of the SNU hotline number;
- 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.
- CC. Information about the Pennsylvania MA Provider Self Audit Protocol which allows Providers to voluntarily disclose overpayments or improper payments of MA funds.

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 Agreement Audits

The PH-MCO shall cause, and bear the costs of, an annual Agreement audit to be performed by an independent, licensed Certified Public Accountant. The Agreement audit shall be completed using guidelines provided by the Commonwealth. Such audit shall be made in accordance with generally accepted government auditing standards. The Agreement audit shall be digitally submitted to OMAP, BFM, Division of Financial Analysis and Reporting via the E-FRM system no later than June 30 after the Agreement year is ended.

If circumstances arise in which the Commonwealth or the PH-MCO invoke the contractual termination clause or determine the Agreement will cease, the Agreement 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 Agreement 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 ten (10) years from the date of final payment under the Agreement, 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, BFM, Division of Financial Analysis and Reporting via E-FRM within 30 days after the Auditors signature date.

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 Agreement;
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 Agreement terms and conditions; and
3. Program audits and reviews to measure the economy, efficiency and effectiveness of program operations under this Agreement.
4. The Commonwealth must periodically, but no less frequently than once every three (3) years, conduct or contract for the conduct of, an independent audit of the accuracy, truthfulness, and completeness of the encounter and financial data submitted by, or on behalf of, the PH-MCO.

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, Agreements 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 Agreement 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 Agreement period and ten 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 Agreement 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."

EXHIBIT XX

ENCOUNTER DATA SUBMISSION REQUIREMENTS AND PENALTY APPLICATIONS

The submission of timely and accurate Encounter Data is critical to the Department'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 REQUIREMENTS**

All PH-MCOs must be certified through the Department's MMIS prior to the submission of live Encounter Data. The certification process is detailed on the Pennsylvania HealthChoices Extranet.

- **SUBMISSION REQUIREMENTS**

- **Timeliness:**

With the exception of NCPDP Encounters, all PH-MCO approved Encounters and those specified PH-MCO-denied Encounters must be approved in the Department's MMIS by the last day of the third month following the month of initial PH-MCO adjudication. NCPDP Encounters must be submitted and approved in the Department's MMIS within thirty (30) days following the PH-MCO adjudication.

- **Metric:**

During the six months following the month of the initial MMIS adjudication, Encounters will be analyzed for timely submission.

- Failure to achieve the Department's MMIS approved/paid status for 98% of all PH-MCO paid/approved and specified PH-MCO denied Encounters by the last day of the third month following initial PH-MCO adjudication may result in a penalty.
- Any Encounter Data corrected or initially submitted after the last day of the third month following initial PH-MCO adjudication may be subject to a penalty.

Accuracy and Completeness:

Accuracy and completeness are based on consistency between Encounter Data submitted to the Department's MMIS and information for the same service maintained by the PH-MCO in their Claims/service history database.

- **Metric:**

Accuracy and completeness will be determined through a series of analyses of PH-MCO Claims history data and Encounters received and processed through the Department's MMIS. This analysis will be done at least yearly but no more than twice a year and will consist of making comparisons between encounter samples and what is found in the PH-MCO's claims history. Samples may also be drawn from the PH-MCO's service history and compared with Encounters processed through the Department's MMIS.

Samples will be drawn proportionally based on the PH-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	\$28,000
5.1 – 6.0 percent	\$34,000
6.1 – 7.0 percent	\$40,000
7.1 – 8.0 percent	\$46,000
8.1 – 9.0 percent	\$52,000
9.1 – 10.0 percent	\$58,000
10.1 percent and higher	\$100,000

EXHIBIT AAA

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 adhere to CMS network adequacy standards as outlined in 42 C.F.R. §438.68(b)(1)(viii), 438.68(b)(3), and 438.206. 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 (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-MCOs operating in Lehigh Capital, Southeast, and Southwest 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	Pediatric Dentistry

PH-MCOs operating in Northeast and Northwest 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
Orthopedic Surgery	Pediatric Dentistry
General Dentistry	

- ii. For the following provider types, the PH-MCOs operating in Lehigh/Capital, Southeast, and Southwest 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

The PH-MCOs operating in Northeast and Northwest 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
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 (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. 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, 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.

s. American Indians and Indian Healthcare Providers

Consistent with 42 C.F.R. §438.14(b)(1-3), 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;
- 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; and
- 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.

