**EXHIBIT F**

# QUALITY MANAGEMENT AND UTILIZATION MANAGEMENT PROGRAM REQUIREMENTS

The Department will monitor the QM and UM programs of the CHC-MCO and retains the right of advance written approval of all QM and UM activities. The CHC-MCO's QM and UM programs must incorporate all the requirements outlined in this Agreement and must be designed to assure and improve the accessibility, availability, and quality of care and services being provided to its Participants. The CHC-MCO's QM and UM programs must, at a minimum:

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

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

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

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

E. Submit all reports on data elements and quality measures as required, and in the manner to be required by the Department;

F. Demonstrate sustained improvement for clinical performance over time;

G. Allow for the timely, complete, and accurate reporting of Encounter Data and other data required to demonstrate clinical and service performance, including HEDIS and CAHPS as outlined in Exhibit W(2), Healthcare Effectiveness Data and Information Set (HEDIS®) and Consumer Assessment of Healthcare Providers and Systems (CAHPS®);

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

   1) Allow for the tracking and trending of issues on an aggregate basis pertaining

to patterns of care and services;

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

I. Obtain accreditation by a nationally recognized organization, such as National Committee for Quality Assurance (NCQA);

J. Maintain NCQA Health Outcomes or Community-Focused Care accreditation;

K. Comply with Battelle Partnership for Quality Measurement or other LTSS quality requirements as designated by the Department.

L. Determine whether algorithms used for case management, disease management, quality management, or decisions about which enrollees receive additional services from the CHC-MCO, contain inadvertent racial bias. If any racial bias is identified, the CHC-MCO must take steps to eliminate that bias to the satisfaction of the Department. As part of the determination of whether the algorithms contain racial bias and the elimination of racial bias, the CHC-MCO will work with entities designated by the Department to identify bias and the actions that can be taken to eliminate or mitigate bias.

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

A. Adhere to current Medicaid CMS guidelines.

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

C. Ensure that all QM and UM activities and initiatives undertaken by the CHC-MCO are based upon clinical and financial analysis of Encounter Data, Participant demographic information, HEDIS, CAHPS, Pennsylvania Performance Measures, comprehensive needs assessments, service coordinator documentation, and/or other identified areas.

D. Contain policies and procedures which provide for the ongoing review of the

entire scope of care and services provided by the CHC-MCO, assuring that all demographic groups, races, ethnicities, disabilities, care and service settings and types and models of services are addressed.

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

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

2) Distinct policies and procedures regarding how Service Coordinators interact with the QM/UM teams, authorize LTSS and communicate those authorizations to providers.

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

   a) Primary, secondary, and tertiary care;
   b) Preventive care and wellness programs;
   c) Acute and/or chronic conditions;
   d) Emergency Department utilization and ED diversion efforts;
   e) Dental care;
   f) LTSS;
   g) Service Coordination; and
   h) Continuity of care.

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

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

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

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

the quality of care rendered to Participants and utilization of services.

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

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

1) Data collection and analysis;
2) Evaluation and reporting of findings;
3) Implementation of improvement actions where applicable; and
4) Individual accountability for each activity.

H. Provide for aggregate and individual analysis and feedback of Provider performance and CHC-MCO performance in improving access to Covered Services, the quality of care and services provided to Participants and utilization of Covered Services.

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

1) Provider Relations;
2) Participant Services; and
3) Management Information Systems.

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

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

L. Include mechanisms and processes which allow for the development and implementation of CHC-MCO-wide and Provider-specific improvement actions in response to identified barriers to care and services, quality of care and services concerns; and overutilization, underutilization, and misutilization of services.

M. The CHC-MCO shall provide for methods of assuring the appropriateness of inpatient care. Such methodologies as described below shall be based on individualized determinations of medical necessity in accordance with UM policies and procedures.

