SECTION V: PROGRAM REQUIREMENTS

The Department may impose remediation for any CHC-MCO non-compliance with the CHC program requirements contained in this section.

A. Covered Services

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

The MCO may but is not required to impose copayments, but only for those services, items, and pharmacy services that have a copayment in the MA FFS delivery system and subject to the exemptions in the MA FFS delivery system. If the MCO imposes copayments, the amount of the copayments may not exceed the amounts imposed in the MA FFS delivery system. If the CHC-MCO is found to have overcharged Participants for copayments, they will be required to return the amount of the overcharge to the Participant. Network Providers and other Providers that may render services under the Agreement may not deny a covered service because a Participant is unable to pay the copayment amount, but the Provider may continue to attempt to collect the copayment amount.

1. Amount, Duration, and Scope

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

The CHC-MCO shall not arbitrarily deny or reduce the amount, duration, or scope of a Covered Service based on a Participant's diagnosis, disability, or type of illness/condition.

2. Home- and Community-Based Services

The CHC-MCO must provide Home and Community Based LTSS as Covered Services for Participants determined to be NFCE. The CHC-MCO must make HCBS LTSS services available seven (7) days per week, twenty-four (24) hours per day at any hour of the day and for any number or combination of hours, as dictated by Participants' needs and outlined in their approved PCSPs.

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

3. Program Exceptions

The CHC-MCO must establish a program exception process, reviewed and approved by the Department, whereby a Provider or Participant may request coverage, under extraordinary circumstances, for items or services that are of a type covered by the MA program but are not currently listed on the MA Program Fee Schedule. The CHC-MCO must use the program exception process to accept requests to exceed limits for items or services that are on the Fee Schedule if the limits are not based in statute or regulation. These requests are recognized by the Department as a Program Exception as described in 55 Pa. Code § 1150.63.

4. Expanded Services and Value-Added Services

The CHC-MCO may provide Expanded Services or Value-Added Services with prior written approval by the Department. Best practice approaches to delivering Covered Services are not Expanded Services or Value-Added Services.

If it provides Expanded Services or Value-Added Services, the CHC-MCO must offer the services to all Participants for whom the services are appropriate and must provide them at no cost to the Department. These services must be made available by appropriate Network Providers. The CHC-MCO may generally not condition these services on specific Participant performance; however, the Department may grant exceptions in limited circumstances if the CHC-MCO demonstrates the benefit of such condition for the Participant. Once an Expanded Service or Value-Added Service is approved, the CHC-MCO must continue to offer the service unless the CHC-

MCO is notified, in writing, by the Department to discontinue the service or the Department approves a request from the CHC-MCO to discontinue the service. The CHC-MCO must send written notice to Participants and affected Providers at least thirty (30) days prior to the effective date of the change and must simultaneously amend all written materials describing its Expanded Service or Value-Added Services.

The CHC-MCO is permitted and encouraged to offer LTSS Services as Expanded Services to Participants who are not NFCE.

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

The CHC-MCO may cover services or settings for Participants that are in lieu of those covered under the state plan if the Department determines that the alternative service or setting is a medically appropriate and cost-effective substitute for the covered service or setting under the state plan.

The CHC-MCO may also cover services or settings for Participants that are in lieu of those covered under the state plan if:

- the Participant is not required by the CHC-MCO to use the alternative service or setting
- the in lieu of service (ILOS) is annually authorized and approved by the Department, utilizing the template developed by the Department in Appendix 5
- the approved ILOS are authorized and identified in the CHC-MCO contract; and
- the approved ILOS are offered to Participants at the option of the CHC-MCO.

The Department may determine that certain in lieu of services, which are medically necessary and cost-effective alternatives to State Plan services or settings, may be provided by the CHC-MCO. CHC-MCOs are not required to provide in lieu of services but have the option to provide these approved services. Appendix 5 contains the required process/instructions for obtaining Department approval and a list of approved ILOS.

5. Referrals

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

The CHC-MCO must allow an Out-of-Network I/T/U HCP to refer a Participant who is an Indian to a CHC-MCO Network Provider as defined in 42 CFR § 438.14(a).

6. Self-Referral/Direct Access

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

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

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

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

delivery.

7. Drug Services

The CHC-MCO must provide coverage of prescription and OTC medicines for Participants who are not otherwise eligible for a Medicare Part D prescription drug plan. The CHC-MCO must provide pharmacy services for all other Participants. The CHC-MCO must coordinate pharmacy services with Medicare Part D, and other third-party pharmacy coverage so that the Participant receives the pharmacy services outlined in the Participant's PCSP. The CHC-MCO must offer assistance to Dual Eligible Participants in selecting a Medicare Part D plan, including advising on the benefit of enrolling in a Medicare Part D plan with a zero co-pay and assisting the Participant with obtaining health insurance counseling through Pennsylvania Medicare Education and Decision Insight (PA MEDI).

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

8. Emergency Services

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

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

The CHC-MCO may not:

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

Provider that is a licensed emergency medical services agency solely because the Participant did not require transportation or refused transportation.

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

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

The CHC-MCO may not deny payment for Emergency Services when:

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

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

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

A CHC-MCO may:

- Track, trend, and profile ED utilization;
- Retrospectively review and, where appropriate, deny payment for inappropriate ED use;
- Use appropriate methods to encourage Participants to use PCPs rather than EDs for symptoms that do not qualify as an Emergency Medical Condition; and
- Use a Participant Lock-In methodology for Participants with a history of significant inappropriate ED usage as referenced in Section V.X.1., Recipient Restriction Program.

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

CHC-MCOs must have procedures in place detailing actions to be taken when a CHC-MCO staff, such as a Service Coordinator, encounters or receives a call from someone experiencing a life-threatening medical or behavioral health crisis.

9. Post-Stabilization Services

The CHC-MCO must cover Post-Stabilization Services.

The CHC-MCO must limit charges to a Participant for Post-Stabilization Services to an amount no greater than what the CHC-MCO would charge the Participant if he or she had obtained the services through the Network.

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

a. The Post-Stabilization Services were administered to maintain the Participant's stabilized condition within one (1) hour of the Provider's request to the CHC-MCO for pre-approval of Post-Stabilization Services.

b. The Post-Stabilization Services were not pre-approved by the CHC-MCO because the CHC-MCO did not respond to the Provider's request for pre-approval of the Post-Stabilization Services within one (1) hour of the request.

c. The Post-Stabilization Services were not pre-approved by the CHC-MCO because the Provider could not reach the CHC-MCO to request pre-approval.

d. The CHC-MCO and the treating physician could not reach an agreement

concerning the Participant's care and a CHC-MCO physician is not available for consultation. In this situation, the CHC-MCO must give the treating physician the opportunity to consult with a CHC-MCO physician, and the treating physician may continue with the care of the Participant until a CHC-MCO physician is reached or one of the criteria applicable to termination of a CHC-MCO's financial responsibility described below is met.

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

a. A Network physician with privileges at the treating hospital assumes responsibility for the Participant's care;

b. A Network physician assumes responsibility for the Participant's care through transfer;

c. The CHC-MCO and the treating physician reach an agreement concerning the Participant's care; or

d. The Participant is discharged.

10. Examinations to Determine Abuse or Neglect

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

b. The CHC-MCO must inform Network Providers they are mandatory reporters and must require all Network Providers to know the procedures for reporting suspected abuse and neglect. This requirement must be included in all applicable Provider Agreements. The CHC-MCO must have a sufficient number of Network Providers qualified to conduct the specialty evaluations necessary for investigating alleged physical, psychological, emotional, and sexual abuse.

c. Should a Network PCP determine that a mental health assessment is needed, the PCP must inform the Participant or the APS or OAPS representative on how to access mental health services and coordinate access to these services, when necessary.

11. Hospice Services

The CHC-MCO must provide Hospice and use certified Hospice Providers in

accordance with 42 C.F.R. Part 418, Subpart G. The CHC-MCO must coordinate with Hospice Providers for Dual Eligible Participants who are receiving Hospice through their Medicare coverage. Hospice provided to Participants by Medicare-approved Hospice Providers is directly reimbursed by Medicare.

12. Organ Transplants

The CHC-MCO must pay for transplants to the extent that the MA FFS Program pays for such transplants. When Medically Necessary, the MA FFS program currently covers the following transplants: kidney, heart, heart/lung, lung, liver, pancreas, pancreas/kidney, intestinal, corneal, stem cell, bone marrow, or peripheral stem cell.

13. Transportation

The CHC-MCO must provide all Participants with Medically Necessary emergency ambulance transportation and Medically Necessary non-emergency ambulance transportation. The CHC-MCO must provide all NFCE Participants with non-medical transportation. The CHC-MCO may provide non-medical transportation to other Participants at its own discretion and own cost. Non-medical transportation includes transportation to community activities, grocery shopping, religious services, Adult Daily Living centers, employment and volunteering, and other activities or LTSS services as specified in the Participant's PCSP. CHC-MCOs must report non-medical transportation data on the OPS 008 (CHC-MCO Home Health (HH/Personal Assistance Services (PAS)/Transportation Services Not Delivered Report) report by the due date specified in the Operations Reporting Requirements Schedule. The CHC-MCO must provide at least 86% of requested non-medical transportation trips as authorized on the PCSP.

a) The CHC-MCO must pay rates for ambulance services that are not less than the amounts listed in PA's MA fee schedule.

b) Pending federal approval of a state plan amendment effective for dates of service on or after January 1, 2026, PA's MA schedule will include rates for ground ambulance services up to average commercial rates applicable only to ambulance providers owned by cities of the first or second class.

c) The requirements in subsections 13.a., and 13.b. above apply to any Subcontractor of the CHC-MCO, as required by Section V.X.2.

d) The CHC-MCO must provide confirmation to the Department as requested, on forms specified by the Department within the requested

timeframe, that payments to ambulance service providers have been made by the CHC-MCO in accordance with 13.a. and 13.b.

The CHC-MCO must provide non-emergency medical transportation for NF residents. The CHC-MCO must also provide any specialized non-emergency medical transportation for Participants, including transportation for Participants who are stretcher-bound.

All other non-emergency transportation for Participants to and from Medicare-covered services and Covered Services must be arranged through the MATP vendor.

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

1. Providing non-emergency medical transportation to and/or from a MA covered service received at a medical facility, doctor's or dentist's offices, hospital or clinic, pharmacy or supplier of medical equipment.

2. Providing the least costly and most appropriate transportation to meet the needs of Participants, including paid mass transit trips on buses or trains or rides in paratransit vehicles.

3. Reimbursement to the Participants for mileage at a rate determined by the Department, parking fees, and tolls with valid receipts, when the consumer uses their own car or someone else's to get to their medical provider.

4. Paratransit services that pick up and drop off Participants at the curb or driveway of their home or destination.

5. Providing transportation services when the Participant has no other available means of transportation for urgent, short notice trip requests. Requests for non-emergency medical needs requiring professional attention that can potentially develop into an emergency medical condition if treatment is delayed beyond 24 hours. During normal business hours, transportation must be scheduled within 3 hours of the request, and corresponding trips must be scheduled to enable completion within 24 hours of the request.

6. A hospital discharge shall be considered an urgent short-notice trip. Hospital discharges require especially prompt attention due to the associated costs of continuing a hospital stay. Therefore, trips for hospital discharges must be scheduled and provided within 24 hours, even when requested outside business hours. However, MATP Administrators are not obligated to accommodate unsafe discharge

conditions.

When requested, the CHC-MCO must arrange non-emergency medical transportation for urgent appointments for its Participants through the MATP. Some Participants may qualify for non-emergency medical transportation through programs such as Shared Ride. Because MATP is the payor of last resort, for Participants who require CHC-MCO assistance in coordinating non-emergency medical transportation the CHC-MCO must coordinate access to transportation through all available programs and not just the MATP program.

MATP agencies have been instructed to contact the CHC-MCO for verification that a Participant's request is for transportation to a Covered Service. The CHC-MCO should jointly undertake activities with MATP agencies such as sharing Provider Network information, developing informational brochures, and establishing procedures which enhance transportation services for Participants.

The CHC-MCO must arrange and coordinate transportation with the MATP providers so Participants receive the MATP services outlined in their PCSP.

MATP Administrators refer Participants who are enrolled in Community Health Choices to their respective CHC-MCO when requesting medically necessary non-emergency ambulance or stretcher transportation that the MATP Administrator is not able to provide.

If the MATP Administrator is unable to provide the requested transportation and has made efforts to seek possible local resources, the MATP Administrator will complete the MA 583 Transportation Referral Form, available on the MATP Website under the Provider Forms section and send it to the CHC-MCO's mailbox.

- The CHC-MCO will review the referral and determine if the Participant meets the criteria for Medically Necessary non-emergency ambulance transportation within two (2) business days of receipt and provide notification of the determination to both the Participant and MATP Administrator. Notification to the Participant must include, at minimum, a letter informing the Participant of determination and any applicable next steps, such as the CHC-MCO forwarding the referral to their CAO.

- If the CHC-MCO is also unable to accommodate the request, the CHC-MCO will complete and sign the referral form, attach it to the email from the MATP Administrator and forward to the CAO resource account, including the MATP Administrator and DHS Program Monitor, for consideration of a Medical Transportation Allowance (MTA). All denied referrals must be forwarded to the appropriate CAO within two (2) business days of the receipt of initial referral. A complete list of CAO

resource accounts may be found on the MATP website under Provider Information, Transportation Referral.

When a Participant reaches out directly to the CHC-MCO with a non-emergency medical transportation request, and the MATP Administrator has not already provided a referral, the CHC-MCO must complete the MA 583 Transportation Referral Form and forward it the MATP Administrator within 2 business days.

The county MATP Administrator, DHS Program Monitor, and/or MATP Standards and Guidelines, found on the MATP website, should be contacted or referenced for detailed policies and procedures in carrying MATP services.

14. Healthy Beginnings Plus Program

The CHC-MCO must provide services that meet or exceed HBP standards in effect as defined in 55 Pa. Code Chapter 1140 (relating to Healthy Beginnings Plus Program) and current or future guidance provided in MA Bulletins. The CHC-MCO must also continue the coordinated services relating to pregnancy included in the HBP Program by utilizing enrolled HBP Providers or developing comparable resources. The CHC-MCO must submit any such comparable programs to the Department for review and approval.

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

The HBP Program requires that pregnant women be adequately screened for substance use disorders and referred to treatment for positive screenings.

15. Nursing Facility Services

The CHC-MCO is responsible for payment for Medically Necessary NF services, including bed hold days up to fifteen (15) days per hospitalization if the NF satisfies the occupancy percentage requirements and up to thirty (30) Therapeutic Leave Days per year if a Participant is admitted to a NF or resides in a NF at the time of Enrollment.

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

personal care accounts, or other identified processes. CHC-MCOs must cover all Program required and necessary specialized services for CHC-enrolled Participants as mandated in the Federal PASRR regulations. In accordance with those regulations, which control, CHC-MCOs are required to provide supportive services to individuals residing in nursing facilities who have been determined to have a condition that meets program criteria for Mental Health, ID/DD, and ORC (Physical, Sensory, or Neurological disability), for which they require specialized services. These services are ancillary to the services a nursing facility generally provides. For individuals with Mental Health conditions, the CHC-MCOs in coordination with the BH-MCO, must at a minimum provide specialized services for partial psychiatric hospitalization, psychiatric outpatient clinic, mobile mental health treatment, crisis intervention services, targeted mental health case management and resource coordination, peer support services, and outpatient drug and alcohol services. For individuals with ID/DD, the CHC-MCOs must at a minimum provide assistive technology, behavioral support, communication specialist, companion services, housing transition and tenancy sustaining services, in-home and community support, supports coordination, support in a medical environment, and transportation. For individuals with an Other Related Condition, the CHC-MCOs must at a minimum provide specialized services for service coordination/advocacy, community integration, peer counseling/support groups, training, and transportation needed to access specialized services. BH-MCOs are responsible for payment of behavioral health specialized services. CHC-MCOs must ensure that their staff is adequately educated on the PASRR process to include specialized services.

16. Participant Self-Directed Services

When Personal Assistant Services are identified as a service need in a PCSP, CHC-MCOs must offer and educate Participants who are eligible for HCBS the opportunity to self-direct Personal Assistance Services as the first option over the traditional agency model, through one of the following models. CHC-MCOs must discuss what this model entails and provide educational materials to Participants on the self-directed model of care. CHC-MCOs must document the rationale given if a Participant decides to opt out of the self-directed model.

a. Vendor/Fiscal Employer Agent

- Participants may elect the Participant-Directed Employer Authority model, in which the Participant employs his or her own personal assistance and/or respite provider, who can be a family member, a friend, a neighbor, or any other qualified personal assistance worker as determined by the Department. Participants in this model may elect to

also receive some of their services through an agency or both; or

- Participants may elect the Budget Authority model called Services My Way, in which the PCSP is converted to a budget and the Participant develops a spending plan to purchase needed goods and services. Participants in this model may elect to receive personal assistance and/or respite services through an agency or to employ their own personal assistance providers, or both.

Under the Participant-Directed Employer Authority model and Budget Authority model an FMS vendor processes timesheets, makes payments, and manages all required tax withholdings, including Federal Insurance Contributions Act (FICA) taxes, for personal assistance workers employed by Participants under either self-directed model. A full FMS description can be found in Exhibit CC, Financial Management Services (FMS).

b. Agency with Choice

- Upon Federal approval, Participants may elect the Participant-Directed Agency with Choice (AWC) model, in which the participant selects his or her own personal assistance service and/or respite worker, who can be a family member, a friend, a neighbor, or any other qualified personal assistance worker as determined by the Department. The Participant is supported by an agency that provides administrative functions to the DCWs recruited by the Participant. The Participant directs the DCWs and is considered their managing employer. The Participant, as the managing employer, is responsible for, selecting and dismissing DCWs, directing the responsibilities of their DCWs, scheduling, and arranging for back-up services (with assistance from the Agency as requested), and any individualized training.

  The CHC-MCO may use only the AWC entity(ies) procured by the Department and must establish agreements and cooperate with the Commonwealth-procured AWC entity in order that necessary AWC services are provided to Participants. The CHC-MCO is responsible for paying the AWC provider:

- Reimbursement for payments the AWC FMS provider makes on behalf of the Participant-employer for workers' training, required pre-service orientation and wages.

- A per-member per-month fee to perform the tasks outlined in the AWC FMS service description

CHC-MCOs must at a minimum exceed baseline counts per CHC-MCO as of September 2025 as determined by Department data for the number of

Participants receiving services in the self-directed model of care in each of the CHC Zones.