Consistent with 42 C.F.R. §438.14(b)(5-6), the PH-MCO must permit American Indian members to access out of state IHCPs; or permit an out-of-network IHCP to refer an American Indian member to a network provider.

When an IHCP is enrolled in Medicaid as an FQHC, but not a participating

provider of the PH-MCO, the IHCP must be paid an amount equal to the amount the PH-MCO would have paid to a network FQHC. When the IHCP is not enrolled in Medicaid as an FQHC, the PH-MCO must reimburse the IHCP at the same rate as the IHCP's applicable encounter rate published annually in the Federal Register by the Indian Health Service. If there is no published encounter rate, the IHCP must receive the amount it would have been reimbursed if the services were provided under the Pennsylvania MA FFS FQHC payment methodology.

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

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

Per 42 C.F.R. §438.68(b)(1)(viii), the PH-MCO must adhere to any time and distance access standards established by CMS. 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 each zone of operation, has the capacity to serve the expected Enrollment in each zone of operation. 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 BBB

OUTPATIENT DRUG SERVICES

1. General Requirements

- a. All requirements in this Exhibit apply to all Covered Outpatient Drugs regardless of the setting in which the drug is dispensed or administered, the billing provider type, or how the PH-MCO makes payment for the drug (pharmacy benefit and/or medical benefit).
- b. The amount, duration, and scope of Covered Outpatient Drugs must be consistent with coverage under the Fee-for-Service (FFS) program. 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.
- c. 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.
- d. 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.
- e. 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.
- f. 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.
- g. All proposed pharmacy policies, programs and drug utilization management programs, such as but not limited to prior authorization, step therapy, partial fills, specialty pharmacy, pill-splitting, mail order, 90-day supply programs, limited pharmacy networks, outcomes based contracting, medication therapy management programs, etc. must be submitted to the Department for review and

written approval prior to implementation, prior to implementation of any changes, and annually thereafter.

- h. 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, Statewide Preferred Drug List (PDL) prior authorization guidelines, if applicable, and FFS guidelines to determine medical necessity of drugs that require prior authorization in the MA FFS Program, when designated by the Department.
- i. The PH-MCO must submit for review and approval a policy for each section of Exhibit BBB that includes the requirements in the respective section and the PH-MCO’s procedures to demonstrate compliance.
- j. The PH-MCO must agree to adopt the same requirements for prior authorization and some or all of 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.
- k. 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.
- l. 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 Statewide PDL or MCO Formulary for drugs and products not included in the Statewide PDL, or through prior authorization, within ten (10) days from their availability in the marketplace.

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 must utilize the Statewide PDL developed by the Department's Pharmacy and Therapeutics (P&T) Committee.
If the PH-MCO fails to meet Statewide PDL quarterly compliance of 95% (excluding TPL) a financial sanction consistent with the difference in net cost using PH-MCO actual compliance rate and the net cost if compliance rate was 95%. The minimum penalty of \$25,000 per quarter will be imposed.
- b. The PH-MCO must implement use of the Statewide PDL, any changes to the Statewide PDL, the Statewide PDL prior authorization guidelines, and any changes to the Statewide PDL prior authorization guidelines on the effective date provided by the Department.
- c. The PH-MCO must apply Statewide PDL prior authorization guidelines to all drugs and products included on the Statewide PDL. The PH-MCO may not impose additional prior authorization requirements for drugs and products included on the Statewide PDL. Quantity limits can be no more restrictive than the Department's quantity limits.