- Pre-admission certification process for non-emergency admissions;
- A concurrent review program to monitor and review continued inpatient hospitalization, length of stay, or diagnostic ancillary services regarding their appropriateness and medical necessity. In addition, the CHC-MCO shall have a process in place to determine for emergency admissions, based upon medical criteria, if and when a Participant can be transferred to a contract facility in the network, if presently in a non-contract facility;
- Admission review for urgent and/or emergency admissions, on a retroactive basis when necessary, in order to determine if the admission is medically necessary and if the requested length of stay for the admission is reasonable based upon an individualized determination of medical necessity. Such reviews shall not result in delays in the provision of medically necessary urgent or emergency care;
- Restrictions against requiring pre-admission certification for admissions for the normal delivery of children; and
- Prospective review of same day surgery procedures.

N. The CHC-MCO shall monitor the Participant's condition for ongoing care, avoidable ED/hospitalizations or worsening conditions, infection controls, and potential discharge back to community living.

O. The CHC-MCO shall utilize the following guidelines in identifying and managing care for Participants who are determined to have excessive and/or inappropriate ED utilization:

- Review ED utilization data, at a minimum, every six (6) months to identify Participants with utilization exceeding the threshold defined as six (6) or more visits in the defined six (6) month period (January through June, and July through December);
- For Participants whose utilization exceeds the threshold of ED visits defined above in the previous six (6) month period, the CHC-MCO shall conduct appropriate follow-up to identify the issues causing frequent ED utilization and determine appropriate next steps.
- As appropriate, make contact with Participants whose utilization exceeded the threshold of ED visits in the previous six (6) month period and their primary care providers for the purpose of providing education on appropriate ED utilization.
- Assess the most likely cause of high utilization and develop a PCSP based on results of the assessment for each Participant.

P. The CHC-MCO shall comply with any applicable Federal and State laws or rules related to length of hospital stay.

Q. In addition to meeting the reporting requirement for oversight and monitoring of the program, the CHC-MCO must report all information required for early implementation evaluation, as outlined by the Department. The CHC-MCO must also comply with all implementation, monitoring, and oversight requirements. The CHC-MCO must comply with any program policy changes resulting from the Department's rapid cycle, implementation monitoring, or other evaluation of the CHC Program.

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

A. The Governing Body:

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

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

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

B. The Quality Management Committee (QMC):

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

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

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

c) Provide for documentation of the QMC's activities, findings,

recommendations, and actions.

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

C. The Director of LTSS ensures the provision of LTSS in home and community-based settings is provided in accordance with the requirements outlined in this Agreement and the CHC 1915(c) Waiver.

D. The Director of Quality Management serves as liaison and is accountable to the governing body and Quality Management Committee for all QM and UM activities and initiatives.

E. The Senior Medical Director must be directly accountable to and act as liaison to the Department's Chief Medical Officer.

F. The Medical Director:

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

2) Is directly involved in the CHC-MCO's recruiting and credentialing activities;
3) Is familiar with local standards of medical practice and nationally accepted standards of practice, including those for LTSS and with "most integrated setting" requirements under the ADA;

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

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

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

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

8) Has knowledge of risk management standards;

9) Is directly accountable for all Quality Management and Utilization Management activities; and

10) Oversees and is accountable for:

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

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

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

**Standard III:** The QM and UM programs must include methodologies that allow for the objective and systematic monitoring, measurement, and evaluation of the quality and appropriateness of care and services provided to Participants through quality- of-care studies and related activities with a focus on identifying and pursuing opportunities for continuous and sustained improvement.

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

1) Written in measurable and accepted professional formats;
2) Based on scientific evidence; and
3) Applicable to Providers for the delivery of certain types or aspects of healthcare or LTSS.

B. The QM and UM programs must include clinical/quality Indicators in the form of written, professionally developed, objective and measurable variables of a specified clinical or health services delivery area, which are reviewed over a period of time to screen delivered healthcare and/or monitor the process or outcome of care delivered in that clinical area.

C. Practice guidelines and clinical indicators must address the full range of healthcare and LTSS needs of the populations served by the CHC-MCO. The areas addressed must include but are not limited to:

1) Adult preventive care;
2) LTSS;
3) Service Coordination provision;
4) Obstetrical care, including a requirement that Participants be referred to obstetricians or certified nurse midwives at the first visit during which pregnancy is determined;
5) Selected diagnoses and procedures relevant to the CHC-MCO's Participant population;

6) Selected diagnoses and procedures relevant to racial and ethnic subpopulations within the CHC-MCO's Participant population; and
7) Preventive dental care.