CHC-MCOs must develop and implement strategies to increase education on the use of participant self-directed services. The Department will monitor the CHC-MCOs progress towards an increase in the use of Participant self-directed services through ad hoc and operations reports.

17. Health and Wellness Education and Outreach for Participants and Caregivers

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

18. Settings for HCBS

The CHC-MCO must provide services in the least restrictive and most integrated setting. The CHC-MCO shall only provide HCBS in settings that comply with 42 C.F.R. § 441.301. NFCE Participants who are residing in Personal Care Homes as of the Implementation Date will be permitted to remain in those settings while in CHC. Settings cannot be located on the grounds of a NF, Intermediate Care Facility, Institution for Mental Disease, or a Hospital, unless it meets the standards for the heightened scrutiny process established under 42 C.F.R. § 441.301(c)(5) and is included in the PCSP.

The CHC-MCO must work in collaboration with the Department to assess settings for compliance, which includes, but is not limited to, the following:

a. The CHC-MCO must identify a point person to participate in Department activities related to settings compliance with 42 C.F.R. § 441.301.

b. The CHC-MCO must comply with Department decisions on provider disenrollment in accordance with Exhibit V, CHC-MCO Requirements for Provider Terminations.

CHC-MCOs must also submit within ten (10) business days of identification any possible instances of non-compliance they identify in a format determined by the Department. The CHC-MCO remains obligated to comply with the regulations and may not provide services in a non-compliant setting.

19. Service Delivery Innovation

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

a. Housing innovation that includes but is not limited to:

   i. Pre-tenancy and tenancy supports that help Participants at risk of homelessness or institutionalization obtain and maintain homes in the community, including but not limited to: outreach to and engagement of Participants, housing search assistance, assistance applying for housing and benefits, assistance with SSI eligibility processes, advocacy and negotiation with landlords and other tenants, moving assistance, eviction prevention, motivational interviewing, and incorporating social determinants of health into the person-centered planning process.

   ii. Participation in local and statewide housing collaboratives to address housing barriers for individuals transitioning from a nursing facility or at risk of a nursing facility placement and cooperating with other local and state housing agencies and social services organizations on housing initiatives.

b. Employment innovation that supports a Participant's ability and efforts to seek, find, and maintain competitive integrated employment or self-employment.

c. Workforce innovation that improves the recruitment, retention, and skills of direct care workers, which may include but are not limited to direct or enhanced payment and other incentives to Providers, Participant-Directed employers, and direct care workers for education,

training, and other initiatives designed to enable direct care workers to become a more functional member of the PCPT. Such initiatives may include but not be limited to:

- Labor/management partnerships or employee/employer partnerships;
- Training programs that exceed DOH and DHS requirements for direct-care worker qualifications, including programs to address complex needs of Participants;
- Pre-service orientation;
- Promotion of direct-care worker organizations and associations;
- Professional support, certifications, and career-ladder opportunities;
- Care team integration that engages front line workers;
- Marketing for the purposes of education and increased awareness of Participant-directed services options.

d. Technology innovation that supports a Participant's ability and efforts to lead a healthy and independent life in the community, which may include but not be limited to home monitoring and telemedicine applications and any future Departmental initiatives related to the utilization of advanced technology.

e. CHC-MCOs must contract with at least one Health Information Organization that is capable of connecting to the PA Patient and Provider Network (or "P3N"). CHC-MCOs must work to ensure that any SDOH assessment or referral tool used by the CHC-MCO will be interoperable with the Health Information Exchange and the statewide resource and referral tool, PA Navigate.

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

20. Exceptional Durable Medical Equipment

The CHC-MCO must provide Exceptional DME to NF residents. The CHC-MCO must have a process to provide a separate payment for Exceptional DME, Ventilators, and related supplies. The CHC-MCO must also have a process for directly paying a DME vendor for Exceptional DME.

The Department separately includes Exceptional DME from standard DME in

developing the capitation rates. In the event of an Exceptional DME purchase, the equipment will belong to the Participant. The CHC-MCO will pay the DME vendor directly for Exceptional DME. The amount of the additional payment authorized is based upon the necessary, reasonable, and prudent cost of the Exceptional DME.

A Ventilator Authorization allows exceptional payments under specific terms to a NF, in addition to the NF's per diem rate, for NF services that are provided for the use of certain ventilator supplies. The amount of the additional payment authorized is based upon the necessary, reasonable, and prudent cost of the Ventilators and related supplies specified in the agreement with the NF.

The CHC-MCO must provide, in accordance with then-existing Department policies and procedures, an Exceptional DME or Ventilator payment where the Exceptional DME or Ventilator is Medically Necessary, and it must be specially adapted for the Participant or designated by the Department. The Department will publish an annual list of Exceptional DME by notice in the *Pennsylvania Bulletin.*

21. Dental Benefit Limit Exceptions (BLEs)

The CHC-MCO has the option to impose the same benefit limits or lesser benefit limits as the Department. For dental services that are covered in a Participant's benefit package only with an approved BLE, the CHC-MCO must use the same criteria as the Department or may use criteria that are less restrictive for its review of a BLE request.

The CHC-MCO must establish and maintain written policies and procedures for its dental BLE process. The CHC-MCO must receive advance written approval from the Department of these policies and procedures. The policies and procedures must comply with guidance issued by the Department. The CHC-MCO's submission of revised policies and procedures for review and approval by the Department shall not act to void any existing policies and procedures which have been prior approved by the Department for operation in a CHC Zone. Unless otherwise required by law, the CHC-MCO may continue to operate under such existing policies and procedures until such time as the Department approves the new or revised version thereof.

The Department may periodically request ad hoc information related to CHC-MCO operations surrounding these dental BLE requests.

If the CHC-MCO imposes benefit limits, the CHC-MCO must issue notices to its Participants and notify network providers at least thirty (30) days in advance of the changes. The Participant notices must receive advance Department approval prior to being sent to Participants.

The time frames for notices of decisions for prior authorization set forth at Section V.B.2 and V.B.3. apply to requests for BLEs. If the CHC-MCO denies a BLE request, the CHC-MCO must issue a written denial notice, using the appropriate template available in DocuShare.

If the Participant is currently receiving a service or item that is subject to a benefit limit and the request for a BLE is denied, and the Participant files a complaint, grievance or request for a Fair Hearing that is postmarked or hand-delivered within 10 days of the date of the notice, the CHC-MCO must continue to provide the service until a decision is made.

Participants with approved BLE's are in a course of treatment. As such, the requirements for Continuity of Care for Course of Treatment Services Not Requiring Prior Authorization for Adults Age 21 and Older and Children Under the Age of 21, set forth in MA Bulletin 99-03-13, Attachment D, apply. CHC-MCOs are required to honor all approved BLE requests issued by the Fee-for-Service (FFS) program, another CHC-MCO, or a PH-MCO. The FFS delivery system and PH-MCOs will also honor all approved BLE requests issued by CHC-MCOs.

22. Complex Care Unit

The CHC-MCO must develop, train, and maintain a Complex Care Unit for complex case management and hard to place cases within its organizational structure that will be responsible to provide support and case management services to Participants with complex care needs. The purpose of the Complex Care Unit is to ensure that all Participants with complex circumstances, such as traumatic brain injury or ventilator dependence, are able to receive all necessary services and supports in a timely manner. The Complex Care Unit must also assist each Participant with a complex condition with access to services and information relevant to their special condition or circumstance. The Complex Care Unit must proactively identify and outreach to both NFCE and NFI Participants with special needs to provide these services and information. These services will include all those needed by a Participant with a complex condition to address their condition or circumstance.

23. Telemedicine

The CHC-MCO shall pay for Medically Necessary In-Plan Services provided through Telemedicine if the health care service would be covered through an in-person encounter and the provision of the health care service through Telemedicine is consistent with Federal law and regulations, the laws of this Commonwealth, applicable regulations and clinical guidance. This payment responsibility does not apply if the Telemedicine-enabling device, technology or service fails to comply with HIPAA, the HITECH Act, or other applicable statutes, regulation or guidance from the federal government or the

Department.

The CHC-MCO shall pay a Network Provider for In-Plan Services delivered through Telemedicine in accordance with the terms and conditions of this Agreement.

B. Prior Authorization of Services

1. General Prior Authorization Requirements

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

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

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

When the CHC-MCO makes a decision to deny, in whole or in part, a request for a service or item, the CHC-MCO must issue a written notice of denial using the appropriate notice templates provided by the Department. Denial notices must include specific details regarding every reason for denial, citing specific factors that were considered and why the Participant's condition did not meet criteria for approval. The CHC-MCO must write denial notices at a 6th grade reading level and must include specific references to approved medical necessity guidelines, rules, and/or protocols on which the decision was based. If the request was denied because of insufficient information, the

CHC-MCO must identify all additional information needed to render a decision. In the case of a denial of a previously authorized service, a reduction in benefits, the denial notice must contain specific information about the change in the Participant's condition, or the error made when the CHC-MCO previously authorized the service, that justifies the denial or reduction. In addition, the CHC-MCO must make the notice available in accessible formats for individuals with visual impairments and for persons with LEP. If the CHC-MCO receives a request from the Participant, prior to the end of the required period of advance notice, for a translated and/or accessible version of the notice of denial, the required period of advance notice will begin anew as of the date that the CHC-MCO mails the translated and/or accessible notice of denial to the Participant.

The CHC-MCO may not require Prior Authorization of Medicare services for Dual Eligible Participants. If coverage of the service is denied by Medicare, the CHC-MCO may require Prior Authorization if such authorization is required under the CHC-MCO's approved Prior Authorization policies and procedures. If the CHC-MCO does not require Prior Authorization of the services, the CHC-MCO will approve the service.

Service Coordinators are required to work with the Participant's Medicare plan to obtain expeditious decision-making and communication of decisions.

2. Time Frames for Notice of Decisions

a. The CHC-MCO must process each request for Prior Authorization and notify the Participant of the decision as expeditiously as the Participant's health condition requires, or at least orally, within two (2) business days of receiving the request, unless additional information is needed. If no additional information is needed, the CHC-MCO must mail written notice of the decision to the Participant, the Participant's PCP, and the prescribing Provider within two (2) business days after the decision is made. The CHC-MCO may make notification of coverage approvals via electronic notices as permitted under 28 Pa. Code § 9.753(b). The two (2) business day decision timeframe for physical health services requests begins on the date the prescribing provider submits the request. The two (2) business day notification timeframe for HCBS requests begins on the date that the updated PCSP is finalized as a result of the assessment and signed by the Participant, or when an assessment is not necessary, on the date the request is made by the Participant or Participant's representative, which may include the Participant's Provider, or the Participant's Service Coordinator. If additional information is needed to make a decision, the CHC-MCO must request such information from the appropriate Provider within two (2) business days of receiving the request and allow fourteen (14) days for the Provider to submit the additional information. If the CHC-MCO requests additional information,

the CHC-MCO must notify the Participant on the date the additional information is requested, using the template provided by the Department, Request for Additional Information Letter. Timeframes specific to home/vehicle modifications, pest eradication, or assistive technology decisions are addressed in Section V.B.3.

b. If the requested information is provided within fourteen (14) days, the CHC-MCO must make the decision to approve or deny the service, and notify the Participant orally, within two (2) business days of receipt of the additional information. The CHC-MCO must mail written notice of the decision to the Participant, the Participant's PCP, and the prescribing Provider within two (2) business days after the decision is made.

c. If the requested information is not received within fourteen (14) days, the CHC-MCO must make the decision to approve or deny the service based upon the available information and notify the Participant orally within two (2) business days after the additional information was to have been received. The CHC-MCO must mail written notice of the decision to the Participant, the Participant's PCP, and the prescribing Provider within two (2) business days after the decision is made.

d. In all cases, the CHC-MCO must make the decision to approve or deny a covered service or item and the Participant must receive written notification of the decision no later than twenty-one (21) calendar days from the date the CHC-MCO received the request, or the service or item is automatically approved. To satisfy the twenty-one (21) day time period, the CHC-MCO may mail written notice to the Participant, the Participant's PCP, and the prescribing Provider on or before the eighteenth (18th) day from the date the request is received. If the notice is not mailed by the eighteenth (18th) day after the request is received, the CHC-MCO must hand deliver the notice to the Participant by the twenty-first (21st) day, or the request is automatically approved.

e. If the Participant is currently receiving a requested service and the CHC-MCO decides to deny the Prior Authorization request, the CHC-MCO must mail the written notice of denial at least ten (10) days prior to the effective date of the denial of authorization for continued services. If probable Participant fraud has been verified, the period of advance notice is shortened to five (5) days. The CHC-MCO is not required to provide advance notice when it has factual information of the following:

- confirmation of a Participant's death.
- receipt of a clear written statement signed by a Participant that she or he no longer wishes the requested service or gives information that requires termination or reduction of services and indicates that she or he understands that termination will be the

result of supplying that information. The Participant's signature on the PCSP alone does not constitute the "clear written statement" that is required under this provision.

- the Participant has been admitted to an institution where she or he is ineligible under CHC for further services.
- the Participant's whereabouts are unknown and the post office returns mail directed to him or her indicating no forwarding address.
- the CHC-MCO established the fact that the Participant has been accepted for MA by another State.
- a change in the level of medical care is prescribed by the Participant's physician.
- the notice involves an adverse determination with regard to preadmission screening requirements of section 1919(e)(7) of the Act (relating to nursing facility admission of individuals with mental illness or intellectual disabilities).
- the transfer or discharge from a facility will occur in an expedited fashion.

3. Time Frames for Notice of Decision for HCBS Waiver Home or Vehicle Modifications, Pest Eradication, or Assistive Technology Requests

The CHC-MCO must evaluate and mail a decision for each home/vehicle modification, pest eradication, or assistive technology request within sixty (60) business days of the date of request. The date of the request is deemed as when the Participant or Participant's representative requests the service or item, or the date the need for these services are identified during an assessment or nursing home transition process. During the sixty-day time frame the CHC-MCO must obtain all information pertinent to rendering a decision and mail the Participant the notice of decision by sixty (60) business days. Requests for additional information must be mailed within fifteen (15) business days of receiving the request and must allow thirty (30) business days for the additional information to be provided. Upon receipt of the additional information the CHC-MCO must make a determination as expeditiously as the Participant's health condition requires and send the Participant notification of the decision. If the service is approved, the CHC-MCO must initiate the process necessary to complete the task within seven (7) business days of authorization by inclusion on the Participant's PCSP. If by sixty (60) business days the CHC-MCO has not been provided the information necessary to render a decision a denial notice shall be mailed. If the service is denied due to missing information and that information is later received, the request should be reopened as a new request and the process should continue when feasible.

During the sixty (60) business days, the CHC-MCO must obtain all information pertinent to rendering a decision as detailed in the CHC 1915(c) waiver.

Service Coordinators must clearly communicate the process to the Participant, including the information needed within sixty (60) business days and that when feasible the request may be reopened if the needed documentation is received after the denial notice is issued.

In cases where the item or service requested is not a covered service, the CHC-MCO must make a determination within two (2) business days of receipt of the request and mail a denial notice within two (2) business days of the decision.

4. Prior Authorization of Pharmacy Services

The CHC-MCO must comply with the requirements of Exhibit D, Drug Services, specific to Prior Authorization of Drug Services.

C. Continuity of Care

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

1. NF Residents

A Participant who was already residing in a NF on the CHC Implementation Date must receive NF services from the same NF until the earliest date any of the following:

a. The Participant's stay in the NF ends.
b. The Participant is disenrolled from CHC.
c. The NF is no longer enrolled in the MA Program.

If a Participant appeals a decision to transfer or discharge the Participant from the NF, the continuity of care period will continue until the Participant's appeal is adjudicated by BHA.

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

The CHC-MCO in which the Participant is enrolled must enter into an agreement or payment arrangement with the Participant's NF to make payments for the Participant's NF services during the continuity of care period, regardless of whether the NF is in the CHC-MCO Network. The Department is requiring the extended continuity of care provision described above to avoid unnecessary disruptions in continuity of care for NF residents and to promote their quality of care and quality of life. To meet this requirement the Department expects CHC-MCOs to pay all NFs at the FFS level unless the parties otherwise agree to another payment arrangement. The CHC-MCO may require Out-of-Network NFs to meet the same requirements as Network NFs, with the exception that a CHC-MCO may not require Out-of-Network Providers to undergo full credentialing.

Participants who do not qualify for the continuity of care period in this section, will receive the continuity of care described in Sections C. 3.

2. All Participants

For all Participants, the CHC-MCO must comply with continuity of care requirements for continuation of physical health Providers, services, and any ongoing course of treatment outlined in MA Bulletin 99-03-13, Continuity of Care for Recipients Transferring Between and Among Fee-for-Service and Managed Care Organizations. To ensure continuity of services for Participants receiving LTSS, CHC-MCOs must obtain the transitioning Participants' current PCSP or obtain an electronic record that includes all of the information contained in the current PCSP. CHC-MCOs must contact the providers identified in the service plan from the transferring Fee-for-Service program or CHC-MCO to confirm continuation of service authorization and payment. The term contact means the CHC-MCO provides an authorization of service that includes the type, scope, amount, duration, and frequency of services to be provided. The CHC-MCO must initiate contact within two business days of the date the CHC-MCO receives the PCSP or electronic record. LTSS identified on the Participants PCSP must remain in place until a reassessment is completed.

3. Other Care or Service Plan Transition

For a Participant who is receiving home- and community-based services other than through an HCBS Waiver on the Participant's Start Date, the CHC-MCO must coordinate the Participant's transition into CHC with entities that are providing care or Service Coordination to the Participant at the time of their CHC Enrollment. Entities might include but are not limited to the Act 150 program, the OPTIONS program or OMAP's Special Needs Unit. If a Participant becomes financially ineligible for CHC, their service coordinator shall provide them with information for the Act 150 Program.

D. Choice of Provider

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

E. Comprehensive Needs Assessments and Reassessments

The CHC MCOs must screen each new Participant who is not NFCE for need within ninety (90) days of the Start Date. For purposes of this screening, a Participant would be considered new to the CHC-MCO if they were not enrolled with the CHC-MCO 365 days prior to the current enrollment. This requirement is separate from the assessment of those with LTSS or other special health needs.