The PH-MCO must submit the policies, procedures, and guidelines to determine medical necessity of drugs included on the Statewide PDL to the Department. Submissions must occur prior to the effective date of the changes as determined by the Department and at least annually.

- d. The PH-MCO may use a Formulary or PDL to manage MA covered drugs and products that are outside the scope of the Statewide PDL as long as the Department has prior approved it and the Formulary or PDL meets the clinical

needs of the MA population.

The Formulary or PDL must be developed and reviewed at least annually by the PH-MCO's P&T Committee, as defined in Section 6 of this Exhibit.

- e. 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, and this Exhibit.
- f. The PH-MCO must receive written approval from the Department of the Formulary or PDL, the list of specialty drugs, quantity limits, age edits, and the policies, procedures and guidelines to determine medical necessity of drugs and products not included on the Statewide PDL 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, the designation of specialty, and the requirements. PH-MCOs may add drugs to the specialty drug list that are in therapeutic classes already included on the specialty drug list prior to receiving approval from the Department. However, these additions must be included in the specialty drug designations submitted to the Department for written approval. Submissions for annual reviews must occur at least thirty (30) days before effective date of the updated information.
- g. The PH-MCO must submit all Formulary or PDL deletions for drugs and products outside the scope of the Statewide PDL to the Department for review and written approval prior to implementation.
- h. The PH-MCO must submit written notification of any Formulary or PDL additions for drugs outside the scope of the statewide PDL to the Department within fifteen (15) days of implementation.
- i. In addition to providing a link to the Statewide PDL on the PH-MCO's website, the PH-MCO must make available on the website in a machine readable file and format, information about its drug formulary or PDL, listing which medications are covered, including both brand and generic names.

4. Prior Authorization of Outpatient Drugs

- a. For Covered Outpatient Drugs that require Prior Authorization (including step therapy) as a condition of coverage or payment:
 - i. The PH-MCO must provide 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 must instruct the pharmacist to dispense either 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
 - 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 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. Requests for prior authorization will not be denied for lack of medical necessity unless a physician reviews the request for a medical necessity determination. Such a request for prior authorization must be approved when, in the professional judgment of the physician reviewer, the services are medically necessary to meet the medical needs of the Member.
- h. In addition, 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:

- i. That the prescriber did not make a good faith effort to submit a complete request, or
 - ii. That the service or item is not medically necessary, after making a minimum of three reasonable attempts to contact the prescriber prior to issuing a denial for the requested service. The reasonable attempts to contact the prescriber must be documented in writing.
- i. 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.
 - j. The PH-MCO guidelines to determine medical necessity of Covered Outpatient Drugs outside the scope of the Statewide PDL cannot be more stringent than the FFS guidelines. The PH-MCO must follow the Statewide PDL Prior Authorization guidelines for drugs and products included on the Statewide PDL.
 - k. 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 and annually thereafter.

5. Provider and Member Notification

The PH-MCO must have policies and procedures for notification to Providers and Members of changes to the Statewide PDL or MCO Formulary used by the PH-MCO for drugs and products outside the scope of the Statewide PDL, Prior Authorization requirements and other requirements for Covered Outpatient Drugs such as, but not limited to, specialty program requirements.

- a. Written notification for changes to 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 requirements upon request.
- c. The PH-MCO also must generally notify Providers and Members of changes through Member and Provider newsletters, its web site, or other regularly

published media of general distribution.

- d. Member notices must be submitted to the Department for review and approval prior to mailing.

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 thirty (30) days of the date of the meeting at which the minutes are approved. Minutes will include vote totals.