D. The QM and UM programs must provide practice guidelines, clinical indicators, and medical record keeping standards to all Providers, appropriate subcontractors, and to potential Participants upon request. This information must also be provided to Participants upon request.

E. The CHC-MCO must develop methodologies for assessing performance of PCPs/PCP sites, high risk/high volume specialists, dental Providers, LTSS Providers, and Providers of ancillary services not less than every two (2) years (i.e., medical record audits). These methodologies must, at a minimum:

1) Demonstrate the degree to which PCPs, specialists, and dental Providers are complying with clinical and preventive care guidelines adopted by the CHC-MCO;

2) Demonstrate the degree to which LTSS Providers are complying with requirements of the Department and the CHC-MCO;

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

4) Include active mechanisms and processes that allow for the identification, investigation, and resolution of quality of care and services concerns, including events such as Healthcare-Associated Infections, medical errors, and adverse patient outcomes; and

5) Include mechanisms for detecting instances of overutilization, underutilization, and misutilization.

F. The QM and UM program must have policies and procedures for implementing and monitoring improvement plans. These policies and procedures must include the following:

1) Processes that allow for the identification, investigation and resolution of quality of care and services concerns, including Healthcare-Associated Infections, medical errors, and adverse patient outcomes;

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

3) Use of progressive sanctions as indicated;

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

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

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

G. The QM and UM programs must include methodologies that allow for the identification, verification, and timely resolution of inpatient and outpatient quality of care and services concerns, Participant quality of care and services complaints, overutilization, underutilization, and/or misutilization, access/availability issues, and quality of care and services referrals from other sources.

H. The QM and UM programs must contain procedures for Participant satisfaction surveys that are conducted on at least an annual basis, including the collection of annual Participant satisfaction data through application of the CAHPS instrument as outlined in Exhibit W(2), Healthcare Effectiveness Data and Information Set (HEDIS®) and Consumer Assessment of Healthcare Providers and Systems (CAHPS®). The Department will continue to monitor the development of evidence-based LTSS satisfaction surveys and reserves the right to implement a CAHPS, CAHPS-like, or other survey at a later date.

I. The QM and UM programs must contain procedures for Provider satisfaction surveys to be conducted on at least an annual basis. Surveys are to include PCPs, specialists, LTSS Providers, Nursing Facilities, dental Providers, hospitals, and Providers of ancillary services.

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

K. The QM and UM programs must contain procedures for measuring Participant and Provider satisfaction with LTSS Service delivery.

**Standard IV:** The QM and UM programs must objectively and systematically monitor and evaluate the appropriateness and cost effectiveness of care and services provided to Participants through utilization review activities with a focus on identifying and correcting instances and patterns of overutilization, underutilization and misutilization.

A. Semi-annually, or more frequently as appropriate, the QM and UM programs must provide for production and distribution to Providers, (in either hard copy or web-based electronic formats) profiles comparing the average medical care utilization rates of the Participants of each PCP to the average utilization rates of all CHC-MCO Participants. The CHC-MCO must develop statistically valid methodologies for data collection (Denominator must be ≥ 30 participants) regarding Provider profiling. PCP can be defined as individual PCP or can be group practices identified by group tax ID or NPI numbers. Profiles shall include, but not be limited to:

1) Utilization information on Participant Encounters with PCPs;
2) Specialty Claims;
3) Prescriptions;
4) Inpatient stays;
5) Nursing Facility use;
6) Community-based LTSS use;
7) Emergency room use; and
8) Clinical indicators for preventive care services (i.e., mammograms, immunizations, pap smears, etc.).

B. The CHC-MCO must have mechanisms and processes for profiling all Providers using risk-adjusted diagnostic data for profiles.

C. The CHC-MCO must have mechanisms and processes for aggregate trending of changes to services and reporting aggregate data to the Department.