The CHC-MCO must conduct a Comprehensive Needs Assessment (Assessment) of every Participant who is determined NFCE. If the Participant has not been determined NFCE, then the CHC-MCO must conduct an Assessment of a Participant when the Participant requests an Assessment or self-identifies as needing LTSS or if either the CHC-MCO or the IEB identifies that the Participant has unmet needs, service gaps, or a need for Service Coordination.

The CHC MCO must complete an in-person Assessment in accordance with the timeframes noted below.

- For NFCE Participants who are not receiving LTSS on their Enrollment Date, no later than five (5) business days from the Start Date.
- For Dual Eligible Participants identified by the IEB as having a need for immediate services, no later than five (5) business days from the Start Date.
- For Participants who are identified as having unmet needs, service gaps, or a need for Service Coordination, no later than fifteen (15) business days from the date the CHC-MCO is aware of the unmet needs, service gaps, or need for Service Coordination.
- When requested by a Participant or a Participant's designee or family member, no later than fifteen (15) days from the request.

The CHC-MCO must conduct a Comprehensive Needs Reassessment (Reassessment) of NFCE Participants at least annually (at least once every 365 days) following the most recent prior Assessment or Reassessment unless a trigger event occurs. CHC-MCOs may conduct a Reassessment prior to the

one-year mark of the last Assessment for Participants who are transitioning to them from another CHC-MCO. If a trigger event occurs, the CHC-MCO must complete a Reassessment as expeditiously as possible in accordance with the circumstances and as clinically indicated by the Participant's health status and needs, but in no case more than fourteen (14) days after the occurrence of the following trigger events:

- A significant healthcare event to include but not be limited to a hospital admission, a transition between healthcare settings, or a hospital discharge.
- A change in functional status.
- A change in caregiver or informal support status if the change impacts one or more areas of health or functional status.
- A change in the home setting or environment if the change impacts one or more areas of health or functional status.
- A change in diagnosis that is not temporary or episodic and that impacts one or more area of health status or functioning.
- As requested by the Participant or designee, caregiver, Provider, or the PCPT or PCPT Participant, or the Department.

In addition to the trigger events listed above, if the CHC-MCO identifies that a Participant has not been receiving services to assist with activities of daily living, as indicated on the service plan, for five (5) consecutive scheduled days of service or more, and the suspension of services was not pre-planned, the CHC-MCO must communicate with the Participant to determine the reason for the service suspension within 24 hours of identifying the issue. If a Participant receives an alternative HCBS in this five (5) day span during which activities of daily living are addressed, outreach by the CHC-MCO is not required.

If, after communicating, the CHC-MCO determined that the Participant's health status or needs have changed, then the CHC-MCO must conduct a Reassessment within fourteen (14) days of identifying the issue. Unless one of the trigger events listed in this section occur, or the Participant has transitioned from another CHC-MCO, the Reassessment cannot be conducted more than sixty (60) days prior to the one-year mark of the last Assessment date.

CHC-MCOs must have a process in place for the identification and real-time review of Participants whose Reassessments have resulted in a significant change in level of care. CHC-MCOs must submit their process to DHS for review and approval utilizing a mechanism prescribed by the Department. The process should include how the CHC-MCO will identify Participants with significant changes (e.g., those participants who were previously assessed NFCE and are now being assessed as NFI, and Participants who have new crisis level behavioral health needs), and how these situations are being concurrently identified and reviewed before Reassessments are finalized. In addition, CHC-MCOs must detail their process for how their Service

Coordinators can consult with CHC-MCO clinical teams regarding any questions or concerns.
CHC-MCOs should utilize the Minimum Data Set (MDS) to evaluate if a Participant requires a Reassessment while in a nursing facility. For Participants who have been in a nursing facility for more than six (6) months, the MCO should conduct an appropriate assessment, including the Inter RAI for Participants who will be receiving HCBS in the community, to determine the Participant's HCBS needs in order to develop a new PCSP upon discharge to community living.

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

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

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

Participants in the participant self-directed model of care assessed as requiring greater than sixteen (16) hours of PAS per day must receive all of the following:

- A Service Coordinator with at least one year of experience.
- A minimum of four (4) in person visits by the Service Coordinator per year.
- A quarterly in-person or video visit by a clinician or a Service Coordinator Supervisor (that is also a clinician) must be offered

directly to the Participant, or if the Participant cannot speak, to their designee.

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

F. Person-Centered Planning Team Approach Required

The CHC-MCO must develop a PCPT policy for PCSP development and implementation for Participants who require LTSS. The PCPT approach must comply with the PCPT requirements of 42 C.F.R. § 441.301(c)(1) through (3) and of this Agreement. The CHC-MCO must include the PCPT approach as part of the service planning and Service Coordination processes for Participants who require LTSS. The CHC-MCO may include the PCPT approach as part of the overall care coordination approach for Participants who do not require LTSS. The CHC-MCO PCPT approach must be person-centered and must consider all goals and requirements of CHC. The CHC-MCO must annually submit and obtain Department approval of its PCPT policy prior to the expiration date of the previously approved policy.

G. Person-Centered Service Plans

The CHC-MCO must develop and implement a written, holistic PCSP for each Participant who requires LTSS. The CHC-MCO must comply with the PCSP requirements specified in 42 C.F.R. § 438.208(c)(3) and § 441.301(b) and (c) in developing the PCSP. The developer of the PCSP must be trained in person-centered planning using a person-centered process. Refer to Exhibit Z Person-Centered Service Planning for additional information on PCSP requirements.

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

1. Care Management Plan

A Care Management Plan to identify and address how the Participant's physical, cognitive, and behavioral healthcare needs will be care managed, including:

- Active chronic problems, current non-chronic problems, cognitive needs,

and problems that were previously controlled or classified as maintenance care but have been exacerbated by disease progression or other intervening conditions.

- Current medications.
- All services authorized and the scope, amount, duration and frequency of the services authorized, including any services that were authorized by the CHC-MCO since the last PCSP was finalized that need to be authorized moving forward.
- A schedule of preventive service needs or requirements.
- Disease Management action steps.
- Known needed physical and behavioral healthcare and services.
- All designated points of contact and the Participant's authorizations of who may request and receive information about the Participant's services.
- How the Service Coordinator will assist the Participant in accessing Services identified in the PCSP.
- How the Service Coordinator will address and offer assistance with barriers to compliance with the physical or behavioral health treatment plans.
- How the CHC-MCO will coordinate with the Participant's Medicare, Veterans, BH-MCO, and other health insurers and other supports.

2. LTSS Service Plan

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

- All LTSS services necessary to support the Participant in living as independently as possible and remaining as engaged in his or her community as possible.
- The needs identified in the Assessment, the interventions to address each need or preference, reasonable long-term and short-term goals, the measurable outcomes to be achieved by the interventions, the anticipated timelines in which to achieve the desired outcomes, and the staff responsible for conducting the interventions and monitoring the outcomes.
- Potential problems that can be anticipated, including the risks and how these risks can be minimized to foster the Participant's maximum functional level of well-being.
- Participant decisions concerning self-directed care and whether the Participant is participating in Participant-Direction.
- Communications plan.
- The scope, amount, duration and frequency that specific services will be provided.

- Whether and, if so, how technology and telehealth will be used.
- Participant choice of Providers.
- Participant preferences for how often they would like to engage with their Service Coordinator (Participants must not be steered toward minimal quarterly contacts).
- Participant communication preferences including how they would like to be identified, addressed and preferred method of communication.
- Participant identified goals.
- Health related education needs and a plan to ensure understanding of health needs and treatment plan.
- Individualized Back-Up Plan that is verified by the service coordinator.
- Individuals and organizations identified to be included as part of the PCPT.
- The person(s) and Providers responsible for specific interventions or services.
- Participant's available, willing, and able informal support network and services.
- Participant's need for and plan to access community resources, non-covered services, and other supports, including any reasonable accommodations.
- How to accommodate preferences for leisure activities, hobbies, and community engagement.
- Any other needs or preferences of the Participant.
- Participant's goals for the least restrictive setting possible, if he or she is being discharged or transitioned from an inpatient setting.
- How the CHC-MCO will coordinate with the Participant's Medicare, Veterans Benefits, BH-MCO, other health coverage insurers, and other supports.
- Participant's employment and educational goals.
- Emergency back-up plan that is verified by the Service Coordinator as safe and realistic.
- A plan for regularly scheduled follow up communications with the Participant.
- Barriers to the Participant meeting defined goals.
- Measures to prevent future falls which must include at a minimum offering exercise therapy or referral to exercise for participants who have a history of falls or who have been assessed as a fall risk.

The PCSP must specify the need for referrals and the need for assistance from the Service Coordinator in obtaining referrals. To the extent that the PCP is part of the PCSP development or PCTP process, the PCSP must also articulate referrals that the Service Coordinator will enter in the appropriate systems. CHC-MCOs are required to utilize the PCSP checklist template developed by the Department.

If requested, the MCO must share minimum necessary service plan

information with providers, consistent with HIPAA rules and regulations. If sufficient justification is demonstrated by a provider, that information may include the following:

- Total number of authorized units per week (i.e., amount);
- Service provision dates (i.e., service begin and end dates);
- Preferred schedule (i.e., duration and frequency);
- List of tasks detailing participant needs (i.e., ADLs/IADLs);
- Service coordinator name, phone, and email address;
- Off hours service coordination contact number;• Special conditions and instructions;
- Unique circumstances (e.g., allergies, smoking, pets, children under 18 years of age, etc.)

When new services are authorized or services are increased via inclusion on a Participant's PCSP, the new service or increased service level must commence within seven (7) business days of the approval, unless the Participant requests a longer timeframe for the services to start.

If a Participant requests a voluntary reduction or termination of services authorized on their PCSP, the CHC-MCO must obtain a clear written statement signed by the Participant attesting to the fact that they no longer wish to receive the service as previously authorized.

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

PCSPs must be developed and implemented no more than fifteen (15) business days from the date the Assessment or Reassessment is completed.

PCSPs must be developed by the Service Coordinator, the Participant, the Participant's representative, as appropriate, and the Participant's PCPT. Participants may appeal part or all of their Service Plan as provided in Exhibit G, Complaint, Grievance and DHS Fair Hearing Processes.

H. Care Management Plans

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

The CHC-MCO must include in care management plans for Participants who do not require LTSS, at a minimum, the following:

- Active chronic problems, current non-chronic problems, cognitive needs, and problems that were previously controlled or classified as maintenance care but have been exacerbated by disease progression or other intervening conditions.
- Most recent, up to date, medications list.
- Current PCP and specialty providers.
- Potential future LTSS needs based on reasonably anticipated disease progression.
- All services authorized and the scope, amount, duration and frequency of the services authorized, including any services that were authorized by the CHC-MCO since the last care management plan was finalized that need to be authorized moving forward.
- A schedule of preventive service needs or requirements.
- Disease Management action steps.
- Known needed physical and behavioral healthcare and services.
- All designated points of contact and the Participant's authorizations of who may request and receive information about the Participant's services.
- How the care manager will assist the Participant in accessing services identified in the care management plan.
- How the CHC-MCO will coordinate with the Participant's Medicare, Veterans Benefits, BH-MCO, Lottery-funded Services and other healthcare insurance providers.

I. Department Review of Changes in PCSPs

The Department may review, question, and request revisions to PCSPs. The CHC-MCO must provide the Department with monthly aggregate reports on PCSP changes in a format specified by the Department. Additional PCSP requirements can be found in Exhibit Z.

J. Service Coordination

Service Coordinators must assist Participants who need LTSS in obtaining the services that they need. Service Coordinators lead the PCSP process and oversee the implementation of PCSPs. The CHC-MCO must annually submit and obtain Department approval of its Service Coordination staffing plan, including a staff-to-Participant ratio that is consistent with the ratio in its proposal, after-hours and emergency staffing, Service Coordinator to Participant communications and contact plans, including the required frequency of in-person Service Coordinator contact, Service Coordinator caseloads, and how

Service Coordinators share and receive real-time information about Participants and Participant encounters. The CHC-MCO must provide each Participant with a choice of available Service Coordinators employed by the CHC-MCO or Service Coordination entity contracted with the CHC-MCO. Service coordinators must meet with LTSS Participant's at least once every three (3) months by phone or in-person to assure that a Participant's LTSS are meeting their needs. At least two (2) of these visits must be in-person every year. Service Coordinators must allow for more frequent contacts based on Participant's preferences. Service Coordinators must not steer Participants toward minimal quarterly contacts. For Participants receiving services from the Office of Vocational Rehabilitation (OVR) Service Coordinators should inform Participants that they are available to participate in OVR support team meetings. For Participants residing in a nursing facility that do not have direct telephone access the remote contact can be with the nursing facility staff that oversees the Participants care plan.

Service Coordinators must identify, coordinate, and assist Participants in gaining access to needed LTSS services and other Covered Services, as well as noncovered medical, social, housing, educational, employment, and other services and supports. Service Coordination includes the primary functions of providing information to Participants and facilitating access to, locating, coordinating, and monitoring needed services and supports for Participants. Service Coordinators are also responsible for: informing Participants about available LTSS, required needs assessments, the PCSP process, service alternatives, service delivery options (including opportunities for Participant-Direction), roles, rights (including complaint, grievance, and DHS Fair Hearing rights), Participant's risks and responsibilities; assisting with fair hearing requests when needed and requested; and protecting a Participant's health, welfare, and safety on an ongoing basis.

On an annual basis, CHC-MCOs must submit a policy that outlines how participants will get connected and have access to a Service Coordinator outside of normal working hours, including weekends, and overnight (8 p.m. to 8 a.m.).

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

The CHC-MCO must oversee pre-tenancy and transition services for housing, which prepare and support the Participant's move to housing in an integrated setting. These services include assistance to obtain and retain housing, activities to foster independence, and assistance in developing community resources to support successful tenancy and maintain residency in the community.

The CHC-MCO must develop, submit for DHS approval, and implement a plan to monitor the performance of Service Coordinators. The maximum caseload ratio for Service Coordinators serving HCBS Participants is 1:50. The maximum caseload ratio for Service Coordinators serving Participants in nursing facilities is 1:200.

CHC-MCOs must ensure that Participants are provided both their Service Coordinator phone number and e-mail address and be notified both verbally and in writing if their Service Coordinator changes. Service Coordinators must respond to Participant outreach within two (2) business days, or sooner when an imminent risk to a participant's health and safety is involved.

The CHC-MCO must assist Service Coordination entities with data sharing that supports quality of services for Participants.

The CHC-MCO must provide Service Coordination as an administrative function through appropriately qualified staff or contracts with Service Coordination entities.

All Service Coordinators assigned to nursing homes must have a PPD test for tuberculosis prior to providing services to Participants in nursing homes. See Exhibit B(1)R for additional information on PPD testing requirements.

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

For Participants not already receiving Service Coordination, the CHC-MCO must coordinate with the Participant's Medicare, Veterans, BH-MCO, other health insurers and other supports, including but not limited to the Act 150 program, the OPTIONS program or OMAP's Special Needs Unit, to assist the Participant in accessing all necessary services and supports.

K. Service Coordinator and Service Coordinator Supervisor Qualification Requirements

The CHC-MCO must provide Service Coordinators and Service Coordinator

supervisors that have the following qualifications:

- Service Coordinators must: (1) be a Registered Nurse (RN); or (2) have a Bachelor's degree in Social Work, Psychology, or other related fields; or (3) have at least three (3) or more years of experience in a social service or a healthcare related setting. Service Coordinators hired prior to the CHC zone Implementation Date must have the qualifications and standards proposed by the CHC-MCOs and approved by the Department.
- Service Coordinator supervisors must either: (1) be a RN; or (2) have a Master's degree in Social Work or in a human services or healthcare field and three (3) years of relevant experience with a commitment to obtain either a Pennsylvania Social Work or mental health professional license within one year of hire. Service Coordinator supervisors hired prior to the CHC zone Implementation Date (who do not have a license) must either: 1) obtain a license within one Year of the Implementation Date in the applicable CHC zone, or 2) have the qualifications and standards proposed by the CHC-MCOs and approved by the Department.

L. Nursing Home Transition

CHC-MCOs must provide NHT activities to Participants residing in NFs who express a desire to move back to their homes or other community-based settings. The CHC-MCO must provide NHT as an administrative function through appropriately qualified staff or contracts with nursing home transition entities.

Participants interested in transitioning to a community setting must be referred for NHT services. When a Participant requests to be transitioned out of a NF, the CHC-MCO must initiate the NHT planning process within seven (7) business days of the SC receiving the referral. CHC-MCOs and the NHT provider are responsible to talk to the Participant and their support network about NHT, HCBS, community supports, and their options. If the Participant expresses a choice to move forward with the transition, the CHC-MCOs NHT provider must refer the Participant to the IEB to complete a Medical Assistance HCBS application. If the Participant is found to be ineligible for HCBS for any reason, a denial notice with appeals rights will be issued by the IEB. If a Participant is found eligible for HCBS services, but the CHC-MCO assesses the Participant and determines it would not be a safe discharge from the nursing facility, the CHC-MCO must issue a notice of denial of HCBS services with appeal rights.

M. CHC-MCO and BH-MCO Coordination

To enhance the treatment of Participants who need both Covered Services and BH Services, the CHC-MCO must develop and implement written agreements

with each BH-MCO in the CHC zone regarding the interaction and coordination of services provided to Participants. This agreement must include the provisions specified in Exhibit H, coordination with Behavioral Health Managed Care Organizations. The CHC-MCO must submit any newly executed agreements for Department review and prior approval at least thirty (30) days prior to the implementation and make the agreements available to the Department upon request. The CHC-MCO is encouraged to develop uniform coordination agreements with the BH-MCOs to promote consistency in the delivery and administration of services.

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

a. Information exchanges, including BH utilization data provided by the Department to control avoidable hospital admissions, readmissions and emergency department usage for Participants with SMI or SUDs or both.

b. Specific coordination mechanisms to assess and, where appropriate, reduce the use of psychotropic medications prescribed for Participants.

c. The CHC-MCO must, and the Department will require BH-MCOs to submit to independent binding arbitration in the event of a dispute between the CHC-MCO and a BH-MCO concerning their respective obligations. The Agreement of the CHC-MCO and a BH-MCO to an arbitration process must be included in the written Agreement between the CHC-MCO and the BH-MCO.

d. The CHC-MCO must comply with the requirements specified in Exhibit D, Drug Services.