7. Pharmacy Provider Network

- a. The PH-MCO or Subcontractor 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.
 - i. The provisions for any willing pharmacy apply if the PH-MCO or Subcontractor enters into agreements with specific pharmacies to provide defined drugs or services such as but not limited to, specialty, mail order, and 90-day supplies. 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) and comply with the same terms and conditions for quality standards and reporting.
- ii. Subcontracts and agreements with specific pharmacies contracted to provide defined drugs or services must be submitted to the Department for advance written approval. Any changes to subcontracts or agreements must also be submitted to the Department for advance written approval.
 - iii. The PH-MCO must submit annually the list of specific pharmacies contracted to provide defined drugs or services, and a list of the drugs or services each pharmacy is contracted to provide, to the Department for review and written approval. Submissions for annual reviews must occur at least thirty (30) days before the effective date of the updated information.
 - iv. The PH-MCO must notify the Department on an ongoing basis of the following: (1) specific pharmacies that are no longer contracted to provide defined drugs or services and the reason why, (2) pharmacies that request contracting to provide defined drugs or services but are not admitted into the specific pharmacy network and the reason why, (3) any pharmacies that are only contracted to provide a limited scope of defined drugs or services and the reason why.
- b. The PH-MCO must develop, implement, and maintain a process that ensures the amount paid to all network pharmacies reflects the pharmacy's acquisition cost, professional services and cost to dispense the prescription to a Medicaid beneficiary. The PH-MCO must submit to the Department the policies and procedures for development of network pharmacy payment methodology including the process to ensure that brand and generic payment rates reflect the pharmacy's acquisition cost (from a readily available distributor doing business in Pennsylvania) and the professional dispensing fee accurately reflects the pharmacist's professional services and cost to dispense the prescription to a Medicaid beneficiary.
- c. The PH-MCO or subcontractor must submit to the Department for review and approval all changes to the payment methodology prior to implementation.
- d. The PH-MCO or subcontractor must report all changes to the payment methodology and rates, including but not limited to the maximum allowable cost rates, to network pharmacy providers.
- e. (1) If a network pharmacy's claim is approved through the adjudication process, the PH-MCO and any subcontractor may not retroactively deny or modify the payment unless any of the following:
- i. The claim was fraudulent.
 - ii. The claim was duplicative of a previously paid claim.
 - iii. The pharmacy did not render the service.
- (2) Nothing in 7.e.(1) shall be construed to prohibit the modification of or recovery of an adjudicated claim that was determined to be an overpayment or

underpayment resulting from audit, review or investigation by a federal or state agency or PH MCO.

- f. The PH-MCO and any subcontractor will not charge a fee related to a network pharmacy's claim unless the amount of the fee is disclosed and applied at the time of claim adjudication.

8. Drug 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 Outpatient Drug 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.

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.

The PH-MCO or subcontractor may not negotiate rebates and discounts for Covered Outpatient Drugs. The PH-MCO or subcontractor may not negotiate its own rebates and discounts for non-drug products included on the Statewide PDL. If the PH-MCO negotiates and collects its own rebates and discounts for non-drug products that are not included on the Statewide PDL, the PH-MCO must report to the Department the full value of the rebates and discounts in a format designated by the Department. If the PH-MCO assigns responsibility for negotiating and/or collecting the rebates and discounts for non-drug products not included on the Statewide PDL to a subcontractor, the subcontractor must pass the full value of all rebates and discounts on drugs dispensed to the PH-MCO's Members back to the PH-MCO. The subcontractor may not retain any portion of the rebates or discounts. The PH-MCO must report the full value of all the rebates and discounts to the Department in a format designated by the Department.

The PH-MCO or subcontractor may negotiate outcomes-based contracts for Covered Outpatient Drugs. The PH-MCO must submit the contract to DHS for review and

approval prior to implementation and report to the Department the full value of the financial impact of the outcomes-based contract in a format designated by the Department.

9. Outpatient Drug Encounters

- a. The PH-MCO shall submit all Outpatient Drug Encounters to the Department within 30 days (for NCPDP) and 90 days (for 837P and 837I) 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 by the Department to collect rebates through the Medicaid Drug Rebate Program and the Statewide PDL. 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.
 - 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.
 - 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
 - The PH-MCO shall also include the HCPCS units 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.
 - iii. Actual paid amount by the PH-MCO, or the PH-MCO's PBM, 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 PH-MCO, or the PH-MCO's PBM, to the provider for the drug dispensed.
 - vii. The billing provider's:

- NPI and/or Medical Assistance Identification Number
 - Full address and phone number associated with the NPI
- viii. The prescribing provider's:
- NPI and/or Medical Assistance Identification Number
 - 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, or the PH-MCO's PBM, 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, or the PH-MCO's PBM, 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 prescriber 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.
- 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.