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

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

**Standard V:** The CHC-MCO must develop mechanisms for integration of case/disease and health management programs that rely on wellness promotion, prevention of complications, and treatment of chronic conditions for Participants identified. The CHC-MCO must have a Complex Case Management Program and a Disease Management Program that must:

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

B. Include mechanisms and processes that allow for the identification of

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

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

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

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

F. Include collaboration with the Department and Health Information Organizations (HIOs) to develop, adopt and disseminate a resource and referral tool. The CHC-MCO must make any SDOH assessment or referral tool used by the CHC-MCO interoperable with the Health Information Exchange and the statewide resource and referral tool, PA Navigate.

G. Include meaningful participation in the DOH Health Equity Action Team for each region in which the CHC-MCO operates.

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

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

B. Other CHC-MCOs;

C. The CHC-MCO and Medicare D-SNPs whether aligned or not aligned;

D. The CHC-MCO and Medicare FFS or Medicare Advantage;

E. The CHC-MCO and HealthChoices BH-MCOs;

F. The CHC-MCOs and Physical Health HealthChoices MCOs;

G. The CHC-MCO and the Department's FFS Program;

H. The CHC-MCO and other third party insurers;

I. The CHC-MCOs and LIFE providers;

J. The CHC-MCOs and State Lottery-funded services;

K. The CHC-MCOs and Hospitals or Nursing Facilities; and

L. The CHC-MCO and any other agency providing services to the Participant.

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

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

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

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

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

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

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

**Standard VIII**: The QM/UM program must have standards for credentialing/ recredentialing Providers to determine whether all Providers who provide healthcare services or LTSS under contract to the CHC-MCO are qualified to perform their services.

A. The CHC-MCO must establish and maintain minimum credentialing and recredentialing criteria for all Provider types that satisfies the Department's requirements outlined in this Agreement and through the credentialing framework to be provided to plans. Recredentialing activities must be conducted by the CHC-MCO at least every five (5) years. Criteria must include, but not be limited to, the following as applicable to the Provider type:

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

2) Verification that each Provider has not been suspended, terminated, or party to a settlement for voluntary withdrawal from the Medicaid or Medicare Programs;

3) Verification that each Provider and subcontractor has a current Provider Agreement and an active MMIS Provider ID number issued by the Department;

4) Evidence of malpractice/liability insurance;

5) A valid Drug Enforcement Agency (DEA) certification;

6) Adherence to the Principles of Ethics of the American Medical Association, the American Osteopathic Association, or any appropriate professional organization involved in a multidisciplinary approach;

7) Consideration of quality issues such as Participant Complaint and/or Participant satisfaction information, sentinel events, and quality of care concerns.

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

C. Appropriate PCP qualifications:

1) Seventy-five to one hundred percent (75-100%) of the Network consists of PCPs who have completed an approved primary care residency in family medicine, osteopathic general medicine, internal medicine or geriatrics;

2) No more than twenty-five percent (25%) of the Network consists of PCPs without appropriate residencies but who have, within the past seven (7) years, five (5) years of post-training clinical practice experience in family medicine, osteopathic general medicine, internal medicine or geriatrics.

Post-training experience is defined as having practiced at least as a half (0.5) full-time equivalent in the practice areas described;

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

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

5) Membership of the medical staff with admitting privileges of at least one (1) general hospital or an acceptable arrangement with a PCP with admitting privileges;

6) Evidence of continuing professional medical education;

7) Attendance at least one CHC-MCO sponsored Provider education training session as outlined in Section V.AA.2, Provider Education;

8) Assurance that any CRNP, Certified Registered Midwife, or physician's assistant, functioning as part of a PCP team, is performing under the scope of his or her respective license.

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

E. The Department will recoup from the CHC-MCO any and all payments made to a Provider that does not meet the enrollment and credentialing criteria for participation or is used by the CHC-MCO in a manner that is not consistent with the Provider's licensure.

F. The CHC-MCO must notify its PCPs and all subcontractors of the prohibitions and sanctions for the submission of false Claims and statements.

