

2026 COMMUNITY HEALTHCHOICES AGREEMENT

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AGREEMENT ACRONYMS

For the purpose of this Agreement, the acronyms set forth shall apply.

AAPOR — American Association for Public Opinion Research.
ACA — Affordable Care Act.
ACO — Accountable Care Organization.
ADA — Americans with Disabilities Act.
ADL — Activities of Daily Living.
APS — Adult Protective Services.
APT — Advanced Persistent Threat.
AWC — Agency with Choice.
BETP — Bureau of Employment & Training Programs.
BH — Behavioral Health.
BHA — Bureau of Hearings and Appeals.
BH-MCO — Behavioral Health Managed Care Organization.
BIN — Bank Identification Number.
BLE — Benefit Limit Exception.
BMC — Bureau of Managed Care.
BPI — Bureau of Program Integrity.
CAHPS — Consumer Assessment of Healthcare Providers and Systems.
CAO — County Assistance Office.
CBO—Community Based Organization.
CDC — Centers for Disease Control and Prevention.
CHC — Community HealthChoices.
CHC-MCO — Community HealthChoices MCO.
CHS — Contract Health Services.
CLIA — Clinical Laboratory Improvement Amendment.
CMN — Certificate of Medical Necessity.
CMS — Centers for Medicare & Medicaid Services.
CNM — Certified Nurse Midwife.
COB — Coordination of Benefits.
CONUS – Continental United States and Hawaii.
CPP — Contractor Partnership Program.
CRNP — Certified Registered Nurse Practitioner.
CWDS — Commonwealth Workforce Development.
DCW — Direct Care Worker.DD — Developmental Disabilities
DEA — Drug Enforcement Agency.
DESI —Drug Efficacy Study Implementation.
DHS — Department of Human Services of Commonwealth of Pennsylvania.
DLP — Data Loss Prevention.
DME — Durable Medical Equipment.
DOH — Department of Health of the Commonwealth of Pennsylvania.
D-SNP — Dual Eligible Special Needs Plan.

DRG — Diagnosis Related Group.
DUR — Drug Utilization Review.
eCIS — Client Information System.
ED — Emergency Department.
EIM — Enterprise Incident Management System.
EOB — Explanation of Benefits.
EQR — External Quality Review.
EQRO — External Quality Review Organization.
ERISA — Employees Retirement Income Security Act of 1974.
ESC — Error Status Code.
EVV — Electronic Visit Verification.
EVS — Eligibility Verification System.
FDA — Food and Drug Administration.
FFS — Fee-for-Service.
FIPS — Federal Information Processing Standards.
FMS — Financial Management Services.
FQHC — Federally Qualified Health Center.
FTE — Full-time Equivalent.
FTP — File Transfer Protocol.
HBP — Healthy Beginnings Plus.
HAC — Healthcare-Acquired Condition.
HCBS — Home and Community-Based Services.
HCPCS — Healthcare Common Procedure Coding System.
HEDIS — Healthcare Effectiveness Data and Information Set.
HHS — Health and Human Services.
HIO — Health Information Organization.
HIPAA — Health Insurance Portability and Accountability Act.
HIPPP — Health Insurance Premium Payment.
HMO — Health Maintenance Organization.
IADL — Instrumental Activities of Daily Living.
ICN — Internal Control Number.
ID — Intellectual Disability.
IEB — Independent Enrollment Broker.
IHS — Indian Health Service.
IMD — Institution for Mental Diseases.
IRM — Information Resource Management.
IRO — Independent Review Organization.
IRP — Incident Response Plan.
ISO — Information Security Officers.
ITP — Information Technology Policies.
I/T/U — Indian Tribe, Tribal Organization, or Urban Indian Organization.
JCAHO — Joint Commission for the Accreditation of Healthcare Organizations.

LEP — Limited English Proficiency.
 LIFE — Living Independence for the Elderly.
 LN — Learning Network.
 LTC — Long-Term Care.
 LTSS — Long-Term Services and Supports.
 MA — Medical Assistance.
 MAAC — Medical Assistance Advisory Committee.
 MATP — Medical Assistance Transportation Program.
 MCO — Managed Care Organization.
 MDS — Minimum Data Set.
 MIPPA — Medicare Improvements for Patients and Providers Act of 2008.
 MIS — Management Information System.
 MLR — Medical Loss Ratio.
 MMIS — Medicaid Management Information System.
 MPI — Master Provider Index.
 NCPDP — National Council for Prescription Drug Programs.
 NCQA — National Committee for Quality Assurance.
 NF — Nursing Facility.
 NFCE — Nursing Facility Clinically Eligible.
 NFI — Nursing Facility Ineligible.
 NHT — Nursing Home Transition.
 NPDB — National Practitioner Data Bank.
 NPI — National Provider Identifier.
 NPPES — National Provider Plan and Enumeration System.
 OAPS — Older Adult Protective Services.
 OBRA — Omnibus Budget Reconciliation Act.
 OCONUS — Outside of the Continental United States and Hawaii.
 OIP — Other Insurance Paid.
 OLTL — Office of Long-Term Living.
 OMAP — Office of Medical Assistance Programs.
 ORC — Other Related Conditions.
 OTC — Over-the-Counter.
 OUD-COE — Opioid Use Disorder Centers of Excellence
 OVR — Department of Labor & Industry, Office of Vocational Rehabilitation
 of the Commonwealth of Pennsylvania.
 P&T — Pharmacy & Therapeutics.
 P4P — Pay for Performance.
 PAC — Participant Advisory Committee.
 PAPMs — Pennsylvania Performance Measures.
 PARP — Prior Authorization Review Panel.
 PASRR — Preadmission Screening and Resident Review.
 PBC — Performance Based Contracting.
 PBM — Pharmacy Benefit Manager.
 PCD — Participant Coverage Document.