10. Prospective Drug Utilization Review (Pro-DUR)

- a. 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.
- b. The PH-MCO must provide for counseling of Members receiving benefits from pharmacists in accordance with State Board of Pharmacy requirements.

11. Retrospective Drug Utilization Review (Retro-DUR)

- a. 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.
- b. 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.
- c. 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.

12. Annual Drug Utilization Review (DUR) Report

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.

13. 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.

14. 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 XII: Subcontractual 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, and identify the proposed PBM Subcontract, the PH-MCO's payment methodology or methodologies (ingredient cost and dispensing fee) for payment to the PBM Subcontractor, the PBM's payment methodology or methodologies (ingredient cost and dispensing fee) for actual payment to the providers of covered outpatient drugs, and the ownership of the proposed PBM subcontractor. If the PBM is owned wholly, in part, or by the same parent company as 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.

The PH-MCO must:

- a. Report the PBM's payment methodology, or methodologies for actual payment to all network pharmacy providers of covered outpatient drugs, including community pharmacies, long-term care pharmacies, network pharmacies contracted to provide specialty drugs, and dispensing prescribers for existing PBM Subcontractors and new PBM Subcontractors.
- b. Include on each outpatient drug encounter the PBM received amount (amount paid to the PBM by the PH-MCO [ingredient cost and dispensing fee]) and the provider received amount (the actual amount paid by the PBM [ingredient cost and dispensing fee] to the dispensing pharmacy or prescribing provider).

- c. Report differences between the amount paid by the PH-MCO to the PBM and the amount paid by the PBM to the providers of covered outpatient drugs as administrative fees.
- d. Report all PBM administrative fees, including the differences in amounts paid as described in d. above, in a format designated by the Department.
- e. Submit a written description of the procedures that the PH-MCO will put in place to monitor the PBM for compliance with the term and conditions of the Agreement related to covered outpatient drugs and actual payments to the providers of covered outpatient drugs.
- f. Upon request by the Department, conduct an independent audit of the PBM's transparent pricing arrangement in compliance with the provision in Exhibit WW HealthChoices Audit Clause.
- g. Ensure that the PBM is fully compliant with the requirements in Section V. K. Provider Dispute Resolution System.
- h. Develop, implement, and maintain a Second Level PBM Provider Pricing Dispute Resolution Process that provides for settlement of a PBM network Provider's pricing dispute with the PBM, on the condition that the PBM's network Provider exhausted all of its remedies against the PBM.
- i. Submit to the Department, prior to implementation, the PH-MCO's policies and procedures relating to the resolution of PBM Provider pricing disputes.
 - i. The PH-MCO must submit any changes to the policies and procedures to the Department for approval prior to implementation of the changes.
 - ii. The PH-MCO's submission of new or revised policies and procedures for review and approval by the Department shall not act to void any existing policies and procedures that have been prior approved by the Department for operation in a HC Zone. Unless otherwise required by law, the PH-MCO may continue to operate under such existing policies and procedures until the Department approves the new or revised version.
- j. At a minimum, include in the PH-MCO's Second Level PBM Provider Pricing Dispute Resolution policies and procedures the following:
 - i. The process for submission and settlement of Second Level PBM Provider Pricing Disputes;
 - ii. A requirement that the PBM Provider must exhaust all of its remedies against the PBM before requesting a PH-MCO Second Level PBM Provider Pricing Dispute Resolution;
 - iii. Acceptance and usage of the Department's definition/delineation of Provider Disputes;