The CHC-MCO may only use substance use disorder-related information contained within the Service History Data File for purposes authorized by 42 C.F.R. § 2.53(c), and must:

- Maintain and destroy the patient identifying information in a manner consistent with the policies and procedures established under 42 C.F.R. § 2.16;
- Retain records in compliance with applicable federal, state, and local record retention laws; and
- Comply with the limitations on use and disclosure in 42 C.F.R. § 2.53(f).

N. CHC-MCO Responsibility for Reportable Conditions

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

O. Participant Enrollment, Disenrollment, Outreach, and Communications

1. General

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

The CHC-MCO, its sub-contractors, and Network Providers are prohibited from offering or exchanging financial payments, incentives, or commissions, to another CHC-MCO not receiving a CHC Agreement or choosing not to continue in CHC for the exchange of information on the other MCO's Participants. This includes offering incentives to a terminating CHC-MCO to recommend that its Participants join the CHC-MCO offering the incentives.

2. CHC-MCO Outreach Materials

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

The CHC-MCO must develop outreach materials, including the Participant Handbook, and other Participant materials which are accessible, easily understood, written at not more than a sixth (6th) grade reading level and comply with the other requirements in 42 C.F.R. § 438.10 pertaining to information requirements.

The CHC-MCO is prohibited from distributing, directly or through an agent or independent contractor, outreach materials without advance written approval of

the Department. In addition, the CHC-MCO must comply with the following:

a. The CHC-MCO may not seek to influence an individual's Enrollment with the CHC-MCO in conjunction with the sale of any other insurance.

b. The CHC-MCO must comply with the Enrollment procedures established by the Department so that an individual is provided with accurate oral and written information sufficient to make an informed decision on Enrollment.

c. The CHC-MCO may not directly or indirectly conduct door-to-door, telephone, email, or texting marketing activities.

d. The CHC-MCO must develop and provide outreach plans, procedures and materials that are accurate and do not mislead, confuse, or defraud either the Participant or the Department and must comply with Exhibit I, Guidelines for CHC-MCO Advertising, Sponsorships, and Outreach.

3. CHC-MCO Outreach Activities

a. The CHC-MCO, its subcontractors, and Network Providers are prohibited from engaging in Marketing activities associated with Enrollment into the CHC-MCO, except as provided below. Marketing is any interaction with a potential Participant who is not enrolled in the CHC-MCO, that can reasonably be interpreted as intended to:

   1. Influence a potential Participant to enroll in the CHC-MCO,
   2. Persuade a potential Participant to change enrollment from another managed care organization in CHC to the CHC-MCO contacting the potential Participant, or
   3. Dissuade a potential Participant from enrolling with another managed care organization in CHC and enrolling with the CHC-MCO contacting the potential Participant.

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

   - CAOs
   - Providers' offices
   - Malls, Commercial, or retail establishments
   - Hospitals
   - NFs
   - Adult Day Centers

- Senior Centers
- Check cashing establishments
- Door-to-door visitations
- Telemarketing
- Direct Mail
- Community Centers
- Churches
- Emails
- Texting

b. The CHC-MCO may market its approved companion D-SNP product to Dual Eligible Participants.

c. The CHC-MCO, either individually or as a joint effort with other CHC-MCOs in the zone, may use commonly accepted media methods for the advertisement of quality initiatives, educational outreach, and health-related materials and activities.

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

d. The CHC-MCO may participate in or sponsor health fairs or community events. The Department may set limits on contributions and payments made to non-profit groups in connection with health fairs or community events and requires advance written approval for contributions and payments of Two Thousand Dollars ($2,000.00) or more. The Department will consider participation or sponsorship when the CHC-MCO submits a written request thirty (30) days in advance of the event or fair, thus allowing the Department reasonable time to review the request and provide timely advance written approval. All contributions and payments are subject to audit by the Department and its designees.

e. The CHC-MCO may offer items of little or no intrinsic value such as trinkets with promotional CHC-MCO logos at approved health fairs or other approved community events. The CHC-MCO must make such items available to the general public; such items may not exceed Five Dollars ($5.00) in retail value and must not be connected in any way to Enrollment activity. All such items are subject to advance written approval by the Department.

f. As permitted by Section V.A.4, Expanded Services and Value-Added Services, the CHC-MCO may offer Participants Expanded or Value-Added Services and is permitted to feature such Services in approved outreach

materials.

g. The CHC-MCO may offer Participants consumer incentives only if they are directly related to improving health outcomes. The CHC-MCO may not use an incentive to influence a Participant to receive any item or service from a Provider, practitioner, or supplier. In addition, the incentive cannot exceed the total cost of the service being provided. The CHC-MCO must receive advance written approval from the Department prior to offering a Participant incentive. CHC-MCOs must comply with any managed care ops memos related to Participant incentives.

h. Unless approved by the Department, CHC-MCOs are not permitted to directly provide products of value unless they are health-related and are prescribed by a licensed Provider. CHC-MCOs may not offer Participants coupons for products of value.

i. Except where review and approval are specifically required, the Department may review any and all other outreach activities and advertising materials and procedures used by the CHC-MCO, including all outreach activities, advertising materials, and corporate initiatives that are likely to reach MA Beneficiaries. In addition to any other sanctions, the Department may impose monetary penalties or restrict Enrollment if the Department determines the CHC-MCO used unapproved outreach materials or engaged in unapproved outreach practices. The Department may suspend all outreach activities and the completion of applications for new Participants. Such suspensions may be imposed for a period of up to sixty (60) days from notification by the Department to the CHC-MCO citing the violation.

j. The CHC-MCO may not under any conditions use the Department's eligibility system to identify and market to individuals participating in the LIFE Program or enrolled in another CHC-MCO. The CHC-MCO may not share or sell Participant lists for any purpose, with the limited exception of sharing Participant information with Affiliates or subcontractors under Department-approved arrangements to fulfill the requirements of this Agreement.

k. The CHC-MCO must submit a plan for advertising, sponsorship, and outreach procedures to the Department for advance written approval in accordance with Exhibit I, Guidelines for CHC-MCO Advertising, Sponsorships, and Outreach.

l. The CHC-MCO must conduct and participate in Department Provider and Participant outreach efforts.

m. The CHC-MCO shall include the following statement or a substantially

similar statement in all marketing materials in boldface type: "Your managed care plan may not cover all your health care expenses. Read your participant handbook carefully to determine which health care services are covered."

4. Limited English Proficiency Requirements

Beginning at Enrollment, the CHC-MCO must seek to identify Participants who speak a language other than English as their primary language and who have a limited ability to read, write, speak, or understand English. The CHC-MCO must identify and communicate using spoken and written language preferences identified by the IEB and CHC-MCO during their contacts with the Participant.

The CHC-MCO must provide, at no cost to Participants, oral interpretation and written translation services in the requested language, including American sign language, to meet the needs of Participants. Oral interpretation requirements apply to all non-English languages, not just those that are identified as prevalent. The CHC-MCO must notify Participants that oral interpretation for any language and written translation in prevalent languages, are available upon request at no cost to the Participant. The CHC-MCO must require Network Providers to offer interpretation services and prohibit Network Providers from requiring that a Participant's family member be used for interpretation. Interpretation services must also include all services dictated by federal requirements. If a Network Provider is unable or unwilling to provide these services, the CHC-MCO must provide interpretation services.

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

Vital Documents must be readily accessible and in an electronic form which can be electronically retained and printed. The CHC-MCO must post Vital Documents on its website and a location that is prominent and Readily Accessible and inform Participants that the information is available in paper form without charge upon request. The CHC-MCO must provide paper forms upon request within five (5) business days.

5. Alternative Format Requirements

The CHC-MCO must provide alternative methods of communication for

Participants who have neurocognitive impairments or who are visually or hearing impaired or both, including Braille, audio tapes, large print, compact disc, DVD, computer diskette, special support services, and electronic communication. The CHC-MCO must, upon request from the Participant, make all written materials disseminated to Participants accessible to visually impaired Participants at no cost to the Participant.

The CHC-MCO must include appropriate instructions in all materials about how to access or receive assistance to access materials in an alternative format. The CHC-MCO must include in all written material taglines as well as large print, explaining the availability of written translation or oral interpretation to understand the information provided and the toll-free telephone number of the CHC-MCO's call center. Large print means printed in a font size no smaller than eighteen (18) points.

6. Enrollment Procedures

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

The CHC-MCO must enroll any Potential Participant who selects or is assigned to the CHC-MCO in accordance with the Enrollment and Disenrollment dating rules that are determined and provided by the Department on the Pennsylvania HealthChoices Extranet and Exhibit J, Participant CHC-MCO Selection and Assignment, regardless of the individual’s race, color, creed, religion, age, sex, national origin, ancestry, marital status, sexual orientation, gender identity, income status, program participation, Grievance status, MA category status, health status, pre-existing condition, physical or mental disability or anticipated need for healthcare. CHC-MCOs must offer assistance to Participants enrolled in their Plan with completing all paperwork necessary for the Participant to maintain MA eligibility. To the extent permitted by law, CHC-MCOs are permitted to outreach to former Participants of their MCO that have lost MA eligibility for up to ninety (90) calendar days from the date of disenrollment for purposes of re-establishing eligibility.

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

7. Enrollment of Newborns

Newborns will not be enrolled in CHC. Newborns will be auto-assigned to the HealthChoices PH-MCO aligned with the mother's CHC-MCO if available in the Zone where they reside.

8. Transitioning Participants Between CHC-MCOs

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

The CHC-MCO must provide an electronic or hard paper copy of a Participant's existing Comprehensive Medical and Service Record, including PCSPs and case notes for the most recent 12 months available. Notifications regarding critical incidents must be provided if the Participant has had more than three (3) critical incidents within a 12-month period and when there is a substantiated incident related to abuse, neglect, exploitation or abandonment, to the CHC-MCO to which a Participant transfers. The CHC-MCO must expeditiously transfer the information as soon as they are made aware of the transfer, electronically, if possible, not to exceed five (5) business days after notification of the transfer. The CHC-MCO receiving the documentation from the previous CHC-MCO must make the previous CHC-MCO aware if any documentation is missing within two (2) business days of the expected due date of the documents.

9. Transitioning Participants Between the CHC-MCO and LIFE

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

10. Change in Participant Status

The CHC-MCO must report the following to the Department's MMIS on the Weekly Enrollment/Disenrollment/Alert file: pregnancy (not in eCIS), death (not in eCIS), and returned mail alerts in accordance with Section VIII.C.5, Alerts.

The CHC-MCO must report HCBS Participant status changes to the appropriate CAO using the PA 1768 Form within ten (10) business days of the change becoming known.

The CHC-MCO must report the following status changes for all other Participants using the CAO Notification Form within ten (10) business days of the change becoming known: phone number, address, and family additions/deletions. The CHC-MCO must also provide a detailed explanation on the CAO Notification form of how the information was verified.

For additional details regarding how to submit a Change in Participant Status, refer to the HealthChoices Extranet.

11. Participant Files

a. Monthly File

The Department will provide a Monthly 834 Eligibility File to the CHC-MCO on the next to the last Saturday of each month. The file contains the MA Eligibility Period, CHC-MCO coverage, BH-MCO coverage, and Participant demographic information. It will contain only the most current record for each CHC Participant where the Participant is both MA and CHC eligible at some point in the following month. The CHC-MCO must reconcile this Participant file against its internal Participant information.

If the membership information in the MCO's system does not match the membership information on the Monthly File, the CHC-MCO must first check eCIS and Daily 834 files, dated after the Monthly File, to see if the discrepancy has been resolved prior to reaching out to the Department. If the CHC-MCO cannot resolve the discrepancy, the CHC-MCO must notify the Department within thirty (30) calendar days of receipt of the Monthly 834 file with the discrepancy.

Participants not included on the Monthly 834 Eligibility File with a specification of prospective coverage will not be the responsibility of the CHC-MCO unless a subsequent Daily 834 Membership File indicates otherwise.

b. Daily File

The Department will provide a Daily 834 Eligibility File to the CHC-MCO that contains one record for each action taken in eCIS for each Participant where data for that Participant has changed that day. The file will contain add, termination, and change records, but will not contain BH-related information. The file will contain demographic changes, eligibility changes, Enrollment changes, Participants enrolled through the automatic

assignment process, and TPL information. The CHC-MCO must process this file within twenty-four (24) hours of receipt.

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

12. Enrollment and Disenrollment Updates

a. Weekly Enrollment/Disenrollment/Alert Reconciliation File

The Department will provide a weekly file with information on Participants enrolled or disenrolled in CHC and the dispositions of Alerts previously submitted by the CHC-MCO. The CHC-MCO must use this file to reconcile Alerts submitted to the Department.

b. Disenrollment Effective Dates

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

13. Involuntary Disenrollment

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

The CHC-MCO must aid the disenrolled Participant in transitioning to other resources to provide for continuity of care.

14. New Participant Orientation

The CHC-MCO must provide an orientation to a new Participant within thirty (30) days of the new Participant's start date with the CHC-MCO. For new Participant's receiving LTSS, the CHC-MCO must conduct the orientation face-to-face (the orientation may be part of the service coordination visit). For purposes of New Participant Orientation, a Participant would be considered new to the CHC-MCO if they were not enrolled with the CHC-MCO 365 days prior to the current enrollment. The CHC-MCO must have a written

orientation plan or program for new Participants that includes:

- Educational and preventive care programs that include an emphasis on health promotion, wellness and healthy lifestyles and practices,
- The proper use of the CHC-MCO identification card and the ACCESS Card,
- The role of the PCP,
- The Assessment process,
- Access to behavioral health services, transportation, home modifications, etc.,
- What to do in an emergency or urgent medical situation,
- How to report abuse, neglect, and exploitation,
- How to utilize services in other circumstances,
- How to request information from the CHC-MCO,
- How to register a Complaint, file a Grievance or request a DHS Fair Hearing,
- Notice that balance billing is prohibited and what to do in the event a Provider balance bills,
- What Expanded Services or Value-Added Services the CHC-MCO has been approved to provide and how long these are required to be available to Participants who qualify to receive them,
- Assistance in coordinating Medicare services that are available to the Participant,
- The benefit of enrolling in a Medicare Part D plan with a zero copay,
- Information about the CHC-MCO Participant Advisory Committees and LTSS Subcommittee, and how to participate, join, or apply if interested.

For participant's receiving LTSS, the orientation must also include the following topics:

- The role of the Service Coordinator,
- The role of the PCPT,
- PCSPs and the service planning process,
- Participant Self-Directed models (for Participants receiving HCBS),
- Individual back-up plan,
- Emergency Preparedness,
- Employment Services,
- The role of Service Coordination Unit and how to contact it directly, if necessary.

The CHC-MCO must obtain the Department's advance written approval of the orientation plan or program.

The CHC-MCO is prohibited from contacting a Potential Participant who is identified on the Daily Participant Enrollment File with an automatic assignment indicator (either an "A" auto-assigned or "M" Participant assigned)

until five (5) business days before the Enrollment Date, unless otherwise requested by the Department.

15. CHC-MCO Identification Cards

The CHC-MCO must issue its own identification card to Participants. The CHC-MCO must issue an identification card(s) to Participants enrolled in the aligned D-SNP for both the CHC-MCO and the D-SNP.

The Department also issues an identification card, called an ACCESS Card, to each Recipient, which the Participant is required to use when accessing services. Providers must use this card to verify the Participant's most current eligibility in the EVS system.

16. Participant Handbook

The CHC-MCO must provide a Participant handbook with information on Participant rights and protections as outlined in this Agreement and Exhibit L, Participant Rights and Responsibilities, and how to access services, in the appropriate language or alternative format to Participants within five (5) business days of a Participant's Start Date. As directed by the Department, the CHC-MCO must use the Participant handbook template developed by the Department to create a Participant handbook that complies with this section and Exhibit M, Participant handbook.

The CHC-MCO may provide the Participant handbook in formats other than hard copy. The CHC-MCO will provide Participants with the handbook in one of the following manners:

- A printed copy of the information mailed to the Participant's mailing address;
- By email after obtaining the Participant's agreement to receive the information by email;
- By posting on the CHC-MCO's website and advising the Participant in paper or electronic form that the information is available on the Internet and including the applicable Internet address, provided that Participants with disabilities who cannot access this information online are provided auxiliary aids and services upon request at no cost; or
- By any other method that can reasonably be expected to result in the enrollee receiving that information.

The CHC-MCO must inform Participants what formats are available and how to access each format. The CHC-MCO must annually review the Participant handbook and document that it reviewed the Participant handbook for accuracy and that all necessary modifications were made. The CHC-MCO

must notify all Participants on an annual basis of any changes made, and the formats and methods available to access the handbook. Upon request, the CHC-MCO must provide a hard copy of the Participant handbook to the Participant.

a. Participant Handbook Requirements

The Participant handbook must be accessible, easily understood, and written at no higher than a sixth (6th) grade reading level and must include, at a minimum, the information outlined in Exhibit M, Participant Handbook. The CHC-MCO must include a reference and a link to the handbook for the aligned D-SNP so that Participants enrolled in both plans may easily reference the D-SNP handbook.

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

b. Department Approval

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

17. Provider Directory

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

The CHC-MCO must utilize a searchable web-based Provider directory. The web-based Provider directory must be available in a machine-readable file and format as specified in 42 C.F.R. § 438.10. The web-based Provider directory must be updated no less than thirty (30) days after the CHC-MCO receives updated information from the Provider. The CHC-MCO must establish a process to address the accuracy of electronically posted content, including a method to monitor and update changes in Provider information.

The CHC-MCO must perform at least monthly reviews and revisions of the web-based Provider directory, subject to random monitoring by the Department.
The CHC-MCO must provide the IEB with an updated electronic version of its Provider directory on at least a weekly basis. The file must include information regarding terminations, additions, PCPs and specialists not

accepting new assignments, and other information determined by the Department to be necessary. The CHC-MCO must utilize the file layout and format specified by the Department. The file must include the information specified in Exhibit N, Provider Directory, but not be limited to:

- Correct MMIS Provider ID
- All Providers in the CHC-MCO's Network
- Locations where the PCP will see Participants and if evening or weekend hours are available
- Wheelchair accessibility of Provider sites
- List of non-English language(s) spoken by Providers.

The CHC-MCO must notify its Participants annually of their right to request and obtain a hard copy of the Provider directory and where the online directory may be found. Upon request, the CHC-MCO must provide Participants with a hard copy of its Provider directory in the prevalent languages specified by the Department and in alternative formats. The CHC-MCO must review the Provider directory information and make any necessary updates at least monthly. Upon request from a Participant, the CHC-MCO must print the most recent electronic version from its Provider file and mail it to the Participant.