PCMH — Patient Centered Medical Home
PCN — Processor Control Number
PCP — Primary Care Practitioner.
PCSP — Person-Centered Service Plan.
PCPT — Person-Centered Planning Team.
PDA — Pennsylvania Department of Aging.
PDCA — Plan, Do, Check, Act.
PDL — Preferred Drug List.
PEMA — Participant Enrollment Mix Adjustment.
PH — Physical Health.
PHP — Prepaid Health Plan.
PID — Pennsylvania Insurance Department.
PIP — Performance Improvement Plan.
PMPM — Per-Member, Per-Month.
POSNet — Pennsylvania Open Systems Network.
PPC — Provider Preventable Condition.
QA — Quality Assurance.
QAP — Quality Assurance Plan.
QAPI — Quality Assurance and Performance Improvement.
QARI — Quality Assurance Reform Initiative.
QM — Quality Management.
QMC — Quality Management Committee.
QM/QI — Quality Management/Quality Improvement.
RAC — Reassessments and Care Planning after
Inpatient Discharge.
RBC — Risk Based Capital.
RFA — Request for Applications.
RFP — Request for Proposal.
RHC — Rural Health Center/Clinic.
RN — Registered Nurse.
SAP — Statutory Accounting Principles.
SDOH—Social Determinants of Health.
SLA — Service Level Agreements.
SMI — Serious Mental Illness.
SP — Special Publications.
SSA — Social Security Act.
SSADMF — Social Security Administration's Death Master File.
SSAE — Statement of Standards for Attestation Engagements.
SSI — Supplemental Security Income.
SUD — Substance Use Disorder.
TANF — Temporary Assistance for Needy Families.
TB — Tuberculosis.
TPL — Third Party Liability.
TPR — Third Party Resources.
TTY — Text Telephone Typewriter.
UM — Utilization Management.

URCAP — Utilization Review Criteria Assessment Process.
US DHHS — United States Department of Health and Human Services.
VBP — Value-Based Purchasing
WIC — Women, Infants and Children.
WPM — Waiver Performance Measures.

SECTION I: INCORPORATION OF DOCUMENTS

A. Operative Documents

This Agreement is comprised of the following documents, which are listed in the order of precedence in the event of a conflict between documents:

1. This document consisting of its Recitals and Sections I-XVI and Appendices 3-5 and Exhibits A – FF.
2. RFP Number 12-15 attached as Appendix 1.
3. The CHC-MCO's Proposal, attached as Appendix 2.

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

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

SECTION II: DEFINITIONS

Abuse — Any practices that are inconsistent with sound fiscal, business, or medical practices and result in unnecessary costs to the MA Program or in reimbursement for services that are not Medically Necessary or that fail to meet professionally recognized standards or Agreement obligations and the requirements of Federal or State statutes and regulations for healthcare in a managed care setting, committed by the CHC-MCO, a subcontractor, Provider, or Participant, among others.

Note: When referring to alleged acts committed against Participants, the Abuse definition differs, as indicated in Exhibit W(1).

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

Act 150 Program — A state-funded program under the Attendant Care Services Act (62 P.S. §§ 3051 – 3058), which provides certain personal assistance services to eligible adults.

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

Actuarially Sound Capitation Rate — Actuarially sound Capitation rates are projected to provide reasonable, appropriate and attainable costs that are required under the terms of the contract and for the operation of the Primary Contractor for the time period and the population covered under the terms of the contracts, and such Capitation rates are developed in accordance with the requirement in 42 C.F.R. §438.4(b).

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

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

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

Asynchronous Interaction — An exchange of information between a patient and a health care provider that does not occur in real time, including the secure collection and transmission of a patient's medical information, clinical data, clinical images, laboratory results and self-reported medical history.

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

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

Beneficiary — A person determined eligible to receive services in the MA Program.

Capitation Payment — A payment the Department pays per month to the CHC-MCO for each Participant to provide coverage of all Covered Services, whether or not the Participant receives services during the period covered by the payment.

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

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

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

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

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

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

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

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

Cloud Computing Service — Any computing service that is procured through and hosted by or within a third-party vendor, licensor, contractor, or supplier (Service Organizations) or its subcontractor(s) (Subservice Organization(s)) managed infrastructure regardless of deployment model (public, private, or hybrid) or type such as, but not limited to, software-as-a-service (SaaS) for web-based applications, infrastructure-as-a-service (IaaS) for Internet-based access to storage and computing power, and platform-as-a-service (PaaS) that gives developers the tools to build and host Web applications. Solutions deployed through traditional hosting methods and without the use of NIST Cloud capabilities (i.e., rapid elasticity, resource pooling, measured service, broad network access, and on demand self-service) are also included.

Commonwealth — The Commonwealth of Pennsylvania

Community-Based Organizations (CBOs)— Community-Based Organizations (CBOs) are nonprofit organizations that work at a local level to improve life for residents and normally focus on building equality across society in many areas, including but not limited to access to social services. These organizations must also be registered as a 501(c)(3) nonprofit corporation in Pennsylvania. A health care provider is not considered a CBO.

Complaint — A dispute or objection regarding a particular Provider or the coverage operations, or management of a CHC-MCO, which has not been resolved by the CHC-MCO and has been filed with the CHC-MCO or with PID's Bureau of Managed Care (BMC), including but not limited to:

- a denial because the requested service or item is not a Covered Service; which does not include BLE;
- the failure of the CHC-MCO to provide a service or item in a timely manner, as defined by the Department;
- the failure of the CHC-MCO to decide a Complaint or Grievance within the specified time frames;
- a denial of payment by the CHC-MCO after a service has been delivered because the service or item was provided without authorization by a provider not enrolled in the MA Program;
- a denial of payment by the CHC-MCO after a service or item has been delivered because the service or item provided is not a Covered Service for the Participant; or
- a denial of a Participant's request to dispute a financial liability, including cost sharing, copayments, premiums, deductibles, coinsurance, and other Participant financial liabilities.

The term does not include a Grievance.

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

Comprehensive Needs Assessment (Assessment)— An evaluation, utilizing a Department approved tool, of the Participant's physical health; the Participant's behavioral health; and the Participant's social, psychosocial, environmental, caregiver, LTSS, and other needs and the Participant's preferences, goals, housing, and informal supports.

Concurrent Review — A review conducted by the CHC-MCO during a course of treatment to determine whether the amount, duration, and scope of the prescribed service continues to be Medically Necessary or whether any service,

a different service, or lesser level of service is Medically Necessary.

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

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

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

- Is approved by the FDA;
- Is distributed by a manufacturer that entered into a Federal Drug Rebate Program Agreement with the CMS;
- May be dispensed only upon prescription in the MA Program;
- Has been prescribed or ordered by a licensed prescriber within the scope of the prescriber's practice.

The term includes biological products and insulin.

Covered Services — Services which the CHC-MCO is required to offer to Participants as specified in Exhibit A, Covered Services List.

Critical Incident — An occurrence of an event that jeopardizes the participant's health or welfare.

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

Daily 834 Eligibility File — An electronic file in a HIPAA compliant 834 format using data from eCIS that is transmitted to the CHC-MCO daily on state business days by the Department's MMIS contractor.

Day — A calendar day unless specified otherwise.

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

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

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

Direct Care Worker — A person employed for compensation by a provider or Participant who provides personal assistance services or respite services.

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

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

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

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

Dual Eligible — A Beneficiary who is enrolled in Medicare and Medicaid.