- iv. Timeframes for submission and resolution of Second Level PBM Provider Pricing Disputes;
- v. Processes to ensure equal treatment of all PBM providers in the resolution of pricing disputes.
- vi. Process to ensure the paid amount reflects the pharmacy's drug acquisition cost, professional services, and cost to dispense the prescription to an MA beneficiary.
- vii. A requirement for both the PBM Provider and the PBM to provide documentation supporting each entity's position(s) related to the pricing dispute;
- viii. Designation of PH-MCO staff responsible for resolution of the PBM Provider Pricing Dispute who have:
 - The knowledge and expertise to address and resolve PBM Provider Pricing Disputes;
 - Access to data and documentation of the informal resolution of the PBM Provider Dispute and the formal PBM Provider Appeal and decisions necessary to assist in making decisions; and
- ix. Mechanisms and time-frames for reporting PH-MCO PBM Provider Pricing Dispute decisions to the PBM Provider, the PBM and the Department. If the dispute is denied by the PH-MCO, the Provider Pricing Dispute decisions must include the specific rationale for the denial;
- k. Require the PBM and the PBM provider to abide by the final decision of the PH-MCO. If the Provider Pricing Dispute is overturned by the PH-MCO, adjustment must be made to the appealed claim and to future claims for the appealed drug. The PBM/PH-MCO must update their payment methodology for the appealed drug; and
- l. Require the PBM to inform all PBM providers of the process and conditions to request a Second Level PBM Provider Pricing Dispute.

15. 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.

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 is also required to ensure that its participating providers are enrolled in Medical Assistance, and to require that their information is kept up to date in the DHS PROMIS^e™ system.

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 a Member 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 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 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-MCO's 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.
- x. The PH-MCO must require that each provider furnishing services to members maintains and shares, as appropriate, a member health record in accordance with professional standards.

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.

Exhibit DDD

PATIENT CENTERED MEDICAL HOME (PCMH) PROGRAM

The PCMH model of care includes key components such as: whole person focus on behavioral health and physical health, comprehensive focus on wellness as well as acute and chronic conditions, increased access to care, improved quality of care, team-based approach to care management/coordination, and use of electronic health records (EHR) and health information technology to track and improve care.

The PH-MCO will contract with high volume providers in their network who meet the requirements of a PCMH, make payments to their contracted PCMHs, collect quality related data from the PCMHs, reward PCMHs with quality-based enhanced payments, develop a learning network that includes PCMHs and other PH-MCOs, and report annually on the clinical and financial outcomes of their PCMH program.

- A. The PH-MCO will educate members what the PCMH model is and inform members of the resources available through the PCMH.
- B. The PH-MCO will ensure the PCMH provider meets the following requirements:
 - 1. Will be a high-volume Medicaid practice already participating in the PH-MCO provider pay for performance program or a defined set of practices willing to share care management resources,
 - 2. Will accept all new patients or be open for face-to-face visits at least 45 hours per week,
 - 3. Will join a Pennsylvania Patient and Provider Network (P3N) certified health information organization (HIO) by 12/31/2021 in order to share health related data,
 - 4. Will deploy a community-based care management team as described below:

The PCMH must deploy a community-based care management (CBCM) team that consists of licensed professionals such as nurses, pharmacists or social workers and unlicensed professionals such as peer recovery specialists, peer specialists, community health workers or medical assistants. The CBCM team's activities can replicate but not duplicate already existing and CBCM reimbursed care management services. The care management team will work within their local community to accept individuals with complex care needs from local emergency departments, physical and behavioral health hospitals, specialty providers, and PH-MCO. Through actively engaging patients and taking into account their preferences and personal health goals, the CBCM team will develop care plans that help individuals with complex chronic conditions to stay engaged in comprehensive treatment regimens that include, but are not limited

to physical health, substance use disorder and mental health treatments. The CBCM team will also connect individuals as needed to community resources and social support services through “warm hand off” referrals for assistance with problems such as food insecurity and housing instability.