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

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

18. Participant Advisory Committee

The CHC-MCO must establish and maintain a PAC for each zone in which it operates. The PAC must include Participants, Network Providers and direct care worker representatives to advise on the experiences and needs of Participants. The CHC-MCO must include Participants who are representative of the population being served as well as family caregivers as members of the PAC. Provider representation must include PH, BH, dental health and LTSS. The CHC-MCO must provide the Department annually with the membership (including designation) of the PAC. The PAC membership must be composed of at least fifty percent (50%) Participants, with twenty-five percent (25%) of the total membership receiving LTSS, ten percent (10%) of which must be nursing facility residents or a representative of a nursing facility resident. In addition to the individual diversity, the CHC-MCO should seek geographic

diversity, including both rural and urban representation.

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

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

As part of the PAC meetings the CHC-MCOs must detail health education and outreach activities including coordination of health education materials, activities, and programs with public health entities, particularly as they relate to public health priorities and population-based interventions. Population-based interventions include those that are relevant to the populations being served and that take into consideration the ability of these populations to understand and act upon health information.

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

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

P. Participant Services

1. General

The CHC-MCO's Participant services functions must be operational, at a minimum, during regular business hours (9:00 a.m. to 5:00 p.m., Monday through Friday), plus one (1) evening per week (5:00 p.m. to 8:00 p.m.) or one (1) weekend per month to address non-emergency problems encountered by Participants. The CHC-MCO must have arrangements to

receive, identify, and resolve in a timely manner Emergency Participant Issues on a twenty-four (24) hour-per-day, seven (7) day-per-week basis. The CHC-MCO's Participant services functions include, but are not limited to, the following:

- Explaining the operation of the CHC-MCO and assisting Participants in PCP selection.
- Assisting Participants with making appointments and obtaining services, including interpreter services, as needed.
- Assisting with transportation for Participants through the MATP as required in Section V.A.13., Transportation.
- Receiving, identifying, and resolving Emergency Participant Issues.

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

The CHC-MCO must forward all telephone calls received by the Participant Service area in which the caller requests his or her Service Coordinator to the Participant's Service Coordinator.

2. CHC-MCO Internal Participant Dedicated Hotline

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

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

- Provides for a dedicated toll-free telephone line for Participants.
- Provides for necessary translation and interpreter assistance for LEP Participants.
- Includes a function specific to connecting Participants with their Service Coordinator.
- Requires representatives to document calls and forward call notes to the Participant's Service Coordinator.
- Be staffed by individuals fully trained by the CHC-MCO in the following areas

before allowing staff to assist Participants by handling phone calls:

- Cultural, Linguistic, and Disability Competency.
- Addressing the needs of covered populations.
- The availability of contact information for, and the functions of, the Service Coordinator.
- Requirements for accessibility.
- Coordination with BH-MCOs.
- How to identify and handle any emergency.
- When to transfer callers to the Nurse Hotline.
- Covered Services and the availability of protective and social services within the community.
- Medicare coverage and addressing questions relating to the CHC-MCO's companion D-SNP plan.
- Medical and non-medical transportation.

- Be staffed with adequate service representatives so that the abandonment rate is less than or equal to five percent (5%) of the total calls.
- Be staffed with adequate service representatives so that at least eighty-five percent (85%) of all calls are answered within thirty (30) seconds.

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

3. Nurse Hotline

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

4. Informational Materials

The CHC-MCO must distribute Participant newsletters at least three (3) times per year to each Participant household. The CHC-MCO may provide Participant newsletters in formats other than hard copy, but must provide a hard copy to a Participant who asks for one. The CHC-MCO must include information about common procedures in its Participant newsletter and information provided by the Department related to Department initiatives, including the option for eligible Participants to select the LIFE Program, and

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

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

Q. Additional Addressee

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

R. Complaint, Grievance, and Fair Hearing Processes

The CHC-MCO must develop, implement, and maintain a Complaint and Grievance process that provides for resolution of Participants' Complaints and Grievances and the processing of requests for DHS Fair Hearings as outlined in Exhibit G, Complaint, Grievance, and Fair Hearing Processes. The CHC-MCO must use templates provided by the Department to inform Participants regarding decisions and the process.

The CHC-MCO must have written policies and procedures approved by the Department, for resolving Participant Complaints and for processing Grievances and DHS Fair Hearing requests, that meet the requirements established by the Department and the provisions of 40 P.S. §991.2101 et seq. (known as Act 68), 28 Pa. Code Chapter 9, 31 Pa. Code CHs. 154 and 301, and 42 C.F.R. §431.200 et seq.
The CHC-MCO must also comply with 55 Pa. Code Chapter 275 regarding DHS Fair Hearing Requests and 42 C.F.R. §438.406(b). The CHC-MCO must use the Department's Enterprise Case Management System to process requests for DHS Fair Hearings and all related documentation.

The CHC-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 which have been prior approved by the Department. Unless otherwise required by law, the CHC-MCO may continue to operate under such existing policies and procedures until such time as the Department approves the new or revised version.

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

In accordance with 28 Pa. Code § 9.707(j), when a Participant files an external appeal of a Grievance decision, the CHC-MCO must abide by the decision of the Independent Review Organization (IRO), which was assigned to conduct the independent external review.

The CHC-MCO must abide by the final decision of BHA for those cases when a Participant has requested a DHS Fair Hearing, unless requesting reconsideration by the Secretary of the Department.

S. OLTL and other DHS Hotlines

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

T. Provider Dispute Resolution Process

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

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

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

- Informal and formal processes for settlement of Provider Disputes.
- Acceptance and usage of this Agreement's definition of Provider Appeals and Provider Disputes.
- Time frames for submission and resolution of Provider Disputes and Provider

Appeals.

- Processes to provide equitability for all Providers.
- Establishment of a CHC-MCO Committee to process formal Provider Appeals, which must provide:

  – At least one-fourth (1/4th) of the membership of the Committee must be composed of Providers/peers.
  – Committee members who have the authority, training, and expertise to address and resolve Provider Dispute/Provider Appeal issues.
  – Access to data necessary to assist Committee members in making decisions.
  – Documentation of meetings and decisions of the Committee.

U. Certification of Authority and County Operational Authority

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

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

V. Executive Management

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

- A full-time Chief Administrative Officer with authority over the entire operation of the CHC-MCO.

- A full-time CHC Program Manager to oversee the operation of this Agreement, if different from the Administrator.

- A full-time Medical Director who is a current Pennsylvania-licensed physician. The Medical Director must be actively involved in all major clinical program components of the CHC-MCO and directly participate in the oversight of the QM Department and UM Department. The Medical Director and his or her staff/consultant physicians must devote sufficient time to the CHC-MCO to provide timely medical decisions, including after-hours consultation, as needed.

- A full-time Pharmacy Director who is a current Pennsylvania-licensed pharmacist. The Pharmacy Director must oversee the pharmacy

management and serve on the CHC-MCO P&T Committee.

- A full-time Director of Quality Management who is a Pennsylvania-licensed RN, physician or physician's assistant or is a Certified Professional in Healthcare Quality by the National Association for Healthcare or Quality Certified in Healthcare Quality and Management by the American Board of Quality Assurance and Utilization Review Providers. The Director of Quality Management must be located in Pennsylvania and have experience in quality management and quality improvement. Sufficient local staffing under this position must be in place to meet QM Requirements. The primary functions of the Director of Quality Management position are:

  - Evaluate individual and systemic quality of care
  - Integrate quality throughout the organization
  - Implement process improvement
  - Resolve, track, and trend quality of care complaints
  - Develop and maintain a credentialed Provider network

- A full-time Director of LTSS who is responsible for and oversees all LTSS. The Director of LTSS must have at least five (5) years of experience administering managed long-term care programs. On a case-by-case basis, equivalent experience in administering long-term care programs and services, including HCBS, or in managed care may be substituted, subject to the prior approval of the Department.

- A full-time Chief Financial Officer (CFO) to oversee the budget and accounting systems implemented by the CHC-MCO. The CFO is responsible for providing accurate and timely financial reports. The CFO shall devote sufficient time and resources to responsibilities under this Agreement.

- A full-time Information Systems Coordinator, who is responsible for the oversight of all information systems issues with the Department. The Information Systems Coordinator must have a good working knowledge of the CHC-MCO's entire program and operation, as well as the technical expertise to answer questions related to the operation of the information system.

- A full-time Special Investigations Unit (SIU) Director who serves as the Department’s primary contact for program integrity functions. The SIU Director oversees staff responsible for fraud, waste and abuse activities.

- A Dental Director who is a current Pennsylvania-licensed Doctor of Dental Medicine or Doctor of Dental Surgery. The Dental Director must be actively involved in all program components related to dental services including, but

not limited to, dental provider recruitment strategy, assessment of dental network adequacy, providing oversight and strategic direction in the quality of dental services provided, actively engaged in the development and implementation of quality initiatives, and monitor the performance of the dental benefit manger if dental benefits are subcontracted. The Dental Director must be available a minimum of thirty (30) hours per week. They can be shared across Medicaid products for purposes of satisfying this requirement but must be specific to work in Pennsylvania.

Aside from the CFO and Dental Director, these full-time positions must be solely dedicated to CHC. The CHC-MCO must report immediately any changes to their Executive Management structure to the Department. Resumes for all Executive Management positions must be submitted to the Department.

W. Other Administrative Components

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

- A Quality Management/Quality Improvement Coordinator who is a Pennsylvania-licensed physician, RN, or physician's assistant with prior experience or education in QM systems. At the CHC-MCO's request, the Department may consider other advanced degrees relevant to QM in lieu of professional licensure. The QM/QI Coordinator is responsible for overseeing reporting and outcome measurement and HEDIS data collection, serving as point person between the Department and the Department's EQR contractor.

- A BH Coordinator who is a behavioral health professional and is located in Pennsylvania. The Behavioral Health Coordinator shall monitor the CHC-MCO for adherence to BH requirements in this Agreement. The primary functions of the BH Coordinator are:
    - Coordinate Participant care needs with BH Providers.
    - Develop processes to coordinate behavioral healthcare between PCPs and BH Providers.
    - Participate in the identification of best practices for BH in a primary care setting.
    - Coordinate behavioral care with medically necessary services.
    - Be knowledgeable of the BH Managed Care Agreement requirements and coordinate with the BH-MCO to effectuate the requirements.

- A Director of Network Management who coordinates all communications and contractual relationships between the CHC-MCO and its subcontractors and Providers. The Director of Network Management must be located in

Pennsylvania and is responsible for providing Providers with prompt resolution of their problems or inquiries and appropriate education about participation in CHC and maintaining a sufficient Network. Individual Provider representatives will report directly to the Director of Network Management.

- A UM Coordinator who is a Pennsylvania-licensed physician, RN or physician's assistant with past experience or education in UM systems. At the CHC-MCO's request, the Department may consider other advanced degrees relevant to UM in lieu of professional licensure.

- A Director of Service Coordination who oversees all Service Coordination functions of the CHC plan and who shall have the qualifications of a Service Coordinator and a minimum of five (5) years of management/supervisory experience in the healthcare field. The Director of Service Coordination is responsible for all Service Coordination functions, whether the CHC-MCO provides all Service Coordinator functions in house or contracts with outside entities to meet Service Coordination requirements.

- A Direct Care Worker (DCW) Workforce Coordinator who oversees DCW recruitment and retention.

- A Government Liaison who serves as the Department's primary point of contact with the CHC-MCO for day-to-day management of contractual and operational issues. The CHC-MCO must have a designated back-up trained to be able to handle urgent or time-sensitive issues when the Government Liaison is not available.

- A Participant Services Manager who oversees staff to coordinate communications with Participants and enables Participants to receive prompt resolution of their issues, problems or inquiries.

- A Provider Services Manager who oversees staff to coordinate communications between the CHC-MCO and its Network Providers. There must be sufficient staff in CHC-MCO Provider Services, or an equivalent department that addresses this function, staff to promptly resolve Provider Disputes, problems or inquiries. Staff must also be adequately trained to understand Cultural, Linguistic, and Disability competencies.

- A Provider Claims Educator who is located in Pennsylvania and facilitates the exchange of information between the Grievances, Claims processing, and Provider relations systems. The primary functions of the Provider Claims Educator are to:

  - Educate contracted and non-contracted Providers (e.g., HCBS Providers and Participant-Directed Services Providers) regarding appropriate Claims submission requirements, coding updates, electronic Claims transactions

  and electronic fund transfer, and available CHC-MCO resources such as Provider manuals, website, fee schedules, etc.
  - Interface with the CHC-MCO's call center to compile, analyze, and disseminate information from Provider calls.
  - Identify trends and guide the development and implementation of strategies to improve Provider satisfaction.
  - Communicate frequently (i.e., telephonic and on-site) with Providers to provide for the effective exchange of information and to gain feedback regarding the extent to which Providers are informed about appropriate claims submission practices.

- A Complaint, Grievance and DHS Fair Hearing Coordinator whose qualifications demonstrate the ability to assist Participants throughout the Complaint, Grievance and DHS Fair Hearing processes.

- A Claims Administrator who oversees staff to provide for the timely and accurate processing of Claims, Encounter forms and other information necessary for meeting Agreement requirements and the efficient management of the CHC-MCO.

- A Contract Compliance Officer who monitors the CHC-MCO's compliance with all the requirements of the Agreement.

- An Employment First Coordinator who oversees supported employment related training, resources, and coordination of CHC-MCO employment staff and SCs regarding Employment First and supported employment initiatives.

- A Housing Coordinator who oversees pre-tenancy and tenancy initiatives aimed at assisting Participants in obtaining and maintaining homes in the community.

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

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

- Identify and value differences.

- Acknowledge the interactive dynamics of cultural differences.

- Continually expand cultural knowledge and resources with regard to the populations served.

- Recruit racial and ethnic minority staff in proportion to the populations served.

- Collaborate with the community regarding service provisions and delivery.

- Commit to cross-cultural training of staff and the development of policies to provide relevant, effective programs for the diversity of people served.

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

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

X. Administration

The CHC-MCO must have an administrative office within each CHC zone covered by this Agreement. The Department may grant exceptions to this requirement on an individual basis if the CHC-MCO has administrative offices elsewhere in Pennsylvania and the CHC-MCO is in compliance with all standards set forth by the DOH and PID.

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

1. Recipient Restriction Program

A Centralized Recipient Restriction (Lock-in) Program is in place for the MA FFS and the Managed Care delivery systems and is managed by the

Department's Bureau of Program Integrity (BPI).

The CHC-MCO will maintain a Recipient Restriction Program to interface with the Department's Recipient Restriction Program, and will provide for appropriate professional resources to manage the Program and to cooperate with the Department in all procedures necessary to restrict Participants. In accordance with 42 CFR § 431.54(e), the restrictions do not apply to Emergency Services furnished to the Participant. The Department has the sole authority to restrict Recipients and has oversight responsibility of the CHC-MCO's Recipient Restriction Program. The CHC-MCO must obtain approval from the Department prior to implementing a restriction, including approval of written policies and procedures and correspondence to Participants. The CHC-MCO's process must include:

- Designating a Recipient Restriction Coordinator within the CHC-MCO to manage processes.
- Identifying Participants who are overutilizing and/or mis-utilizing medical services, receiving unnecessary services or may be defrauding the MA program.
- Offering a voluntary restriction to a participant to protect his/her medical card from alleged misuse. For example, a voluntary restriction can be imposed when a Participant loses their card or believes their benefits are being used by someone other than themselves. A voluntary restriction may be ended at any time.
- Evaluating the degree of abuse including review of pharmacy and medical Claims/Encounter history, diagnoses and other documentation, as applicable.
- Proposing whether the Participant should be restricted to obtaining services from a single, designated Provider for a period of five (5) years.
- Forwarding case information and supporting documentation to BPI at the address below or via secure electronic method for review to determine appropriateness of restriction and to approve the action.
- Forwarding case information to BPI for allegations of participant Fraud.
- Upon BPI approval, sending notification to the Participant of the proposed restriction, at least ten days in advance, including reason(s) for restriction, effective date and length of restriction, name of designated Provider(s), option to change Provider(s), with a copy to BPI.
- Sending notification of the Participant's restriciton to the designated Provider(s) and the CAO.
- Enforcing the restrictions through appropriate notifications and edits in the claims payment system.
- Preparing and presenting the case at a DHS Fair Hearing to support restriction action.
- Monitoring subsequent utilization to ensure compliance.
- Changing the selected Provider per the Participant or Provider's request, within thirty (30) days from the date of the request, with notification within

five (5) business days to BPI through the Intranet Provider change process.

- Continuing a Participant restriction from the previous delivery system effective date a Participant enrolls in a MCO, with written notification to BPI.
- Reviewing the Participant's services prior to the end of the five-year period of restriction to determine if the restricition should be removed or maintained, with notification of the results of the review to BPI, Participant, Provider(s) and CAO.
- Submitting a participant's claims data to BPI, upon request, within ten (10) business days.
- Performing necessary administrative activities to maintain accurate records.
- Educating Participants and Providers about the restriction program, including explanations in handbooks and printed materials.

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

Department of Human Services
Office of Administration
Bureau of Program Integrity

Division of Program and Provider Compliance
Recipient Restriction Section
P.O. Box 2675
Harrisburg, Pennsylvania 17105-2675

Phone number: (717) 772-4627

2. Contracts and Subcontracts

The CHC-MCO may, as provided below, rely on Subcontractors to perform and/or arrange for the performance of services to be provided to Participants on whose behalf the Department makes Capitation payments to CHC-MCO. Notwithstanding its use of Subcontractor(s), the CHC-MCO is responsible for compliance with the Agreement, including:

a. The provision of and/or arrangement for the services to be provided under this Agreement;

b. The evaluation of the prospective Subcontractor's ability to perform the activities to be delegated;

c. The payment of any and all Claims payment liabilities owed to Providers

for services rendered to Participants under this Agreement, for which a Subcontractor is the primary obligor, provided that the Provider has exhausted its remedies against the Subcontractor; and provided further that such Provider would not be required to continue to pursue its remedies against the Subcontractor in the event the Subcontractor becomes insolvent, in which case the Provider may seek payment of such Claims from the CHC-MCO. For the purposes of this section, the term “insolvent” shall mean:

i. The adjudication by a court of competent jurisdiction or administrative tribunal of a party as bankrupt or otherwise approving a petition seeking reorganization, readjustment, arrangement, composition, or similar relief under the applicable bankruptcy laws or any other similar, applicable Federal or State law or statute; or

ii. The appointment by such a court or tribunal having competent jurisdiction of a receiver or receivers, or trustee, or liquidator or liquidators of a party or of all or any substantial part of its property upon the application of any creditor or other party entitled to so apply in any insolvency or bankruptcy proceeding or other creditor’s suit; and

d. The oversight and accountability for any functions and responsibilities delegated to any Subcontractor. These functions and responsibilities shall include the requirements provided in 42 C.F.R. §438.230(c)(3)(i).

e. The CHC-MCO shall require Subcontractors to comply with all applicable Medicaid rules, regulations, and guidance including the requirement that the Subcontractor and Network Providers agree to the audit and inspection authority of all Pennsylvania state and federal authorities or their designees pursuant to 42 CFR §438.230(3) for services provided pursuant to the Agreement.