Dual Eligible Special Needs Plan (D-SNP) — A Medicare Advantage Plan that primarily or exclusively enrolls individuals who are enrolled in both Medicare and MA.

Eligibility Period — A period of time during which an individual is eligible to receive MA benefits, indicated by the eligibility start and end dates in eCIS, and a blank eligibility end date signifies a continuous Eligibility Period.

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

Emergency Back-up Plan – The steps to be taken to meet the Participant's medical and non-medical needs during an emergency. Emergency back-up plans address power outages, weather events, travel restrictions, and other events, including failure of individualized back-up plans during emergency events. Federal and state emergency management agencies (FEMA/PEMA) provide guidance on emergency planning.

Emergency Medical Condition — A medical condition manifesting itself by acute symptoms of sufficient severity, including severe pain, such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in: (a)

placing the health of the individual or, in respect to a pregnant woman, the health of the woman or her unborn child, in serious jeopardy, (b) serious impairment to bodily functions, or (c) serious dysfunction of any bodily organ or part.

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

Emergency Services — Covered inpatient and outpatient services that: (a) are furnished by a Provider, and (b) are needed to evaluate or stabilize an Emergency Medical Condition.

Encounter — Any Covered Service provided to a Participant, regardless of whether it has an associated Claim.

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

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

Enrollment Date — Date that a Beneficiary becomes eligible for CHC.

Enterprise Case Management (ECM) System — The information technology system developed and operated by the Department of Human Services that houses official hearings and appeals-related information.

Enterprise Incident Management (EIM) system — Under CHC, EIM is a comprehensive, web-based incident reporting system that provides the capability to record and review incidents for HCBS LTSS program participants.

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

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

External Quality Review Organization (EQRO) — An independent organization that meets the competence and independence requirements set forth in 42 C.F.R. § 438.354, and performs EQR or other EQR-related activities as set forth in 42 C.F.R. § 438.358, or both.

Extranet – An Intranet site that can be accessed by authorized internal and external users to enable information exchange securely over the Internet.

Family Planning Services — Diagnosis, treatment, drugs, supplies, and related counseling which are provided to individuals of child-bearing age to enable the individuals to determine freely the number and spacing of their children.

Federally Qualified Health Center (FQHC) — An individual health center site location that is receiving, or meets all of the requirements to receive (FQHC “look alike”), grant funds under Sections 329, 330, 340, or 340A of the Public Health Services (PHS) Act; or that does not currently meet all of the FQHC requirements under the PHS Act, but does meet all applicable requirements for Medical Assistance (MA) providers as set forth in Chapter 1101 of the MA regulations (including licensure and certification standards under Pennsylvania Law), and receives a temporary waiver from the Secretary of the U.S. Department of Health and Human Services allowing the health center to act as a FQHC.

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

Formulary — A Department-approved list of Medicaid covered drugs and products not included on the Statewide Preferred Drug List (PDL) and determined by the CHC-MCO’s Pharmacy & Therapeutics (P&T) Committee to have a significant, clinically meaningful therapeutic advantage in terms of safety, effectiveness, and cost for the CHC-MCO Participants. MCOs may also refer to this list as the supplemental formulary or supplemental PDL.

Fraud — Any type of intentional deception or misrepresentation, including any act that constitutes fraud under applicable Federal or State law, made by an entity or person with the knowledge that the deception could result in some unauthorized benefit to the entity or person, or some other person in a managed care setting, committed by any entity, including the CHC-MCO, a subcontractor, a Provider, or a Participant.

Grievance — A request to an MA Managed Care Plan by a Participant or a health care provider (with the written consent of the Participant), or a Participant’s authorized representative to have an MA Managed Care Plan reconsider a decision solely concerning the medical necessity, appropriateness, health care setting, level of care or effectiveness of a health care service. If the MA Managed Care Plan is unable to resolve the matter, a grievance may be filed regarding the decision that:

- (1) disapproves full or partial payment for a requested health care service;
- (2) approves the provision of a requested health care service for a lesser scope

or duration than requested; or

- (3) disapproves payment for the provision of a requested health care service but approves payment for the provision of an alternative health care service
- (4) reduces, suspends, or terminates a previously authorized service.

The term does not include a complaint.

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

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

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

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

Health Information Organization (HIO) — An entity that governs the exchange of health-related information among organizations according to nationally recognized standards.

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

Home- and Community-Based Services (HCBS) — A range of services and supports provided to individuals in their homes and communities, including assistance with ADLs and IADLs, which promote the ability for older adults and adults with disabilities to live independently to the greatest degree and remain in their homes for the longest time as is possible.

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

Implementation Date — The date on which an CHC-MCO began in a particular

zone.

In Lieu of Services (ILOS) — A service or setting that is provided to a Participant as a substitute for a State Plan Service or Setting in accordance with 42 CFR § 438.3(e)(2). This includes services and settings defined in 1905(a), 1915(i), or 1915(k) of the Social Security Act, or a waiver under section 1915(c) of the Social Security Act. An ILOS can be used as an immediate or longer-term substitute for a State Plan Service or Setting, or when the ILOS can be expected to reduce or prevent the future need to utilize a State Plan Service or Setting.

Independent Enrollment Entity (IEB) — An independent and conflict-free entity that is responsible for providing information about CHC and the CHC-MCOs and otherwise assist the individual to choose a CHC-MCO and enrollment services to Potential Participants and Participants.

Independent Review Organization (IRO) — An entity approved by the Pennsylvania Insurance Department (PID) that conducts independent reviews of grievances.

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

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

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

Internal Control Number (ICN) — The unique number assigned by the Department's MMIS to identify an individual Claim or Encounter.

Limited English Proficiency (LEP) — An individual's limited ability to read, write, speak, or understand English because English is not the individual's primary language.

Linguistic Competency — The demonstration that an entity or individual has the capacity to communicate effectively and convey information in a manner that is easily understood by diverse audiences including persons with LEP, persons who have low literacy skills or are not literate, and persons with disabilities who

require communication accommodations.

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

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

Long-Term Services and Supports (LTSS) — Services and supports provided to a Participant who has functional limitations or chronic illnesses that have a primary purpose of supporting the ability of the Participant to live or work in the setting of his or her choice, which may include the individual's home or worksite, a provider-owned or -controlled residential setting, a NF, or other institutional setting.

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

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

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

Master Provider Index (MPI) — A component of the Department's MMIS, which is a central repository of Provider profiles and demographic information that registers and identifies Providers uniquely within the Department.

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

Medical Assistance Transportation Program (MATP) — A non-emergency medical transportation service provided to eligible persons who need to make trips to or from most MA covered services for the purpose of receiving treatment,

medical evaluation, or purchasing prescription drugs or medical equipment.