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

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

management factors at the time and in the manner requested by the Department.

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

J. The CHC-MCO must meet the following standards related to timeliness of processing new Provider applications for credentialing:

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

2) The CHC-MCO may not delay processing the application if the Provider does not have a MAID number that is issued by the Department. However, the CHC-MCO cannot complete its process until the Provider has received its MAID number from the Department.

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

**Standard IX:** The CHC-MCO's UM program must have policies and procedures that describe the scope of the program, mechanisms, and information sources used to make decisions on Covered Services in conjunction with the requirements in Exhibit E, Prior Authorization Guidelines for the CHC-MCO.

A. The UM program must contain policies and procedures for Prospective, Concurrent, and Retrospective review and coverage decisions on Covered Services.

B. A PCSP shall be developed and implemented for all NFCE Participants and others who request or require Service Coordination. The CHC-MCO shall audit a Department-approved sample size of the PCSPs to demonstrate compliance with the requirements of the QM/UM program and the CHC monitoring report requirements. The CHC-MCO must use a protocol to select the PCSPs that either has been submitted to and reviewed and approved by the Department or that has been provided by the Department. Audit results must be submitted to the Department as part of the Annual QAPI Program Evaluation or the applicable CHC monitoring report.

C. The UM program must allow for coverage decisions about Covered Services that are consistent with the CHC definition of Medically Necessary found in Section II, Definitions, and the requirements of the CHC 1915(c) Waiver.

Coverage decisions for Covered Services, whether made on a Prior Authorization, Concurrent Review, or Retrospective Review basis, shall be documented in writing. The CHC-MCO shall base its determination on information provided by the Participant, the Participant's family/caretaker, and the PCP, as well as any other Providers, programs and agencies that have evaluated the Participant. Medical necessity determinations must be made by qualified and trained Providers. A Provider who makes such determinations of Medical Necessity is not considered to be providing a healthcare service under this Agreement.

D. If the CHC-MCO wishes to require Prior Authorization of any services, it must establish and maintain written policies and procedures for the Prior Authorization review process as required under Section V.B., Prior Authorization of Services, and Exhibit E, Prior Authorization Guidelines for the CHC-MCO.

E. The CHC-MCO must provide all Licensed Proprietary Products that it will use in evaluating Medical Necessity for medical services. Licensed Proprietary Products may include but are not limited to Interqual and Milliman. All Utilization Review Guidelines and/or policies and procedures that contain Utilization Review Guidelines used to determine Medical Necessity must:

1) Require definitions of Medical Necessity that are consistent with the CHC definition of Medically Necessary;

2) Require that clinical reviewers make determinations of Medical Necessity that are consistent with the CHC definition of Medically Necessary;

3) Require that clinical reviewers assess the Participant's current condition and response to treatment and/or co-morbidities, psychosocial, environmental, and other needs that influence the need for care and services;

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

5) Be developed using a scientific based process;

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

7) Provide for evaluation of the consistency with which clinical reviewers

implement the guidelines on at least an annual basis.

F. The CHC-MCO must ensure that Prior Authorization and Concurrent review decisions:

1) Are made by an individual who has appropriate expertise in addressing the enrollee's medical, behavioral health, or LTSS needs;

2) That result in a denial may only be made by an individual who has appropriate expertise in addressing the enrollee's medical, behavioral health, or long-term services and supports needs;

3) Are made in accordance with established timeframes outlined in this Agreement for routine, urgent, or emergency care; and

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

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

H. Additional Prior Authorization requirements can be found in Exhibit E, Prior Authorization Guidelines for the CHC-MCO.

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

J. The CHC-MCO must ensure that sources of utilization criteria are provided to Participants and Providers upon request.

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

1) Meet requirements outlined in Exhibit G, Complaint, Grievance, and DHS Fair Hearing Processes.

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

3) Include notification to Participants of their right to file a Complaint, Grievance

or DHS Fair Hearing as outlined in Exhibit G, Complaint, Grievance, and DHS Fair Hearing Processes.