The above notwithstanding, if the CHC-MCO makes payments to a Subcontractor over the course of a year that exceed one-half of the amount of the Department’s payments to the CHC-MCO, the CHC-MCO is responsible for any obligation by the Subcontractor to a Provider for services rendered to Participants by such Provider that has not been paid within sixty (60) days after the latter of (i) the determination by the Subcontractor that the Claim is payable, and (ii) the exercise by the Provider and the completion of all levels of the available Provider appeals process of the Subcontractor for a Claim that was, and continues to be, incorrectly denied, rejected or not adjudicated by the Subcontractor. Notwithstanding the foregoing, the CHC-MCO shall not have such an obligation to a Provider under this section in the event the Department has failed to make payment of amounts due and owing to the CHC-MCO, where such amounts past due equal or exceed one percent

of the revenue received by the CHC-MCO in the prior calendar year from the Department under this or any other HealthChoices Agreement. Any such obligation of the CHC-MCO to a Provider under this section shall be considered satisfied if payment thereof is made by the Subcontractor.

CHC-MCOs shall indemnify and hold the Commonwealth of Pennsylvania, the Department and their officials, representatives and employees harmless from any and all liabilities, losses, settlements, Claims, demands, and expenses of any kind (including but not limited to attorneys' fees) which are related to any and all Claims payment liabilities owed to Providers for services rendered to Participants under this Agreement for which a Subcontractor is the primary obligor, except to the extent that the CHC-MCO and/or Subcontractor has acted with respect to such Provider Claims in accordance with the terms of this Agreement.

The CHC-MCO must make all Subcontracts, including contracts between the Subcontractor and its network providers, available to the Department within five (5) days of a request by the Department. All Contracts and Subcontracts must be in writing and must include, at a minimum, the provisions contained in Exhibit P of this Agreement, Required Contract Terms for Administrative Subcontractors.

In accordance with Exhibit B, Standard Terms and Conditions, the CHC-MCO must submit for prior approval Subcontracts between the CHC-MCO and any individual, firm, corporation or any other entity to perform part or all of the selected CHC-MCO's responsibilities under this Agreement. This provision includes, but is not limited to, contracts for vision services, dental services, Claims processing, Participant services, and pharmacy services. This requirement for Department prior approval of Subcontracts also includes any Subcontract or Subcontract amendment which will result in the transmission of Participant personal health information or personally identifiable information to the Subcontractor. The Department requests that Subcontracts be submitted for review and approval 90 days prior to the planned implementation date of the Subcontract.

3. Records Retention

The CHC-MCO will comply with program standards regarding records retention, which are set forth in federal and state law and regulations and in Exhibit B, Standard Terms and Conditions for Services, and Exhibit O, CHC Audit Clause, of this Agreement, except that, for purposes of this Agreement, all records must be retained for a period of ten (10) years beyond expiration or termination of the Agreement, unless otherwise authorized by the Department.

Upon thirty (30) day notice from the Department, the CHC-MCO must provide copies of all records to the Department at the CHC-MCO's site or other location determined by the Department, if requested. This thirty (30) days notice does not apply to records requested by all Pennsylvania state and federal authorities and their designees for purposes of fiscal audits or Fraud and/or Abuse investigations.

In the event records are requested by the state or federal government for the purposes of fiscal audits or Fraud and/or Abuse investigations, the CHC-MCO must provide records requested by federal or state government agencies pursuant to audits or investigations within the timeframe designated by the requesting agency. The retention requirements in this section do not apply to DHS-generated Remittance Advices.

4. Fraud, Waste, and Abuse

The CHC-MCO must develop a written compliance plan that contains the following elements described in 42 CFR §438.608(a)(1)(i-vii) and CMS publication "Guidelines for Constructing a Compliance Program for Medicaid Managed Care Organizations and Prepaid Health Plans" found on the CMS website at:
https://www.cms.gov/Medicare-Medicaid-Coordination/Fraud-Prevention/FraudAbuseforProfs/Downloads/mccomplan.pdf
and that includes the following:

- Written policies, procedures, and standards of conduct that articulate the organization's commitment to comply with all applicable requirements and standards under the Agreement, and all applicable Federal and State requirements.
- The designation of a Compliance Officer who is responsible for developing and implementing policies, procedures, and practices designed to ensure compliance with the requirements of the Agreement and who reports directly to the Chief Executive Officer and the board of directors.
- The establishment of a Regulatory Compliance Committee on the Board of Directors and at the senior management level charged with overseeing the organization's compliance program and its compliance with the requirements under the Agreement.
- A system for training and education for the Compliance Officer, the organization's senior management and organization's employees on the applicable Federal and State requirements and applicable standards and requirements under the Agreement.
- Effective lines of communication between the compliance officer and CHC-MCO employees.
- Enforcement of standards through well publicized disciplinary guidelines.

- Establishment and implementation of procedures and a system with dedicated staff for routine internal monitoring and auditing of compliance risks, prompt response to compliance issues as they are raised, f investigation of potential compliance problems as identified in the course of self-evaluation and audits, correction of such problems promptly and thoroughly (or coordination of suspected criminal acts with law enforcement agencies) to reduce the potential for recurrence, and ensure ongoing compliance with the requirements under the Agreement.
- Procedures for systematic confirmation of services actually provided.
- Policies and procedures for reporting all Fraud, Waste, and Abuse to the Department and applicable law enforcement agencies.
- Policies and procedures for Fraud, Waste, and Abuse prevention, detection, and investigation.
- A policy of non-intimidation and non-retaliation for good faith participation in the compliance program, including, but not limited to, reporting potential issues, investigating issues, conducting self-evaluations, audits and remedial actions, and reporting to appropriate officials.
- A policy and procedure for monitoring Provider preclusion through databases identified by the Department.

a. Fraud, Waste and Abuse Unit

The CHC-MCO must establish a Fraud, Waste and Abuse Unit comprised of experienced Fraud, Waste and Abuse reviewers as required in 42 CFR §438.608(a)(1)(vii). This Unit must have the primary purpose of preventing, detecting, reducing, investigating, referring, and reporting suspected Fraud, Waste and Abuse that may be committed by Network Providers, Subcontractors, Network Providers of Subcontractors, Participants, Caregivers, Employees, or other third parties with whom the CHC-MCO contracts. If the CHC-MCO has multiple lines of business, the Fraud, Waste and Abuse Unit is required to have a dedicated full time CHC MA investigator to Participant ratio of at least one investigator per 60,000 Participants devoted to the CHC Program's Fraud, Waste and Abuse activities. The Department will make the final determination regarding whether or not the CHC-MCO is in compliance with these requirements in accordance with 42 CFR 438.608(a)(7).

b. Written Policies

The CHC-MCO must create and maintain written policies and procedures for the prevention, detection, investigation, reporting and referral of suspected Fraud, Waste and Abuse, including any and all Fraud and Abuse policies delineated under state and or federal mandate including but not limited to 42 CFR §438.608(a)(1)(i).

c. Access to Provider Records

The CHC-MCO's Fraud, Waste and Abuse policies and procedures must provide and certify that the CHC-MCO's Fraud, Waste and Abuse unit, as well as the entire Department, CMS, the HHS Inspector General, the Comptroller General, and Pennsylvania Office of Attorney General Medicaid Fraud Control Section or their designees have timely access to records of Network Providers, Subcontractors, and the CHC-MCO, as outlined in the Agreement.

d. Audit Protocol

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

The protocol is available on the Department's website at https://www.dhs.pa.gov/about/Fraud-And-Abuse/Pages/MA-Provider-Self-Audit-Protocol.aspx

e. Procedure for Identifying Fraud, Waste and Abuse

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

i. A description of the methodology and standard operating procedures used to identify and investigate Fraud, Waste and Abuse.

ii. A method for verifying with Participants whether services billed by Providers were received, as required by 42 CFR § 438.608(a)(5). Active verification requires the CHC-MCO to directly engage with consumers and develop a process to track both methods of verification and the results of verification attempts.

iii. A process to recover Overpayments or otherwise sanction Providers as required by 42 CFR §438.608(a)(5) and §438.608(d)(1)(i-iv).

iv. Provisions for payment suspension to a Network Provider for which the State determines that there is a credible allegation of Fraud as required in 42 CFR §455.23 and §438.608(a)(8).

v. Policies and procedures to initiate a prepayment review of a network provider's services where a review indicates billings are inconsistent with MA regulations or CHC-MCO policies, are unnecessary, are inappropriate to the Participants' health needs or contrary to customary standards of practice.

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

f. Fraud, Waste, and Abuse Referral

The CHC-MCO must establish and implement a policy for prompt referral of a suspected Provider or Direct Care Worker of Fraud, Waste and Abuse to the Department and also referral of suspected Fraud to the Pennsylvania Office of Attorney General, Medicaid Fraud Control Section as required in 42 C.F.R. §438.608(a)(7). A standardized referral process is outlined in Exhibit Q of this Agreement, Reporting Suspected Fraud, Waste, and Abuse to the Department and the Pennsylvania Office of Attorney General Medicaid Fraud Control Section.

If a CHC-MCO fails to promptly refer a case of suspected Fraud, Waste, or Abuse before the suspected fraud or abuse is identified by the Commonwealth of Pennsylvania, its designees, the United States or private parties acting on behalf of the United States, any portion of the Fraud, Waste, or Abuse recovered by the Commonwealth of Pennsylvania or designee shall be retained by the Commonwealth of Pennsylvania or its designees.

g. Education Plan

The CHC-MCO must create and disseminate written materials for the purpose of educating its employees, Providers, Subcontractors, and Subcontractors' employees about healthcare Fraud laws, the CHC-MCO's policies and procedures for preventing and detecting Fraud, Waste, and Abuse and the rights of individuals to act as whistleblowers. The CHC-MCO must provide written policies to all employees and to any contractor or agent that provides detailed information about the False Claims Act and other Federal and State laws described in 42 U.S.C. § 1396a(a)(68) and 62 P.S. §1401, et. seq., including information about rights of employees to be protected as whistleblowers.

h. Referral to Senior Management

The CHC-MCO must develop a certification process that demonstrates the policies and procedures under section 4.b above were reviewed and approved by the CHC-MCO's senior management on an annual basis.

i. Prior Department Approval

The Fraud, Waste and Abuse policies and procedures must be submitted to the Department for prior approval, and the Department may, upon review

of these policies and procedures, require that specified changes be made within a designated time in order for the CHC-MCO to remain in compliance with the terms of the Agreement. To the extent that changes to the Fraud, Waste and Abuse unit are made, or the policies or procedures are altered, updated policies and procedures must be submitted promptly to the Department. The Department may also require new or updated policies and procedures during the course of this Agreement period.

j. Duty to Cooperate with Oversight Agencies

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

Such cooperation must include providing access to all necessary case information, computer files, and appropriate staff as well as the results of associated internal investigations and audits. In addition, such cooperation will include participating in periodic Fraud, Waste and Abuse training sessions, meetings, and joint reviews of Providers, Subcontractors, Caregivers, or Participants.

k. Hotline Information

The CHC-MCO must distribute the Department's toll-free MA Provider Compliance Hotline telephone number and accompanying explanatory statement to its Participants and Providers through its Participant Handbook and Provider Handbooks. The explanatory statement needs to include at a minimum the following information:

i. *Recipient Fraud*: Includes, but is not limited to, someone receiving cash assistance, Supplemental Nutritional Assistance Program (SNAP) benefits, Heating/Energy Assistance (LIHEAP), child care, Medical Assistance, or other public benefits AND that person is not reporting income, not reporting ownership of resources or property, not reporting who lives in the household, allowing another person to use his or her ACCESS/MCO card, forging or altering prescriptions, selling prescriptions/medications, trafficking SNAP benefits or taking advantage of the system in any way.

ii. *Provider Fraud*: Includes, but is not limited to, Billing for services not rendered, billing separately for services in lieu of an available combination code; misrepresentation of the service/supplies rendered (billing brand named for generic drugs; upcoding to more expensive service than was rendered; billing for more time or units of service than provided; billing incorrect provider or service location); altering Claims, submission of any false data on Claims, such as date of service, Provider or prescriber of service, duplicate billing for the same service; billing for services provided by unlicensed or unqualified persons; billing for used items as new.

I. Duty to Notify

i. Department's Responsibility

The Department will provide the CHC-MCO with prompt notice via electronic transmission or access to Medicheck listings or upon request if a Network Provider with whom the CHC-MCO has entered into a Provider Agreement is subsequently suspended or terminated from participation in the MA or Medicare Programs. Upon notification from the Department that a Network Provider is suspended or terminated from participation in the MA or Medicare Programs, the CHC-MCO must immediately act to terminate the Provider from its Network. Terminations for Medicare exclusions and loss of licensure and criminal convictions must coincide with the MA effective date of the action.

ii. CHC-MCO's and Subcontractors' Responsibility

The CHC-MCO and its Subcontractors are required to check the Social Security Administration's Death Master File (SSADMF), and National Plan and Provider Enumeration System (NPPES) at the time of a Provider's initial Enrollment and re-Enrollment. The CHC-MCO and its Subcontractors are also required to check Providers and their owners, agents, and managing employees against the U.S. Department of Health and Human Services-Office of Inspector General's (HHS-OIG) List of Excluded Individuals and Entities (LEIE), the System for Award Management (SAM), and the PA Medicheck list on a monthly basis as required by 42 CFR § 455.436.

The CHC-MCO and its Subcontractors may not have a Relationship with the following:

- Individuals, entities, or subcontractors with a disclosure of any

relationship prohibited by 42 C.F.R. § 438.610(b).

- An individual or entity or an Affiliate (as defined in the Federal Acquisition Regulation at 48 CFR 2.101) of an individual or entity who is debarred, suspended, or otherwise excluded from participating in procurement activities under the Federal Acquisition Regulation, 48 CFR Chapter 1, or from participating in non-procurement activities under regulations issued under Executive Order No. 12549 or under guidelines implementing Executive Order No. 12549.

"Relationship," for purposes of this section, is defined, in accordance with 42 CFR 438.610(c) as follows:

- A director, officer, agent (as defined by 42 CFR §§ 455.101 and 1001.2), or managing employee MCO (as defined by 42 CFR §§ 455.101 and 1001.2), or partner of the CHC-MCO or its Subcontractors.
- A person with ownership interest of five percent (5%) or more of the CHC-MCO's or its Subcontractors Equity.
- A person with an employment, consulting, or other arrangement for the provision of items and services that are significant and material to the CHC-MCO's or it Subcontractors' obligations under this Agreement with the Department.
- An individual entity or Subcontractor as governed by 42 C.F.R. § 438.230.

The CHC-MCO must notify the Department, in writing, within 24 business hours, if a Network Provider or Subcontractor is subsequently suspended, terminated, or withdraws (whether or not voluntarily) from participation in the MA program as a result of suspected or confirmed Fraud, Waste, or Abuse. The CHC-MCO must also immediately notify the Department, in writing, if it or its Subcontractor terminates or suspends an employee as a result of an investigation, review, or audit of suspected or confirmed Fraud, Waste, or Abuse. The CHC-MCO must inform the Department, in writing, of the specific underlying conduct that led to the suspension or termination, including for cause and/or best interest, or withdrawal (whether or not voluntary).

Provider Agreements must carry notification of the prohibition against and sanctions for submission of false Claims and statements. CHC-MCOs are subject to sanctions, penalties, or other actions if the CHC-MCO or its Subcontractor fail to report such information. The Department's enforcement guidelines are outlined in Exhibit Y, Guidelines for Sanctions Regarding Fraud, Waste and Abuse.

The CHC-MCO must also refer to the Department, within 30 days of

identification, if it recovers Overpayments or improper payments related to Fraud, Waste, or Abuse of MA funds from Overpayments or improper payments made to Network Providers. The CHC-MCO or its Subcontractor must also notify the Department of any adverse actions taken against a Provider, such as restricting the Participants or services of a PCP.

m. Sanctions

The Department will impose sanctions or take other actions against the CHC-MCO, as specified in Section VIII.I, if the CHC-MCO fails to report the information required in Section V.X.4.I, and/or if it determines that a CHC-MCO, Network Provider, employee, Caregiver, or Subcontractor has committed Fraud, Waste, or Abuse as defined in this Agreement or has otherwise violated applicable law. See Exhibit Y, Guidelines for Sanctions Regarding Fraud, Waste and Abuse, identifies the Fraud, Waste and Abuse issues that may result in sanctions, as well as the range of sanctions available to the Department.

n. Subcontracts and Provider Agreements

i. The CHC-MCO will require via written agreements that all Network Providers and all Subcontractors take actions as are necessary to permit the CHC-MCO to comply with the Fraud, Waste, and Abuse requirements listed in this Agreement as well as federal regulations including but not limited to 42 CFR § 438.608.

ii. To the extent that the CHC-MCO delegates oversight responsibilities to a third party (such as a Pharmacy Benefit Manager), the CHC-MCO must require that such third party complies with the applicable provisions of this Agreement relating to Fraud, Waste and Abuse.