Medically Necessary (also referred to as Medical Necessity) — Compensable under the MA Program and meeting any one of the following standards:

- Will, or is reasonably expected to, prevent the onset of an illness, injury, condition or disability.
- Will, or is reasonably expected to, reduce or ameliorate the physical, mental or developmental effects of an illness, condition, injury or disability.
- Will assist a Participant to achieve or maintain maximum functional capacity in performing daily activities, taking into account both the functional capacity of the Participant and those functional capacities that are appropriate for Participants of the same age.
- Will provide the opportunity for a Participant receiving LTSS to have access to the benefits of community living, to achieve person-centered goals, and live and work in the setting of his or her choice.

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

MIPPA Agreement — An agreement required under the Medicare Improvements for Patients and Providers Act of 2008, Pub. Law 110–275, between a D-SNP and the Department which documents each entity’s roles and responsibilities with regard to Dual Eligibles and describes the D-SNP’s responsibility to integrate and coordinate Medicare and MA benefits.

MMIS Provider ID — A thirteen (13)-digit number consisting of a combination of the nine (9)-digit base MPI Provider Number and a four (4)-digit service location.

Monthly 834 Eligibility File — An electronic file in a HIPAA-compliant 834 format using data from eCIS that is transmitted to the CHC-MCO on a monthly basis by the Department’s MMIS contractor.

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

Network Provider — An MA-enrolled Provider that has a written Network Provider Agreement and participates in the CHC-MCO’s Network to serve Participants.

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

Non-Participating Provider — A Health Care Provider not enrolled in the Pennsylvania Medicaid Program.

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

Nursing Facility Clinically Eligible (NFCE) — Having clinical needs that require the level of care provided in a NF.

Nursing Facility Ineligible (NFI) — Having clinical needs that do not require the level of care provided in a NF.

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

OPTIONS Program — The Pennsylvania Department of Aging's state-funded program of HCBS for eligible consumers who are 60 years of age and older to assist them in maintaining independence in the community.

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

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

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

Out-of-Network Provider — A Provider that does not have a signed Network

Provider Agreement with the CHC-MCO and does not participate in the CHC MCO's network but provides services to a CHC-MCO participant.

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

Participant — A Beneficiary who is enrolled with the CHC-MCO.

Participant Self-Directed Service — A Covered Service that the Department specifies may be directed by a Participant or their designated representative as a common-law employer.

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

Participant Record — A record contained on the Daily 834 Eligibility File or Monthly 834 Eligibility File that contains information on MA eligibility, managed care coverage, and the category of assistance, which establish the Covered Services for which a Participant is eligible.

Penalty Period — A Period of ineligibility for the payment of LTSS, including NF and HCBS, due to a transfer of assets for less than fair market value or excess home equity.

Pennsylvania Open Systems Network (POSNet) — A peer-to-peer network based on open systems products and protocols that was previously used for the transfer of information between the Department and MCOs and has been replaced by IRM Standards.

Performance Improvement Project — A project in which a CHC-MCO assesses its organization and makes changes to meet its goals through assessment, systematic gathering of information, and making improvements in care or services.

Person-Centered Planning Team (PCPT) — A team of individuals that participates in Person-Centered Service Planning with and provides person-centered coordinated services to a Participant.

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

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

Personal Assistance Services — As set forth in the “Section 1915(c) Home and Community-Based Services Waiver” for Community HealthChoices, services aimed at assisting the participant to complete ADLs and IADLs that would be performed independently if the participant had no disability.

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

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

Post-Stabilization Services — Medically Necessary Covered Services as defined in 42 C.F.R. § 438.114.

Potential Participant — An individual who has applied to enroll in CHC.

Preadmission Screening and Resident Review (PASRR) — A Federally mandated process that applies to all individuals seeking admission to a NF enrolled in the MA Program, regardless of payment source (private pay, private insurance, or MA), and is completed prior to admission and no later than the day of admission, to determine whether an individual who has a mental illness, ID, or an ORC requires NF services and also requires specialized services to treat the co-occurring conditions, based on the criteria established by CMS.

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

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

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

Prior Authorization — A determination made by the CHC-MCO to approve or deny payment for a Provider's request to provide a service or course of treatment of a specific duration and scope to a Participant prior to the Provider's initiation or continuation of the requested service.

Provider — An individual or entity that is engaged in the delivery of medical or professional services, or ordering or referring for those services, and is legally authorized to do so by the Commonwealth or State in which it delivers the services, including a licensed hospital or healthcare facility, medical equipment supplier, or person who is licensed, certified, or otherwise regulated to provide healthcare services under the laws of the Commonwealth or states in which the entity or person provides services, including a physician, podiatrist, optometrist, psychologist, physical therapist, CRNP, RN, clinical nurse specialist, certified registered nurse anesthetist, certified nurse midwife, physician's assistant, chiropractor, dentist, dental hygienist, pharmacist, and an individual accredited or certified to provide behavioral health services.

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

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

- A Provider credentialing denial;
- A Claim denial; or
- A Provider Agreement termination.

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

Provider-Preventable Condition — A condition that meets the definition of an HAC or other condition as defined in 42 C.F.R. § 447.26(b).

Provider Reimbursement (and) Operations Management Information System electronic (PROMISE™) — The Department's Medicaid Management Information System (MMIS) that supports the FFS and managed care delivery programs, or its successor system.

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

Readily Accessible — Electronic information and services which comply with modern accessibility standards such as section 508 guidelines, section 504 of the Rehabilitation Act, and W3C's Web Content Accessibility Guidelines (WCAG) 2.0 AA and successor versions.

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

Recipient Restriction Program — The program to Lock-In Participants for a period of time.

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

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

Remote Patient Monitoring — The collection and monitoring of physiological data from a patient in one location, which is transmitted via an electronic communication technology to a health care provider in a different location for use in care and related support of the patient.

Restraint — A Restraint can be physical or chemical.

- A physical restraint is any apparatus, appliance, device, or garment applied to or adjacent to a Participant's body, which restricts or diminishes the Participant's level of independence or freedom.
- A chemical restraint is a psychopharmacologic drug that is used for discipline or convenience and not required to treat medical symptoms.
- A device used to provide support for functional body position or proper balance or a device used for medical treatment, such as sand bags to limit movement after medical treatment, a wheelchair belt used for body positioning and support, or a helmet to prevent injury during seizure activity is not a restraint.

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

Revenue [for the purposes of the Equity requirement calculation] — The total gross Direct Business Premiums, for all Pennsylvania lines of business, reported in Schedule T, "Premiums and other Considerations," of the PID report, less any payments made to the CHC-MCO from the Department apart from capitation for which there is an associated contract arrangement that directs the CHC-MCO's expenditures as described in 42 C.F.R. § 438.6(c).