L. The CHC-MCO must agree to comply with the Department's quality monitoring and utilization review monitoring processes, including, but not limited to:

1) Submission of a log of all denials issued using formats to be specified by the Department.

2) Submission of denial notices for review as requested by the Department.

3) Submission of utilization review records and documentation as requested by the Department.

4) Ensure that all staff who have any level of responsibility for making determinations to approve or deny services for any reason have completed a utilization review training program.

5) Development of an internal quality assurance process designed to ensure that all denials issued by the plan and utilization review record documentation meet Department requirements. This process must be approved by the Department.

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

A. Denials of Claims and payment of Claims at an alternate level of care than what was provided, i.e., acute versus skilled days. This includes the appeal by a Provider of a CHC-MCO's decision to deny payment for services already rendered by the Provider to a Participant.

B. QM/UM sanctions.

C. Adverse credentialing/recredentialing decisions.

D. Provider Terminations.

**Standard XI:** The CHC-MCO must ensure that findings, conclusions, recommendations, and actions taken as a result of QM and UM program activities are documented and reported to appropriate individuals within the CHC-MCO for use in other management activities.

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

1) CHC-MCO Provider Network changes;
2) Benefit changes;
3) Medical management systems (e.g., pre-certification);
4) Practices feedback to Providers; and
5) Service Coordination or Service Planning changes.

**Standard XII:** The CHC-MCO must have written policies and procedures for conducting prospective and retrospective DUR that meet requirements outlined in Exhibit D, Drug Services.

**Standard XIII:** The CHC-MCO must have written standards for maintaining Comprehensive Medical and Service Record (including PCSPs) record keeping. The CHC-MCO must ensure that the Comprehensive Medical and Service Records contain written documentation of the medical necessity of a rendered, ordered, or prescribed service.

A. The CHC-MCO must have written policies and procedures for the maintenance of Comprehensive Medical and Service Records so that those records are documented accurately and in a timely manner, are Readily Accessible and permit prompt and systematic retrieval of information. Written policies and procedures for the CHC-MCO and its Network Providers must contain standards for medical records that promote maintenance of medical records in a legible, current, detailed, organized, and comprehensive manner that permits effective patient care and quality review.

B. Medical record standards for the CHC-MCO and its Network Providers must meet or exceed medical record keeping requirements contained in at 55 Pa. Code § 1101.51(d)(e) of the Medical Assistance Manual and in medical record keeping standards adopted by DOH.

C. Comprehensive Medical and Service Records must, at a minimum, include the following information to the extent related to CHC-MCO Covered Services or related to other services coordinated by the CHC-MCO but covered by a Participant's Medicare or other source of coverage:

1) History and physical that is appropriate to the patient's current condition;
2) Treatment plan, progress and changes in treatment plan;
3) Diagnostic tests and results;
4) Therapies and other prescribed regimens;
5) Disposition and follow-up;
6) Referrals and results thereof;
7) Hospitalizations;
8) Reports of operative procedures and excised tissues;
9) Medication record\PCSP, where applicable;
10) Services provided as per the PCSP for Participants who have one;

11) Service Coordination contact notes; and
12) All other aspects of patient care or Participant service delivery.

D. The CHC-MCO must have written policies and procedures to assess the content of Comprehensive Medical and Service Records for legibility, organization, completion, and conformance to its standards.

E. The CHC-MCO must ensure access of the Participant to his or her Comprehensive Medical and Service Records at no charge and upon request.

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

G. Comprehensive Medical and Service Records must be preserved and maintained for a minimum of ten (10) years from expiration of the CHC-MCO's contract. Comprehensive Medical and Service Records must be made available in paper form upon request.

H. When a Participant changes PCPs, the CHC-MCO must facilitate the transfer of his or her medical records or copies of medical records to the new PCP within five (5) business days from receipt of the request. In emergency situations, the CHC-MCO must facilitate the transfer of medical records as soon as possible from receipt of the request.