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

iv. The CHC-MCO and their Subcontractors must suspend payment to a Network Provider when the Department determines there is a credible allegation of fraud against that Network Provider, unless the Department determines there is good cause for not suspending such payments pending the investigation.

v. The CHC-MCO shall require its Subcontractors to comply with the

requirements set forth in 42 CFR §438.230(c) .

vi. The CHC-MCO Subcontractor agreement must specifically state that the Subcontractor will agree to the audit and inspection authority of all Pennsylvania state and federal authorities or their designees, access to audit, evaluate, and inspect books, records, etc., which pertain to the delivery of or payment for Medicaid services under this Agreement. Subcontractors must make such books, records, premises, equipment, staff, etc. all available for an audit at any time. The right to inspect extends for ten (10) years after termination of the Agreement, or conclusion of an audit, whichever is later.

o. Fraud, Waste and Abuse and Prosecution Agencies

Disputes of any kind resulting from action taken by the oversight agencies are directed to the responsible agency. Examples include: Pennsylvania Department of Human Services, Pennsylvania Governor's Office of the Budget, Pennsylvania Treasury, Pennsylvania Department of the Auditor General, Centers for Medicare and Medicaid Services, United States Comptroller General, Department's BPI, its vendor or other designee, the Pennsylvania Office of the Attorney General's Medicaid Fraud Control Section, the Pennsylvania Office of State Inspector General, the Department of Health and Human Services' Office of Inspector General, the United States Attorney's Office/Department of Justice, and the Federal Bureau of Investigation.

p. Provider Reviews and Overpayment Recovery

- The CHC-MCO and any Subcontractor must report to the State within 60 calendar days when it has identified any Capitation payments or other payments in excess of amounts specified in the Agreement per 42 CFR § 438.608(c)(3). The CHC-MCO must submit data, documentation and information to the Department as specified under 42 CFR § 438.604 and certify the data, documentation, and information as required by 42 CFR § 438.606.

- The CHC-MCO shall audit, review, and investigate Providers/Participants/caregivers within its Network through prepayment and retrospective payment reviews. The CHC-MCO shall cost avoid or recover any overpayments directly from its Network Providers for audits, reviews or investigations conducted solely by the CHC-MCO or through Network Provider self-audits.

- The CHC-MCO will void Encounters for those claims involving full recovery of the payment and adjust Encounters for partial recoveries.

- The CHC-MCO must notify BPI in writing when it plans to recover and when it has recovered Overpayments or improper payments related to Fraud, Abuse or Waste of Medical Assistance services.

- The CHC-MCO must report all voids and adjustments to Encounters to the Department.

- The Department has the right to audit, review, and investigate CHC-MCO Network and Out-of-Network Medical Assistance Providers.
  - The Department developed a vetting process to coordinate audits, reviews, or investigations of the CHC-MCO Network and out-of-network Providers to avoid duplication of effort.
  - Through the vetting process, the CHC-MCO must provide information to BPI as requested including, but not limited to, the CHC-MCO's Claims history, policies/procedures, Provider contracts and fee schedules, provider/participant review history and current status, Complaints, barriers to reviewing the subject Provider/ Participant/Caregiver and payment methodology/arrangement.
  - The CHC-MCO must provide this information within fifteen (15) business days of the Department's request. The CHC-MCO must respond to urgent requests within two (2) business days.
  - The CHC-MCO cannot initiate or continue a review, project, or recovery of an MA Provider after the Department advises the CHC-MCO of its intention to open a review or investigation by the Department, its designee, or another State or Federal agency, without written Departmental authorization to proceed.
  - The CHC-MCO will not notify Providers/Participants/caregivers of the Department's intention to initiate a review.
  - The Department will inform the CHC-MCO and the Provider(s) of its request for records, and the preliminary and final findings related to BPI's review of MA Providers.
  - Overpayment recoveries resulting from audits, reviews

or investigations initiated by or on behalf of the Department, that are not part of a mutually agreed upon joint investigation, will be recouped from the CHC-MCO.

- The Department may utilize statistically valid random sampling in the selection of claims/encounters for review and apply extrapolation methodology in determining the Overpayment amount.
- The CHC-MCO must submit an annual report of Overpayments identified or recovered as required by 42 C.F.R. § 438.608(d)(3).
- The CHC-MCO should recoup Overpayments resulting from audits, reviews or investigations conducted independently by the Department, from its Medical Assistance Network Providers paid by the CHC-MCO after the CHC-MCO receives notice of the final findings from the Department.
- Overpayment recoveries resulting from audits, reviews or investigations initiated by or on behalf of the Department, that are not part of a mutually agreed upon joint investigation, will be recouped from the CHC-MCO.
- The Department will deduct the restitution demanded from a future payment to the CHC-MCO after forty-five (45) days from the mail date of the Department's notice of final findings.
- The CHC-MCO must submit a corrective action plan to the Department, upon request, to resolve any Network Provider's regulatory violations identified through the Department's, its vendor's, or other designee's audit, review, or investigation.

- The Department may require the CHC-MCO or its Subcontractor to withold payment to a MA Provider or to initiate a pre-payment review as a result of law enforcement reviews and activities or the Department's audits, reviews or investigations as required in 42 CFR §§438.608(a)(8) and 455.23.
- The CHC-MCO or its Subcontractor will monitor Claims to a Provider during a payment suspension. The CHC-MCO will report on a monthly basis, in writing, to BPI, or the Subcontractor will report on a monthly basis to BPI the amount of funds withheld from the provider during the payment suspension. If the Provider is subsequently convicted and restitution is owed, these funds will be adjusted from the capitated payments.
  - Upon completion of the Provider Payment Suspension Report, the CHC-MCO must submit the report via DocuShare. The CHC-MCO must provide a monthly data certification statement signed by the Chief Executive

Officer, the Chief Financial Officer or the Chief Operations Officer and the Special Investigation Unit (SIU) Manager/Compliance Officer with every reporting package it submits. The Provider Payment Suspension Report and monthly data certification statement are located on the HealthChoices Extranet under Fraud and Abuse. If revisions are made to any report, an additional monthly certification statement must be submitted to the Department of Human Services with the revised report.

- Joint reviews, audits, or investigations between the CHC-MCO, the Department or its designee may be conducted. Any recoveries as a result of joint audit, review, or investigation shall be shared equally between the CHC-MCO and Department after payment of any required contingency fee to the vendor. DHS's, its contractor's, or other designee's request for vetting of a Provider and/or the MCO's provision of information related to a Provider review, audit or investigation does not constitute a mutually agreed upon joint review.
- The Department may periodically monitor and evaluate the CHC-MCO's audits, reviews, and investigations of MA Providers/Participants/Caregivers.

5. Electronic Visit Verification

The CHC-MCO must have a fully operational EVV system for in-home personal care and home health services that complies with the requirements of 42 U.S.C. § 1396b(l). The EVV system must verify and record electronically (for example, through a telephone or computer-based system) at least the following: the type of service performed, the individual receiving the service, the individual providing the service, the date of the service, the location of the service, and the time the service begins and ends. In addition to capturing the elements outlined above, the EVV system must meet the technical specifications outlined in the DHS EVV Addendum and be able to interface with the DHS EVV Aggregator.

Providers may choose to use their own EVV vendor/system so long as the system meets all of the necessary requirements. Providers using an alternate EVV system in the CHC program will need to establish an interface with the CHC-MCOs.

The CHC-MCOs must follow all EVV requirements outlined by the Department. The CHC-MCOs are responsible for monitoring provider compliance requirements outlined in the corresponding bulletins and must implement corrective action plans when providers do not meet the compliance requirements. The CHC-MCO must monitor that no individual

Provider exceeds the manual edit threshold established and communicated by the Department via MA Bulletin for more than one quarter. If a Provider exceeds the established manual edit threshold for two or more consecutive quarters, the CHC-MCO shall impose progressive corrective action requirements or penalties upon the Provider until the non-compliance is ameliorated. The CHC-MCO shall ensure that its own aggregate EVV submissions to the Department do not exceed the established manual edit threshold. If this threshold is exceeded for two or more consecutive quarters, the Department may impose sanctions, inclusive of corrective action and financial penalties.

CHC-MCOs are required to validate that visit data submissions support claims submissions as part of the adjudication process. All encounter claims submitted for services subjected to EVV requirements must have corresponding visit data submitted to the DHS Aggregator.

The implementation of EVV must not negatively impact the provision of services. CHC-MCOs and Providers may not limit the locations for EVV as long as the locations are allowable by the program as detailed in bulletins and ops memos issued by the Department. The Department's policies and procedures regarding the provision of services remain the same and service delivery should continue as it did before the implementation of these EVV requirements. EVV does not change the method and location for service delivery.

6. Management Information Systems

The CHC-MCO must have a secure, comprehensive, automated, and integrated MIS that includes a test environment and is capable of meeting the requirements listed below and throughout this Agreement. Information on Business and Technical Standards is available on the DHS website.

a. The CHC-MCO must have a minimum of the following MIS components or the capability to interface with other systems containing Participant, Provider, Claims Processing, Prior Authorization, and Reference data.

b. The CHC-MCO must have a sufficient MIS to support data reporting requirements specified in this Agreement

c. The CHC-MCO's Participant management system must have the capability to receive, update, and maintain Participant files consistent with specifications provided by the Department. The CHC-MCO must have the capability to provide daily updates of Participant information to Subcontractors and Providers who have responsibility for processing Claims or authorizing services based on Participant information.

d. The CHC-MCO's Provider database must be maintained with detailed information on each Provider sufficient to support Provider payment and meet the Department's reporting and Encounter Data requirements.

   The CHC-MCO must be able to cross-reference its internal Provider identification number to the correct MMIS Provider ID and NPI number in the Department's MMIS for each location at which the Provider renders services for the CHC-MCO.

   The CHC-MCO must verify that each Network Provider service location is enrolled and active with MA, and that information for all service locations is maintained in its own system.

   The CHC-MCO must verify that each Network Provider's license information is valid in the Department's MMIS and must outreach to Network Providers to stress the importance of maintaining up-to-date information in the Department's MMIS.

   The CHC-MCO must require Network Providers with specific Provider types and specialties have the same Provider types and specialties in the Department's MMIS for each service location.

e. The CHC-MCO's Claims Processing system must have the capability to process Claims consistent with timeliness and accuracy requirements identified in this Agreement.

f. The CHC-MCO's Prior Authorization system must be linked with its Claims Processing component.

g. The CHC-MCO's MIS must be able to maintain its Claims history with sufficient detail to meet all Department reporting and Encounter Data requirements.

h. The CHC-MCO's credentialing system must have the capability to store and report on Provider-specific data sufficient to meet the Department's credentialing requirements and those listed in Exhibit F, Quality Management and Utilization Management Program Requirements.

i. The CHC-MCO must have sufficient telecommunication capabilities, including email, to meet the requirements of this Agreement.

j. The CHC-MCO must have the capability to electronically exchange data files with the Department and the IEB. The CHC-MCO must use a secure FTP product that is compatible with the Department's product.

k. The CHC-MCO's MIS must be bidirectionally linked to all operational systems listed in this Agreement, so that data captured in Encounter records accurately matches data in Participant, Provider, Claims, and Prior Authorization files. Encounter Data will be utilized for:

- Participant and Provider profiling,
- Claims validation,
- Fraud, Waste, and Abuse monitoring activities,
- Rate setting, and
- Any other research and reporting purposes defined by the Department.

l. The CHC-MCO must comply with the Department's Business and Technical Standards including connectivity to the Commonwealth's network for Extranet access. The CHC-MCO must also comply with any changes made to these Standards.

The CHC-MCO must comply with the Department's Se-Government Data Exchange Standards.

Whenever possible, the Department will provide advance notice of at least sixty (60) days prior to the implementation of changes. For more complex changes, the Department will make every reasonable effort to provide additional notice.

m. The CHC-MCO must be prepared to document its ability to expand claims processing or MIS capacity should either be exceeded through the enrollment of Participants.

n. The CHC-MCO must designate appropriate staff to participate in DHS-directed development and implementation activities.

o. The CHC-MCO must have formalized System Development Life Cycle processes, procedures, controls, and governance frameworks in place for management of its MIS and affiliated infrastructure, affiliated application, technology, and infrastructure roadmaps in place that outline the current capabilities and future direction of the MIS, and procedures for when CHC-MCO and DHS representatives will be engaged to address current and future business needs and requirements.

p. Subcontractors must meet the same MIS requirements as the CHC-MCO, and the CHC-MCO will be held responsible for MIS errors or noncompliance resulting from the action of a Subcontractor. The CHC-MCO must provide its Subcontractors with the appropriate files and information to meet this requirement (e.g., the Daily 834

Eligibility File, Provider files).

q. The CHC-MCO's MIS shall be subject to review and approval during the Department's Readiness Review process.

r. The CHC-MCO must maintain the security of Commonwealth data and information including:

- Compliance with all applicable Federal and State statutes and regulations regarding security standards,
- Demonstration that specific controls are in place to safeguard MIS and Commonwealth data and information, and
- Demonstration of procedures for mitigating data breaches.

s. Prior to any major modifications to the CHC-MCO's MIS, including upgrades and new purchases, the CHC-MCO must inform the Department in writing of the potential changes at least 180 days prior to the change. The CHC-MCO must provide a work plan detailing recovery efforts and the use of parallel system testing.

t. The CHC-MCO must be able to accept and generate HIPAA-compliant transactions as required in the ASC X12 Implementation Guides.

u. The Department will make Drug, Procedure Code, and Diagnosis Code reference files available to the CHC-MCO on a routine basis to allow it to effectively meet its obligation to provide services and record information consistent with requirements in this Agreement.

If the CHC-MCO chooses not to use these files, it must document the use of comparable files to meet its obligation with this Agreement.

Information about these files is available on the Pennsylvania HealthChoices Extranet.

v. The Department will supply Provider files on a routine basis to allow the CHC-MCO to effectively meet its obligation to provide services and record information consistent with requirements in this Agreement. These files include:

- List of Active and Closed Providers (PRV414 and PRV415),
- NPI Crosswalk (PRV430),
- Provider Revalidation File (PRV720),
- Special Indicators (PRV435), and
- Network Provider File (Managed Care Affiliates, PRV640Q).

The CHC-MCO must use the PRV414 or PRV415 files with the PRV430 on a monthly basis to reconcile its Provider database with that of the Department to confirm:

- All participating Providers are enrolled in MA for all service locations as defined by MA enrollment rules,
- Participating Provider license information is valid,
- Provider Types and Specialties match, and
- Each Provider's NPI, taxonomy, and nine-digit zip code for each service location match.

CHC-MCOs must use the PRV640Q to reconcile Provider information previously submitted on the Network Provider file (PRV640M).

Information about these files is available on the Pennsylvania HealthChoices Extranet.

w. The CHC-MCO must have a disaster recovery plan in place with written policies and procedures containing information on system backup and recovery in the event of a disaster.

x. The CHC-MCO must reconcile the 820 Capitation Payment file with its internal membership information and report any discrepancies to the Department within thirty (30) days.

y. To support the CHC-MCO in meeting the requirements of this agreement, the Department will provide access to the following systems:

- The Department's MMIS
- Pennsylvania HealthChoices Extranet
- Client Information System (eCIS)
- DocuShare

Access to these systems is in addition to the various files that CHC-MCOs will receive via secure file transfer. Information on obtaining access to these resources is on the Pennsylvania HealthChoices Extranet.

7. Department Access

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

inspection authority of all Pennsylvania state and federal authorities, or their designees to audit, evaluate, and inspect books, records, etc., which pertain to the delivery of or payment for Medicaid services. Subcontractors must make books, records, premises, equipment, staff, etc. all available for an audit at any time. The right to inspect extends for ten (10) years after termination of Agreement, or conclusion of an audit, whichever is later.

In addition to other access requirements, the CHC-MCO must provide the Department with access to administrative policies and procedures pertaining to operations, including, but not limited to:

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

Y. Selection and Assignment of PCPs

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

- Honors a Participant's selection of a PCP or PCP group, if permitted through the IEB.
- Honors a Dual Eligible Participant's selection of a PCP. A Dual Eligible Participant is not required to have a Network Provider as a PCP and must be permitted to designate his/her Medicare-participating PCP as his or her CHC PCP.
- For all non-dual eligible Participants, the PCP must be a Network Provider except where an Out-Of-Network PCP is permitted under DOH regulations.
- May allow selection of a PCP group. In addition, the CHC-MCO may assign a PCP group to a Participant if the Participant has not selected a PCP or a PCP group at the time of Enrollment.
- If the Participant has not selected a PCP through the IEB for reasons other than cause, the CHC-MCO must make contact with the Participant within seven (7) business days of his or her Enrollment and provide information on options for selecting a PCP, unless the CHC-MCO has information that the Participant should be immediately contacted due to a medical condition requiring immediate care.
- If a Participant does not select a PCP within fourteen (14) business days of Enrollment, the CHC-MCO must make an assignment. If the Participant is enrolled in the D-SNP aligned with the CHC-MCO, the CHC-MCO must assign the PCP who the Participant uses in the D-SNP. The CHC-MCO

must consider such factors to the extent they are known, such as current Provider relationships that may be identified through Encounters, existing Service Plans, or any CHC-MCO contacts with the Participant, specific medical needs, physical disabilities of the Participant, language needs, cultural compatibility, area of residence and access to transportation. The CHC-MCO must then notify the Participant by telephone or in writing of his or her PCP’s name, location, and office telephone number. The CHC-MCO must make every effort to determine PCP choice and confirm this with the Participant prior to the commencement of the CHC-MCO coverage in accordance with Participant Enrollment and Disenrollment, so that new Participants do not go without a PCP for a period of time after Enrollment begins.

- The CHC-MCO must have written policies and procedures for allowing Participants to select or be assigned to a new PCP whenever requested by the Participant, when a PCP is terminated from the Network, or when a PCP change is required as part of the resolution to a Grievance or Complaint proceeding. The policies and procedures must receive advance written approval from the Department.
- In cases where a PCP has been terminated from the Network for reasons other than cause, the CHC-MCO must immediately inform Participants assigned to that PCP in order to allow them to select another PCP prior to the PCP’s termination effective date. In cases where a Participant fails to select a new PCP, re-assignment must take place prior to the PCP’s termination effective date.
- Participants can request a specialist as a PCP. If the CHC-MCO denies the request, that denial is appealable.
- If a Participant uses a Pediatrician or Pediatric Specialist as a PCP, the CHC-MCO must, upon request, assist with the transition to a PCP who provides services for adults.
- The CHC-MCO must allow any Participant who is an Indian as defined in 42 CFR § 438.14(a), and who is both enrolled in the CHC-MCO and eligible to receive services from an I/T/U Health Care Provider ("I/T/U HCP") PCP participating in the CHC-MCO's network, to choose that participating I/T/U HCP as their PCP, as long as the I/T/U HCP has capacity to provide the services.

CHC-MCOs must assist medically fragile young adult Participants and/or their guardians when transitioning to an adult PCP and are required to develop payment mechanisms to enable both pediatric and adult care Providers to receive payment for medically necessary services provided concurrently during the transition process.