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

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

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

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

Social Determinants of Health (SDOH) — Conditions in the environments in which people are born, live, learn, work, play, worship, and age that affect a wide range of health, functioning, and quality-of-life outcomes which can lead to inequities and risks.

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

Statewide Preferred Drug List (Statewide PDL) – A list of drugs and products that are grouped into therapeutic classes. The Department's Pharmacy and Therapeutics (P&T) Committee recommends therapeutic classes to include on the Statewide PDL, preferred or non-preferred status for the drugs in each class, and corresponding prior authorization guidelines for each class. The committee's recommendations are approved by the secretary of the Department of Human Services (DHS) prior to implementation. The Statewide PDL applies to beneficiaries who receive their pharmacy benefits through the FFS and managed care delivery systems.

Step Therapy — A type of Prior Authorization requirement intended as a cost savings that begins drug therapy with the most cost-effective drug therapy, and progresses to other more costly therapies determined to be Medically Necessary.

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

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

Subcontract — A contract between the CHC-MCO and an individual or entity to perform part or all of the CHC-MCO's responsibilities under this Agreement, excluding Provider Agreements.

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

Substantial Financial Risk — Financial risk set at greater than twenty-five percent (25%) of potential payments for Covered Services, regardless of the frequency of assessment (i.e., collection) or distribution of payments. The term "potential payments" means the maximum anticipated total payments that a physician or physician group could receive if the use or cost of referral services were significantly low.

Telemedicine — The delivery of health care services to a patient by a health care Provider who is at a different location, through synchronous interactions, asynchronous interactions or remote patient monitoring that meets the requirements of HIPAA, the HITECH Act or other applicable Federal law or law of this Commonwealth regarding the privacy and security of electronic transmission of health information.

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

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

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

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

Utilization Review Guidelines — Detailed standards, decision algorithms,

models, or informational tools that describe the factors used to make Medical Necessity determinations for services, including but not limited to level of care, place of service, scope of service, and duration of service.

Value-Added Service — A service that is not a Covered Service that the CHC-MCO offers to encourage Participant Enrollment, encourage healthy lifestyles, or otherwise support CHC program objectives.

Value-Based Payments (VBP) Arrangements — Agreements between the MCO and providers, which specify how providers are paid for services rendered. VBP arrangements link provider payments to the value of services provided and to relevant quality measures that are indicative of health outcomes.

Value-Based Purchasing Models — VBP Models define a way to organize and deliver care and may incorporate one or more VBP Payment Strategies as ways to pay providers.

Value-Based Purchasing Payment Strategies — Refers to the mechanism that MCOs use to pay providers (such as performance-based contracting, shared savings, shared risk, population-based payment).

Vital Documents — Documents which contain information that is critical for obtaining or understanding CHC-MCO benefits and services, such as provider directories, Participant handbooks, denial, complaint and grievance notices, and other documents identified by the Department as critical to obtaining services.

SECTION III: RELATIONSHIP OF PARTIES

A. Term of Agreement

The term of this Agreement will commence on January 1, 2018, and will expire on December 31, 2026, provided that no court order, administrative decision, or action by the Federal or State government is outstanding which prevents the commencement of the Agreement.

The Department has the option to extend this Agreement for an additional two (2) six-month periods upon the same terms and conditions. DHS will notify the CHC-MCO of its election to exercise the renewal option in writing at least thirty (30) days prior to the expiration of the then-current term provided, however, that the Department's right to exercise any such renewal option shall not expire unless and until the CHC-MCO has given the Department written notice of the Department's failure to timely exercise its renewal option and has provided a ten (10) day opportunity from the Department's receipt of the notice to cure the failure. If the Department exercises its option to renew, it will promptly commence rate discussions with the CHC-MCO.

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

B. Nature of Agreement

The CHC-MCO must provide for all Covered Services and related services to Participants through Providers in accordance with this Agreement in the following zones: the Southwest Zone, Southeast Zone, Lehigh Capital Zone, Northwest Zone, and Northeast Zone. The Department may impose remediation for any CHC-MCO non-compliance with CHC program requirements contained within this Agreement.

The Department may, in its sole discretion, waive any provision of this Agreement, its Exhibits or Appendices, that is not required by state or federal law or regulation upon written request of the CHC-MCO

SECTION IV: APPLICABLE STATUTES AND REGULATIONS

A. Certification, Licensing and Accreditation

1. Providers

The CHC-MCO must require its Network Providers to comply with all certification and licensing laws and regulations applicable to the profession or entity. All ordering, referring, prescribing, or rendering providers within an MCO's network must be MA enrolled. The CHC-MCO may not employ or enter into a relationship with a Provider that is precluded from participation in the MA Program or other Federally funded healthcare program in any State. The CHC-MCO must screen all Providers at the time of hire or contracting and thereafter, on an ongoing monthly basis, to determine if they have been excluded from participation in any federally funded healthcare programs.

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

2. National Accreditation

The CHC-MCO must be accredited by NCQA and obtain accreditation within the accreditation body's specified timelines. A CHC-MCO applying for accreditation must select an accreditation option and notify the accrediting body of the accreditation option chosen. Accreditation obtained under the NCQA Full Accreditation Survey (First Survey), or the LTSS Distinction for Health Plans options will be accepted by the Department. The Department will accept the use of the NCQA Corporate Survey process, to the extent deemed allowable by NCQA, in the NCQA accreditation of the CHC-MCO, however, the CHC-MCO must obtain accreditation in a manner that allows the plan to submit their HEDIS results to NCQA for the CHC-MCO Participant population only.

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

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

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

B. Specific to the Medical Assistance Program

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

A Participant who is an Indian, as defined in 42 CFR § 438.14(a), and who is eligible to receive or has received an item or service furnished by an I/T/U HCP or through referral under contract health services as defined in 42 CFR § 447.51 is exempt from any premiums or other cost sharing imposed by the Department.

C. Specific to Medicare

The CHC-MCO must operate a CMS-approved D-SNP as provided in this Agreement in each zone.

The D-SNP must enter into a MIPPA Agreement with the Department. The MIPPA Agreement will address the required elements set forth in CMS Medicare Managed Care Manual, Chapter 16b, Available at: <https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/mc86c16b.pdf>, and will include additional requirements to ensure the greatest possible coordination between the CHC-MCO and the D-SNP, including but not limited to the following:

1. The goal of the CHC-MCO and its companion D-SNP is to provide a coordinated experience from the perspective of Dual Eligible Participants who enroll in both. This includes but is not limited to an integrated assessment and care coordination process that spans all MA and Medicare services, including behavioral health services.