5. Will collect and report annual quality data and outcomes pertinent to their patient population as defined by the current PH-MCO provider pay for performance program, the Integrated Care Plan pay for performance program, and additional population specific measures defined by the Department,
 6. Will conduct internal clinical quality data reviews on a quarterly basis, report results and discuss improvement strategies with the PH-MCO,
 7. Will measure patient satisfaction using a validated low literacy appropriate tool to assess individual and family/caregiver experience,
 8. Will include as part of the health care team patient advocates or family members to support the patients’ health goals and advise practices,
 9. Will see 75% of patients within seven days of discharge from the hospital with an ambulatory sensitive condition,
 10. Will participate in a PCMH learning network,
 11. Will complete a Social Determinants of Health assessment, at least annually and more frequent for patients who screen positive, using a Nationally recognized tool focusing on the following domains: food insecurity; health care/medical access/affordability; housing; transportation; childcare; employment; utilities; clothing and financial strain and submit ICD-10 diagnostic codes for all patients with identified needs. For patients with identified needs, the PCMH must assist the member with obtaining the needed services and monitor the outcome of the referral. The PCMH must track referrals and outcomes and be able to submit to the PH-MCO via claims submission the outcome of every Social Determinants of Health assessment performed using the HCPCS codes of G9919 (positive screening result) or G9920 (negative screening result) as well as providing the PH-MCO and Department a report of the SDOH assessment outcomes as may be requested, and
 12. Will educate and disclose to patients through low-literacy appropriate material the practice is a PCMH that has a community-based care management team available to help patients manage complex care needs.
- C. The PH-MCO will make monthly payments to each PCMH based on factors such as: clinical complexity, age, medical costs, and composition of the care management team.

- D. The PH-MCO's PCMH network will include high volume adult and pediatric providers that serve the percentage of total membership and percentage of members that fall within the top 5th percentile of medical costs.
- Calendar year 2021 – PCMHs' must serve at least 20% of their total membership and at least 33% of members that fall within the top 5th percentile of medical costs.
- E. The PH-MCO will collect key quality metrics from the PCMHs and report those results annually to the Department.
- F. The PH-MCO will reward PCMHs with quality-based enhanced payments focusing on key performance measures defined by the Department. Current provider pay for performance dollars may be used for these quality-based payments.
- G. The PH-MCO will develop a quarterly regional learning network that includes all PCMHs, patient advocates or family team members, and PH-MCOs in a HealthChoices region. At least one of the PCMH Learning Collaboratives needs to be face-to-face.
- H. The PH-MCO will report annually on the clinical and financial outcomes of their PCMH program. The report will address key quality, utilization, and financial outcomes as well as a return on investment calculation. The report will also describe the number of PCMHs that have gain share arrangements, risk arrangements, payments made for quality, and payments made for gain share or risk arrangements. The report will also list the total medical costs of the patients attributed to the PCMHs.
- I. Data Sharing
- The PH-MCO must provide timely and actionable data to its PCMHs. This data should include, but is not limited to, the following:
1. Identification of high risk patients;
 2. Comprehensive care gaps inclusive of gaps related to quality metrics used in the value-based payment arrangement; and
 3. Service utilization and claims data across clinical areas such as inpatient admissions, outpatient facility (SPU/ASC), emergency department, radiology services, lab services, durable medical equipment and supplies, specialty physician services, home health services, and prescriptions.
- J. The PH-MCO must work towards developing a value-based arrangement with Person-Centered Ambulatory Intensive Care Centers (PC-AICCs) in each zone they operate, unless the PH-MCO demonstrates to OMAP's satisfaction that the PH-MCO is not

able to reach an agreement with the PC-AICC. A PC-AICC is a practice that provide comprehensive physical and behavioral health care to those individuals who are high cost and in high need of medical and social services. These practices serve individuals who demonstrate non-episodic impactable medical costs over \$30,000 and are typically the costliest 2 - 3% of individuals who account for up to 40% of the PH-MCOs medical spend.