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

Z. Selection and Assignment of Service Coordinators

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

- The CHC-MCO must offer the Participant a choice of Service Coordinators from amongst those employed by or under contract with the CHC-MCO. During the Service Coordinator selection process, the CHC-MCO must provide the Participant with information about Service Coordinators within their coverage area, including a brief description of any special skills and work experience. If requested, the Participant must be allowed to speak to the Service Coordinators as part of the selection process.
- At the time of an Assessment that indicates a need for LTSS, the CHC-MCO must provide the Participant with information on options for selecting or changing a Service Coordinator. If the Participant has not selected a Service Coordinator within seven (7) business days of the Assessment, then the CHC-MCO must assign a Service Coordinator. The CHC-MCO shall assign the Service Coordinator immediately if the CHC-MCO has information that the Participant should be immediately contacted due to a medical condition requiring immediate care.
- When assigning a Service Coordinator the CHC-MCO may consider such factors (to the extent they are known) as current Provider relationships, prior service coordinator, the person assigned to the Participant for care management in the CHC-MCO's aligned D-SNP, specific medical needs, physical disabilities of the Participant, language needs, cultural compatibility, area of residence and access to transportation. The CHC-MCO must then notify the Participant by telephone and in writing of his or her Service Coordinator's name, location, and office telephone number. The CHC-MCO must make every effort to determine Service Coordinator choice and confirm this with the Participant. The CHC-MCO may contact new Participants prior to the commencement of their CHC-MCO coverage, so that new Participants do not go without a Service Coordinator for a period of time after Enrollment begins or after Assessment.
- If a Participant requests a change in his or her selected or assigned Service Coordinator, the CHC-MCO must promptly grant the request and process the change in a timely manner.
- The CHC-MCO must have written policies and procedures for allowing Participants to select or be assigned to a new Service Coordinator whenever requested by the Participant, when a Service Coordinator is terminated from the Network or when a Service Coordinator change is required as part of the resolution to a Grievance or Complaint proceeding.
- The CHC-MCO must submit its policies and procedures for review and approval by the Department.

AA. Provider Services

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

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

CHC-MCOs must maintain a provider portal that complies with 40 P.S. § 991.2153.

The CHC-MCO must publish the following data on its publicly accessible website, excluding data on Covered Drugs, at the plan level, for the previous calendar year no later than March 31:

a. A list of all items and services that require prior authorization.

b. The percentage of each of the following, aggregated for all items and services:

1. Standard requests for prior authorization that were approved, denied, and approved after appeal.
2. Requests for prior authorization with extended timeframe for review that were approved.
3. Expedited requests for prior authorization that were approved and denied.

c. The average and median time elapsed between provider submission and CHC-MCO determination of each of the following, aggregated for all items and services:

1. Standard requests for prior authorization
2. Expedited requests for prior authorization.

1. Provider Manual

The CHC-MCO must keep its Network Providers informed and up-to-date with the latest policy and procedures changes as they affect the MA Program and must develop and maintain a Provider Manual. The CHC-MCO must distribute Provider Manuals in a manner that makes them easily accessible to all Network Providers.

The CHC-MCO may specifically delegate this responsibility to large Providers in its Provider Agreement. The Provider Manual must be updated annually. The Department may grant an exception to this annual requirement upon written request from the CHC-MCO provided there are no major changes to the manual.

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

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

2. Provider Orientation and Ongoing Education

The CHC-MCO must develop and maintain a Provider Network that is knowledgeable and experienced in treating and supporting Participants in CHC. The CHC-MCO must submit and obtain prior approval from the Department for a new Provider orientation and training work plan and an annual ongoing Provider educational plan that outlines its plans to educate and train Network Providers and its process for measuring outcomes, including the tracking of schedules and attendance. The initial Provider orientation must be completed by the CHC-MCO no later than 45 days after the provider's contract effective date. Ongoing Provider education must be completed at a minimum (each calendar year) yearly by each Provider in the MCOs network. The format for this work plan will be designated by the Department through its operations reporting requirements found on the Pennsylvania HealthChoices Extranet. The CHC-MCO must develop its work plan in conjunction with the Department and must include all topic areas identified by the Department. The CHC-MCO must also include Participants, advocates, direct care worker representatives, and family members in designing and implementation of the work plan.

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

a. Needs screening, Assessment and Reassessment, service planning system and protocols and a description of the Provider's role in service planning and Service Coordination.

b. Service Coordination and how the Provider will fit into the PCPT approach.

c. The population being served through CHC.

d. Accessibility requirements with which Providers must comply.

e. Application of the Agreement definition of Medically Necessary.

f. Information about Alzheimer's Disease and related dementias, including information on assisting with and managing the symptoms and care needs of people with dementia throughout the course of their disease.

g. Identification and appropriate referral for mental health, and drug and alcohol and substance abuse services.

h. The diverse needs of persons with disabilities, such as persons who are deaf or hard of hearing, how to obtain sign language interpreters and how to work effectively with sign language interpreters.

i. CHC-MCO policies against discrimination to achieve competency in treating Participants without discrimination on the basis of race, color, creed, sex, religion, age, national origin, ancestry, marital status, sexual orientation, gender identity, language, MA status, income status, program participation, health status, disease or pre-existing condition, anticipated need for healthcare or physical or mental handicap.

j. Cultural, Linguistic and Disability Competency, including: the right of Participants with LEP to engage in effective communication in their language; how to obtain interpreters; and how to work effectively with interpreters.

k. Treating the populations served by the CHC-MCO, including treatment for Participants with disabilities.

l. Administrative processes that include, but are not limited to: COB, Recipient Restriction Program, and Encounter Data reporting.

m. Issues identified by Provider relations or Provider hotline staff in response to calls or complaints by Providers.

n. Issues identified through the QM process.

o. The process to submit materials to the CHC-MCO for utilization review and Prior Authorization review decisions. Submitted materials must include, but are not limited to, letters of medical necessity.

p. The Complaint, Grievance and DHS Fair Hearing and Appeals process,

including, but not limited to, expectations for a Provider should a Provider represent a Participant at a Grievance hearing.

q. Performance Improvement Plans and how Providers may benefit from participation in these programs.

r. Dual eligibility for Medicare and Medicaid and coordination of services for Participants who are Dual Eligible.

s. Inform Providers of the Pennsylvania MA Provider Self Audit Protocol located at https://www.dhs.pa.gov/about/Fraud-And-Abuse/Pages/MA-Provider-Self-Audit-Protocol.aspx

t. Proper utilization of EVS to verify Participant eligibility and enrollment when a patient presents without a Participant identification card.

u. Provider and Participant fraud, waste, and abuse.

v. Mandated reporting requirements.

w. Emergency disaster planning.

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

BB. Provider Network

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

If the CHC-MCO's Provider Network is unable to provide necessary Covered Services covered under the Agreement to a Participant, the CHC-MCO must adequately and timely cover these services out-of-network with an MA-enrolled

Provider for the Participant for as long as the CHC-MCO is unable to provide them and must coordinate with that Provider with respect to payment.

1. Provider Qualifications

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

2. Provider Agreements

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

The requirements for these Provider Agreements are set forth in Exhibit U, Provider Agreements.

Provider Agreements may not prohibit a Provider from contracting with another CHC-MCO or prohibit or penalize the CHC-MCO for contracting with other Providers.

3. Cultural Competency, Linguistic Competency, and Disability Competency

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

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

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

4. Primary Care Practitioner Responsibilities

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

a. Providing primary and preventive care, acting as the Participant's advocate, and providing, recommending, and arranging for services.

b. Documenting all care rendered in a complete and accurate Encounter record that meets or exceeds the DHS data specifications.

c. Maintaining continuity of each Participant’s healthcare

d. Communicating effectively with the Participant by using specialized interpretive services for Participants who are deaf and blind, and oral interpreters for those Participants with LEP when needed. Interpreter services must be free of charge to the Participant and the PCP cannot require family members to be used for interpretation.

e. Making referrals for specialty care and other Medically Necessary services, both in and out-of-plan.

f. Maintaining a current medical and other service record for the Participant, including documentation of all services provided to the Participant by the PCP, as well as any specialty or referral services.

g. Coordinating BH Services by working with BH-MCOs as specified in Exhibit H, Coordination with the BH-MCOs.

h. The CHC-MCO will retain responsibility for monitoring PCP actions for compliance with this Agreement.

5. Specialists as PCPs

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

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

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

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

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

The CHC-MCO must have adequate Network capacity of qualified specialists to act as PCPs. These physicians may be predetermined and listed in the directory but may also be determined on an as-needed basis. The CHC-MCO must establish credentialing and recredentialing policies and procedures to ensure compliance with these specifications that meet the credentialing requirements outlined in the framework provided by the Department.

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

6. Related Party

A hospital, NF, or home health agency that is a Related Party to a CHC-MCO must negotiate in good faith with other CHC-MCOs regarding the provision of services to Participants. The Department may terminate this Agreement with

the CHC-MCO if it determines that a Provider related to the CHC-MCO has refused to negotiate in good faith with other CHC-MCOs. The CHC-MCO must negotiate and make referrals in good faith with non-related providers.

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

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

7. Integration

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

The CHC-MCO must investigate Complaints and take affirmative action when Participants experience discriminatory treatment or are segregated without a medical indication. Examples of prohibited practices include, but are not limited to, the following:

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

If the CHC-MCO knowingly executes an Agreement with a Provider with the intent of allowing or permitting the Provider to implement barriers to care (i.e., the terms of the Provider Agreement are more restrictive than this Agreement), the CHC-MCO shall be in breach of this Agreement.
The CHC-MCO must have explicit policies to provide access to complex interventions such as cardiopulmonary resuscitations, intensive care,

transplantation and rehabilitation when medically indicated and must educate its Network Providers on these policies. Healthcare and treatment necessary to preserve life must be provided to all Participants who are not terminally ill or permanently unconscious, except where a competent Participant objects to such care on his or her own behalf or has objected through an executed Advanced Healthcare Directive.

8. Network Changes/Provider Terminations

a. Network Changes

i) Notification to the Department
Other than terminations outlined below in Section 8.b Provider Terminations, the CHC-MCO must notify the Department within ten (10) days of any changes to its Provider Network such as closed panels, relocations, death of a Provider, and a change in a Network Provider's circumstances that would negatively impact the ability of Participants to access services.

ii) Procedures and Work Plans
The CHC-MCO must have procedures to address changes in its Network that impact Participant access to services, in accordance with the requirements of Exhibit T, Provider Network Composition/Service Access. The Department may find the CHC-MCO in default based on its failure to address changes in Network composition that negatively affect Participant access.

iii) Timeframes for Notification to Participants
The CHC-MCO must update web-based Provider directories to reflect any changes in the Provider Network.

b. Provider Terminations

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

9. Other Provider Enrollment Standards

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

The CHC-MCO must require all Network Providers to be enrolled in the Commonwealth's MA program and possess an active MMIS Provider ID for

each location in which they provide services for the CHC-MCO. In addition, the CHC-MCO must be able to store and utilize the MMIS Provider ID and NPI stored in the Department's MMIS for each location.

CHC-MCOs are not required to contract with all willing Providers (excluding any willing pharmacy requirements) but must accept and respond to letters of interest from any Provider interested in joining the MCO's network.

10. Twenty-Four-Hour Coverage

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

11. Opioid Use Disorder Centers of Excellence

The OUD-COE initiative is designed to increase capacity to care for those seeking treatment for OUD, as well as increase the overall quality of care. CHC-MCOs must comply with the Department's OUD-COE requirements specified in Exhibit EE Opioid Use Disorder Centers of Excellence.

CC. QM and UM Program Requirements

1. Overview

The CHC-MCO shall provide a Quality Assessment and Performance Improvement Program consistent with federal guidelines under Title XIX of the SSA, 42 C.F.R. Part 438, Subpart E and must comply with the Department's QM and UM Program standards and requirements set forth in Exhibit F, Quality Management and Utilization Management Program Requirements; Exhibit W, External Quality Review; and Exhibit W(2), Healthcare Effectiveness Data and

Information Set (HEDIS®) and Consumer Assessment of Healthcare Providers and Systems (CAHPS®). The CHC-MCO must comply with the critical incident reporting and management, provider-preventable condition, and provider serious adverse events reporting requirements outlined in Exhibit W(1), Critical Incident Reporting and Management and Provider Preventable Conditions/Preventable Service Adverse Events Reporting.

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

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

2. Quality Management and Performance Improvement

The Department's goal for CHC is to deliver quality and appropriate care that enables Participants to stay healthy, get better, manage chronic illnesses and disabilities, and maintain/improve their quality of life. The CHC-MCO shall provide quality LTSS to Participants and promote improvement in the quality and appropriateness of care provided to Participants through established quality management and performance improvement processes.

The CHC-MCO shall have a written QM/QI program that clearly defines its quality improvement structures and processes and assigns responsibility to appropriate individuals. The CHC-MCO shall have a QMC which shall include medical and LTSS staff and Providers. The role of the committee is to analyze and evaluate the results of QM/QI activities and to develop appropriate policies, actions and follow-up to provide appropriate services to Participants. The CHC-MCO must establish the QMC as a distinct unit within the organizational structure and the QMC must remain separate from other units in the organization.

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

- A written Quality Assessment and Performance Improvement plan completed on an annual basis with quarterly updates.
- Monitoring and evaluation activities which include peer review and a QMC.
- Protection of Participant records.

- Communicate and honor Participant rights and responsibilities as outlined in this Agreement and Exhibit L, Participant Rights.
- Tracking and trending Participant and Provider issues.
- Mechanism to assess the quality and appropriateness of care furnished to Participants.
- Performance Improvement programs.
- Submission of Participant's specific data.
- Reporting on designated quality measures as outlined in the Department’s reporting requirements, to identify outcomes and trends and how trends will be addressed.
- Procedures outlining how and when information will be entered into the Department’s quality data reporting system.
- Mechanisms to assess the quality and appropriateness of care furnished to Participants with special health care needs as defined by the Department in its quality strategy.

3. Utilization Management

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

4. Healthcare Effectiveness Data and Information Set

The CHC-MCO must comply with the requirements for HEDIS as set forth in Exhibit W(2), Healthcare Effectiveness Data and Information Set (HEDIS®) and Consumer Assessment of Healthcare Providers and Systems (CAHPS®). The previous calendar year is the standard measurement year for HEDIS data.

5. External Quality Review

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

6. Pay for Performance Programs

The Department conducts a Pay for Performance (P4P) Program that provides financial incentives for CHC-MCOs that meet quality goals. Information regarding MCO Pay for Performance Programs may be found in Exhibit DD(1), CHC-MCO Pay for Performance Program and Exhibit DD(2), Nursing Facility Quality Incentive Program.

7. QM/UM Program Reporting Requirements

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

8. Delegated Quality Management and Utilization Management Functions

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

9. Participation in the Quality Management and Utilization Management Programs

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

10. Confidentiality

The CHC-MCO must have written policies and procedures for maintaining the

confidentiality of data that addresses medical records, Participant information and Provider information and is in compliance with the provisions set forth in HIPAA, Section 2131 of the Insurance Company Law of 1921, 40 P.S. § 991.2131; 55 Pa. Code Chapter 105; and 45 C.F.R. Parts 160 and 164 (Standards for Privacy of Individually Identifiable Health Information).

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

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

11. Department Oversight

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

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

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

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

12. CHC-MCO Cooperation with Research and Evaluation

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

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

1. Mergers and Acquisitions

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

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

The CHC-MCO must submit mark, insignia, logo, and product name changes within thirty (30) calendar days of projected implementation for the Department's review. The CHC-MCO logo must appear with the DHS CHC logo in all documents. The CHC-MCO is responsible for the cost of reprinting CHC outreach materials, if a change is made prior to the IEB's annual revision of materials.

EE. Cooperation with IEB

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

FF. Employment Support

The CHC-MCO must include employment-related needs and service requirements of Participants as part of the person-centered service plan. The CHC-MCO will provide information about services available through OVR or similar resources to Participants who are not working but express an interest in work or who are working but whose employment status may be jeopardized due to their disability; and will refer the Participant to OVR or other resources in accordance with the approved CHC 1915(c) waiver, unless the Participant makes an informed choice not to be referred for this support. The CHC-MCO must cooperate with OVR or other resources.

As detailed in Pennsylvania's "Employment First" policy, the first consideration and preferred outcome of publicly funded long-term services and supports for working-age Pennsylvanians with a disability is competitive integrated employment. Competitive integrated employment means any full or part-time work for which a person is:

1. Compensated at not less than federal minimum wage requirements or State or local minimum wage law (whichever is higher) and not less than the customary rate paid by the employer for the same or similar work performed by people without a disability;
2. At a location where the employee interacts with people without a disability (not including supervisory personnel or people who are providing services to such employee); and
3. Presented, as appropriate, opportunities for similar benefits and advancement like those for other employees without a disability and who have similar positions.

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

CHC-MCOs will offer services that promote or lead to securing or maintaining competitive-integrated employment, including, but not limited to, job coaching and job finding, customized employment, discovery (for participants with to-be-defined challenging needs), benefits counseling, and transportation. CHC-MCOs must provide the necessary employment-related training, resources, and communication to their employment staff and SCs. SCs must engage Participants in ongoing education and discussions regarding employment and assist Participants with a goal of achieving competitive integrated employment with accessing all available resources. CHC-MCOs and their SCs must comply with the requirements detailed in Medical Assistance Bulletin 07-23-04 titled Employment and Employment Related Services, subject to amendment by DHS.

GG. Advance Directives

The CHC-MCO must maintain written policies and procedures for advance directives (durable power of attorney, mental health, and living wills) for Participants, which shall include the following information:

a. the description of applicable State law;
b. the process for notifying the Participant of any changes in applicable State law as soon as possible, but no later than ninety (90) days after the effective date of the change;
c. any limitation the CHC-MCO has regarding implementation of advance directives as a matter of conscience;
d. the process for Participants or the Participant’s representative to file a Complaint concerning noncompliance with the advance directive

requirements with the CHC-MCO and DOH;

e. noncompliance with the advance directive requirements with the CHC-MCO and DOH; and
f. how to request written information on advance directive policies.

The CHC-MCO must educate staff concerning its policies and procedures on advance directives.

The CHC-MCO may not condition the provision of care or otherwise discriminate against a Participant based on whether or not the Participant has executed an advance directive.