2. Administrative integration is expected to evolve over the life of CHC. The CHC-MCO will cooperate fully with the Department and CMS in their ongoing efforts to streamline administration of the two programs, which may include, but is not limited to, coordinated readiness reviews, monitoring, enrollment, Participant materials and appeals processes.

D. General Statutes and Regulations

1. The CHC-MCO must comply with Titles VI and VII of the Civil Rights Act of 1964, 42 U.S.C. §§ 2000d et seq. and 2000e et seq.; Title IX of the Education Amendments of 1972, 20 U.S.C. §§ 1681 et seq.; Section 504 of the Rehabilitation Act of 1973, 29 U.S.C. § 794; the Age Discrimination in Employment Act of 1975, 42 U.S.C. §§ 6101 et seq.; the Americans with Disabilities Act, 42 U.S.C. §§ 12101 et seq.; Section 1557 of the Patient Protection and Affordable Care Act (ACA), [42 C.F.R. 438.3(f)(1); 42 C.F.R. 438.100(d)]; the Health Insurance Portability and Accountability Act of 1996 (HIPAA) 42 U.S.C. §§ 1320d-1320d-9; the Pennsylvania Human Relations Act of 1955, 71 P.S. §§ 941 et seq.; Article XXI of the Insurance Company Law of 1921, 40 P.S. §§ 991.2102 et seq.; and the Drug and Alcohol Use and Dependency Coverage Law (Act 106 of 1989), 40 P.S. §§ 908-1 et seq.

2. The CHC-MCO must comply with all applicable regulations and policies of DOH and PID.

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

3. The CHC-MCO and its subcontractors must respect the conscience rights of providers, and comply with the state law prohibiting discrimination on the basis of a refusal or willingness to provide healthcare services on moral or religious grounds as set forth in 40 P.S. § 901.2121(e)(3) and § 991.2171; 43 P.S. § 955.2 and 18 Pa. C.S. § 3213(d).

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

- With its Proposal in response to the RFA
- Whenever it adopts the policy during the term of the Agreement.

The CHC-MCO must provide this information to the IEB for Enrollment purposes and to Participants no less than thirty (30) days prior to the effective date of the policy.

4. Nothing in this Agreement shall be construed to permit or require the Department to pay for any services or items which are not or cease to be compensable under the statutes, rules, and regulations governing the MA Program at the time such services are provided.

E. Limitation on the Department's Obligations

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

F. Statutes, Regulations, Policies, and Procedures

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

The Department will issue CHC Operations (CHC OPS) Memos and Managed Care Operations Memos (MC OPS) via the Pennsylvania HealthChoices Extranet <https://pagov.sharepoint.com/sites/DHS-HC-Extranet> to provide clarifications to requirements pertaining to CHC and copies of required templates referenced in the Agreement. The CHC-MCOs must routinely check the Pennsylvania HealthChoices Extranet site.

a. Unauthorized Programs and Activities

Should any part of the scope of work under this Agreement relate to a state program that is no longer authorized by law (e.g., which has been vacated by a court of law, or for which CMS has withdrawn federal authority, or which is the subject of a legislative repeal), CHC-MCOs must do no work on that part after the effective date of the loss of program authority. The state must adjust capitation rates to remove costs that are specific to any program or activity that is no longer authorized by law. If a CHC-MCO works on a program or activity no longer authorized by law after the date the legal authority for the work ends, the CHC-MCO will not be paid for that work. If the state paid a CHC-MCO in advance to work on a no-longer-authorized program or activity and under the terms of this Agreement the work was to be performed after the date the legal authority ended, the payment for that work should be returned to the state. However, if a CHC-MCO worked on a program or activity prior to the date legal authority ended for that program or activity, and the state included the cost of performing that work in its payments to the MCO, the MCO may keep the payment for that work even if the payment was made after the date the program or activity lost legal authority.

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 manager 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, Subcontractual Relationships. The CHC-MCO is required to keep the Department informed at all times of the management individuals whose duties include each of the responsibilities outlined in this section.

X. Administration

The CHC-MCO must have an administrative office within 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 restriction 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 restriction 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

- i. The appointment by such a court or tribunal having competent jurisdiction of a receiver or receivers, or trustee, or liquidator or liquidators of a party or of all or any substantial part of its property upon the application of any creditor or other party entitled to so apply in any insolvency or bankruptcy proceeding or other creditor's suit; and
- d. The oversight and accountability for any functions and responsibilities delegated to 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, 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.

l. Duty to Notify

i. Department's Responsibility

The Department will provide the CHC-MCO with prompt notice via electronic transmission or access to Medicare 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 (SSADM), 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 Medicare 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 its 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 withhold 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(I). 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.

SECTION VI: PROGRAM OUTCOMES AND DELIVERABLES

Prior to the Enrollment of Participants and a Zone Start Date for a CHC-MCO, the Department will conduct Readiness Review activities to determine the CHC-MCO's ability to provide services as required by this Agreement. The CHC-MCO must cooperate with all the Readiness Review activities, including on-site reviews conducted by the Department. As part of Readiness Review, the CHC-MCO must successfully test

its claims processing system in a given zone. Test samples must include all types of payments and adjustments that are billed through the Department's MMIS claims processing system. If the Department determines the CHC-MCO has not demonstrated readiness to provide services as required by this Agreement, the Department will not permit the enrollment of Potential Participants with the CHC-MCO and may extend the time period for the Readiness Review or not operationalize this Agreement.

SECTION VII: FINANCIAL REQUIREMENTS

A. Financial Standards

1. Equity Requirements and Solvency Protection

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

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

- Twenty Million Dollars (\$20.00 million);
- Seven percent (7.000%) of revenue earned by the CHC-MCO during the most recent four (4) calendar quarters; or
- Seven percent (7.000%) of revenue earned by the CHC-MCO during the current quarter multiplied by three (3).

Revenue, for the purpose of the Equity requirement calculation, is defined as the total gross Direct Business Premiums, for all Pennsylvania lines of business, reported in Schedule T, "Premiums and Other Considerations," of the PID report, less any payments made to the CHC-MCO from the Department apart from capitation for which there is an associated contract arrangement that directs the CHC-MCO's expenditures as described in 42 C.F.R. § 438.6(c).

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

The CHC-MCO must provide the Department with reports as specified in

Section VIII.E and F. Financial Reports and Equity.