H. When a Participant changes CHC-MCOs, the CHC-MCO must facilitate the transfer of his or her Comprehensive Medical and Service Records or copies of the Comprehensive Medical and Service Records to the new CHC-MCO within five (5) business days from the Start Date in the receiving CHC-MCO. In emergency situations, the CHC-MCO must facilitate the transfer of Comprehensive Medical and Service Records as soon as possible from receipt of the request.

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

A. The CHC-MCO must have a written policy that recognizes the rights of Participants outlined in Exhibit L, Participant Rights.

B. The CHC-MCO must have a written policy that addresses Participant's responsibility for cooperating with those providing healthcare services. This written policy must address Participant's responsibility for:

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

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

3) Participants shall be asked to provide consent to the CHC-MCO, Providers, and their respective designees for the purpose of providing patient care management, outcomes improvement and research. For these purposes, Participants will remain anonymous to the greatest extent possible.

C. The CHC-MCO's policies on Participant rights and responsibilities must be provided to all Network Providers.

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

1) Rights and responsibilities of Participants as outlined in Exhibit L, Participant Rights.
2) A Participant Handbook fulfilling the Participant Handbook requirements of this Agreement.

3) All other items outlined in Section V.O., Exhibit M, and requirements of that section for distribution to Participants upon Enrollment.

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

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

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

- How to obtain services during regular hours of operation;
- How to obtain after-hours, urgent and emergency care; and
- How to obtain the names, qualifications, and titles of the Healthcare or

LTSS Provider providing and/or responsible for their care.

H. The CHC-MCO must develop and maintain policies and procedures to ensure that Participant information (e.g., Participant brochures, announcements, and handbooks) is provided in language that is readable and easily understood.

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

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

B. The CHC-MCO must adhere to all systems requirements as outlined in Section V.X.6, Management Information Systems, and Section VIII.C, Systems Reporting, of the Agreement and in Management Information System and Systems Performance Review Standards provided by the Department on the Pennsylvania HealthChoices Extranet.

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

**Standard XVI:** The QM and UM systems must ensure timely, complete, and regular Assessments for Participants who so require and must oversee development and implementation of PCSPs. They must also measure Participant satisfaction with quality of services, quality of life, experience of care, community integration, and quality of Service Coordination.

A. The CHC-MCO must document that it is monitoring the Assessment process across all populations. Assessments must comply with the content and timeline requirements outlined in this Agreement and must be provided to the populations outlined in Section V.E.

B. The CHC-MCO must demonstrate that it is complying with its Department-approved service coordination staffing, communications, and Participant contact plan as required in this Agreement.

C. The CHC-MCO must demonstrate that Participants who require it are provided person-centered service planning with input into who participates in their PCPTs and into the content of their PCSPs.

D. The CHC-MCO must demonstrate how PCSPs are implemented and how they are monitored to ensure that services outlined are being provided or coordinated across coverages, systems, or agencies.

E. The CHC-MCO must conduct annual Participant surveys using a survey tool

approved by the Department to obtain feedback on quality of services, quality of life, experience of care, community integration, and quality of Service Coordination services provided.

**Standard XVII:** CHC-MCOs must help establish a nursing facility (NFs) Learning Network (LN) with a vendor approved by the Department. The LN will be established in conjunction with each of the MCOs and the Department to provide NFs a consistent approach to quality improvement and infection control as referenced in the NF Quality Incentive Program. The LN will help establish training modules, and regional meetings that will assist NFs in clinical and technical assistance. MCOs will collaborate and coordinate with the Department on the following activities of the LN:

1) Participate in regional and statewide trainings and meetings to support NF personnel to enhance and improve quality measures as defined in the NF Quality Incentive Program.
2) Increase BH services within NFs.
3) Help drive quality improvement by helping to collect data, perform rapid PDCA cycles, and share best practices.
4) Work with local health systems to better enhance transitions of care from the emergency department and inpatient discharges.
5) Implement and/or participate in regional quarterly quality meetings for NFs to share best practices, identify and help resolve NF operational issues that affect quality, and share quality improvement results.
6) Participate in an annual statewide quality meeting that will bring all regions together to share regional experiences and report on the effectiveness of the LN.