If the CHC-MCO operates its plan through another legal entity or entities, and if that other entity or those other entities receive(s) from the CHC-MCO a total amount that is at least seventy five percent (75%) of the revenue paid by the Department to the CHC-MCO, then the CHC-MCO may request the following equity requirement as an alternative to the Three (3) Part Test set forth above, subject to the approval of the Department:

1. The CHC-MCO RBC ratio must be at least three (3.0);
2. The CHC-MCO must maintain a SAP-basis Equity no less than an amount that is the higher of:
 - a. Five and one-half percent (5.5%) of revenue earned by the CHC-MCO during the most recent four (4) calendar quarters; or
 - b. Five and one-half percent (5.5%) of revenue earned by the CHC-MCO during the then-current calendar quarter multiplied by 3; and
3. The other entity or other entities that operate(s) the CHC-MCO's plan in a particular zone must maintain (individually, in the case of multiple entities) Equity no less than an amount that is the higher of:
 - a. Eight and three-tenths percent (8.3%) of revenue earned by the entity during the most recent four (4) calendar quarters; or
 - b. Eight and three-tenths percent (8.3%) of revenue earned by the entity during the then-current calendar quarter multiplied by three (3).

Revenue, for the purpose of this alternative equity requirement, would be premiums as noted on the most-recent audited statements.

The CHC-MCO must provide documentation of compliance that is satisfactory to the Department, and failing that, must comply with the standard Three Part Test.

2. Risk Based Capital

The RBC ratio is defined as:

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

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

3. Prior Approval of Payments to Affiliates

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

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

In this event, the Department may require repayment of amounts involved in the transaction.

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

4. Change in Independent Actuary or Independent Auditor

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

5. Modified Current Ratio

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

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

6. Sanctions

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

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

In addition, the Department may impose sanctions described above when a

CHC-MCO, either directly or through a Subcontractor, acts or fails to act as follows:

- Fails substantially to arrange for Medically Necessary services that the CHC-MCO is required to provide to a Participant under law or under its Agreement.
- Imposes on Participants premiums or charges that are in excess of the premiums or charges permitted under the MA program.
- Acts to discriminate among Participants on the basis of their health status or need for healthcare services.
- Misrepresents or falsifies information that it furnishes to CMS, the Department, Participants, Potential Participants, or Healthcare Providers.
- Fails to comply with requirements for PIPs as set forth in 42 C.F.R. §§ 422.208 and 422.210.
- Has distributed directly, or indirectly through any agent or independent contractor, marketing materials that have not been approved by the Department or that contain false or materially misleading information.

7. Payment for Disproportionate Share Hospitals and Graduate Medical Education

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

8. Participant Liability

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

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

If a Participant's eligibility for MA LTSS is terminated retroactively because the

Participant was determined functionally ineligible as a result of the CHC-MCO failure to conduct the Participant's annual Reassessment, the CHC-MCO must continue to provide coverage for services to the Participant until the Participant's functional eligibility determination is made. The CHC-MCO may not recover payments to providers for services provided to the Participant or seek to hold the Participant financially responsible for such services.

9. Restitution for Fees Owed to the Department

The Department may require the CHC-MCO to offset against any payment amount due to a Provider from the CHC-MCO any amounts that are due to the Department from the Provider and that have not been paid by the Provider.

- The Department will notify the CHC-MCO and the Provider in writing of the amount due to the Department.
- If the Network Provider fails to make payment of the amount within 30 days of the written notice, then the Department will notify the CHC-MCO that it must offset the amount due to the Department, for the amount identified by the department, from the CHC-MCO's payments to the Network Provider and pay the Department until the amount due to the Department has been collected in full.
- The Department reserves the right to deduct any unpaid amounts due from the Network Provider from future payments to the CHC-MCO after ninety (90) days from the mailing date of the written notice.

B. Department Capitation Payments

1. Payments for Covered Services

The obligation of the Department to make payments shall be limited to Capitation payments and any other payments provided by this Agreement.

2. Capitation Payments

- i. The CHC-MCO shall receive capitated payments for the previous month for Covered Services as defined in Section VII.B.1, Payments for Covered Services, and in Appendix 3a, Explanation of Capitation Payments.
- ii. The Department will compute Capitation payments using daily per diem rates. The Department will make a monthly payment to the CHC-MCO for each Participant enrolled in the CHC-MCO, for the first (1st) day in the month the Participant is enrolled in the CHC-MCO and for each subsequent day, through and including the last day of the month.
- iii. The Department will not make a Capitation payment for a Participant

Month if the Department notifies the CHC-MCO before the first (1st) of the month that the individual's MA eligibility or CHC-MCO Enrollment ends prior to the first (1st) of the month.

- iv. The Department will make payments by wire transfer or electronic funds transfer unless the CHC-MCO is unable or unwilling to receive payment through wire or electronic funds transfer. If such arrangements are not in place, the Department will provide payments through the U.S. Mail.
- v. Upon notice to the CHC-MCO, and for those months specified by the Department, by the fifteenth (15th) of each month, the Department will make a Capitation payment, referenced in Section VII.B.1, for each Participant for all dates of Enrollment indicated on the Department's eCIS through the last day of the current month. This payment will be limited to those days for which the Department has not previously made payment to the CHC-MCO.
- vi. This paragraph vi. is applicable unless it is superseded by paragraph v. immediately above. By the fifteenth (15th) of each month, the Department will make a Capitation payment, referenced in Section VII.B.1, for each Participant for all dates of Enrollment indicated on the Department's eCIS prior to the first day of the current month. This payment will be limited to those days for which the Department has not previously made payment to the CHC-MCO.
- vii. The Department will recover Capitation payments made for Participants who were later determined to be ineligible for managed care for up to twelve (12) months after the service month for which payment was made. The Department will recover Capitation payments made for deceased Participants for up to twenty-one (21) months after the service month in which the date of death occurred. See Exhibit K, CHC-MCO Participant Coverage Document.
- viii. The CHC-MCO must report to the Department within sixty (60) calendar days when it has identified capitation payments or other payments in excess of amounts specified in the Agreement.
- ix. Upon written notification to the CHC-MCO, the Department may delay the capitation payments made in May and/or June of each calendar year that would have otherwise been made under Section VII.B.2.v above, to payment dates in July of the same calendar year. The Department will include in the written notification the applicable payment dates for the delayed capitation payments.

3. Program Changes

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

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

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

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

C. Acceptance of Actuarially Sound Rates

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

D. Claims Processing Standards, Monthly Report and Sanctions

These requirements and assessments are applied statewide.

1. Timeliness Standards

The CHC-MCO must adjudicate Provider Claims consistent with the requirements below. These requirements apply to Claims processed both by the CHC-MCO and by any subcontractor the CHC-MCO may have contracted with to receive, and process claims for it. Sub capitation payments and claims adjustments are excluded from these requirements.

The adjudication timeliness standards follow for each of four (4) categories of Claims:

a. Claims received from a hospital for inpatient admissions ("Inpatient"):

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

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

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

b. Nursing Facility (NF) Claims:

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

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

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

c. Home and Community Based Services (HCBS) Claims:

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

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

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

d. Other Claims (Not Inpatient, NF, HCBS or Pharmacy):

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

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

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

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

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

The amount of time required to adjudicate a paid Claim is computed by comparing the date the Claim was received with the check date or the CHC-MCO bank notification date for electronic payment. The check date is the date printed on the check.

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

The CHC-MCO must record, on every Claim processed, the date the Claim was received. A date of receipt embedded in a Claim reference number is acceptable. The CHC-MCO must have this date carried on Claims records in the Claims processing computer system. Each hardcopy Claim received by the CHC-MCO, or the electronic image thereof, must be date-stamped with the date of receipt no later than the first (1st) business day after the date of receipt. The CHC-MCO must add a date of receipt to each Claim received in the form of an electronic record or file within one (1) business day of receipt.

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

2. Sanctions

The Department will utilize the monthly report that is due on the fifth (5th)

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

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

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

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

- a) Inpatient Claims.
- b) NF Claims
- c) HCBS Claims
- d) Other Claims (Not Inpatient, NF, HCBS or Pharmacy)

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

The CHC-MCO will be considered in compliance with the requirement for adjudication of one hundred percent (100.0%) of all Inpatient, NF, and HCBS Claims if ninety-nine-and-one-half percent (99.5%) of all Inpatient, NF and HCBS Claims are adjudicated within ninety (90) days of receipt. The CHC-MCO will be considered in compliance with the requirement of adjudication of one hundred percent (100.0%) of all Other Claims (not Inpatient, NF, HCBS or Pharmacy) if ninety-nine-and-one-half percent (99.5%) of all Other Claims (not Inpatient, NF, HCBS or Pharmacy) are adjudicated within ninety (90) days of receipt.

The Department will reduce the sanctions below by one-third (1/3) if the CHC-MCO has fifty thousand (50,000) to one hundred thousand (100,000) Participants and by two-thirds (2/3) if the CHC-MCO has less than fifty thousand (50,000) Participants.

CLAIMS ADJUDICATION MONTHLY SANCTIONS CHART

The Department will compute sanctions for failure to adjudicate Inpatient, NF,

HCBS and Other Claims (not Inpatient, NF, HCBS, or Pharmacy) as shown in the following tables.

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

E. Other Financial Requirements

1. Provider Incentive Arrangements

- a. CHC-MCOs must comply with the PIP requirements included under 42 C.F.R. §§ 422.208 and 422.210, which apply to MA managed care under 42 C.F.R. § 438.3(i).
- b. The CHC-MCO may operate PIPs if 1) no specific payment is made directly or indirectly to a physician or physician group as an inducement to reduce or limit Medically Necessary services furnished to a Participant; and 2) the disclosure, computation of Substantial Financial Risk, Stop-Loss Protection, and Participant survey requirements of this section are met.

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

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

- e. The CHC-MCO must provide the disclosure information specified in 1.d. immediately above to the Department annually unless the Department has notified the CHC-MCO of the suspension of this requirement.
- f. CHC-MCOs shall not use any financial incentive that compensates any provider for providing less than medically necessary and appropriate care to a Participant.

2. Retroactive Eligibility Period

The CHC-MCO shall not be responsible for any payments owed to Providers for services that were rendered prior to the Participants' Start Date.

3. In-Network Services

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

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

4. Payments for Out-of-Network Providers

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

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

The CHC-MCO may not impose any cost on the Participant for using an Out-of-Network Provider that is greater than the cost would have been if a Network Provider furnished the services.

The CHC-MCO must allow a Participant, who is an Indian as defined in 42 CFR § 438.14(a), to obtain Covered Services from Out-of-Network I/T/U HCPs from which that Participant is otherwise eligible to receive services.

The CHC-MCO is not financially liable for:

- a. Services rendered to treat a non-emergency condition in a hospital ED except to the extent required elsewhere in law, unless the services were

Prior Authorized;

- b. Prescriptions presented at Out-of-Network Pharmacies that were written by non-participating or non-network prescribers unless:
 - the Non-Participating Provider or non-network Provider arrangements were approved in advance by the CHC-MCO, and any Prior Authorization requirements (if applicable) were met; or
 - the non-participating or non-network prescriber and the pharmacy are the Participant's Medicare Providers; or
 - the Participant is covered by a third-party carrier and the non-participating or non-network prescriber, and the pharmacy are the Participant's third-party Providers.

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

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

The CHC-MCO must pay all FQHCs and RHCs rates that are not less than FFS Prospective Payment System (PPS) rates, as determined by the Department. The CHC-MCO must also include in its Network every FQHC and RHC that is willing to accept FFS Prospective Payment System rates as payment in full and are located within the CHC zone. The CHC-MCO must consider the FQHC and/or RHC as both the billing and rendering provider of clinic services provided to Participants.

If a FQHC/RHC has opted-out of receiving the PPS rate from the CHC-MCOs, upon notification from the Department of the date that the FQHC/RHC has opted-out, the CHC-MCO is no longer required to make payment at the FFS PPS rate, as noted above. Effective with the FQHC/RHC opt-out, the CHC-MCO must negotiate and pay the opted-out FQHC/RHC at rates that are no less than what the CHC-MCO pays to other providers who provide comparable services within the CHC-MCO's Provider Network.

CHC-MCOs will have 90 days from the date of the Department's notification to the CHC-MCO of a retroactive PPS rate adjustment to reprocess all applicable FQHC and/or RHC claims that were subject to the requirements of this section. The CHC-MCO must send notification to the Department no later than 10 working days after the completion of the required claims reprocessing.

1. Failure to complete the required claims reprocessing for each FQHC and RHC and to submit notification of the completion of the claims

reprocessing to the Department will result in the full assessment of the 90-day claims processing sanctions in Section VII.D. In addition to the sanction amount, the Department will complete a settlement in place of the CHC-MCO's claims reprocessing for the FQHC or RHC. The amount the Department pays to the FQHC or RHC for this settlement will be an obligation of the CHC-MCO to the Department and recovered by the Department from the CHC-MCO through a reduction to a future payment.

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

6. Payments to Nursing Facilities

The CHC-MCO shall pay all NFs at a payment rate that is not less than the facility-specific minimum payment rate established by the Department and shared with the CHC-MCO. The Department will notify the MCO of the facility-specific payment rate. Nothing in this provision should be construed to prohibit the CHC-MCO and the NF to agree to a higher payment rate or to a VBP Payment Arrangement in accordance with Section VII.E.16 that provides an alternative payment for services that is at a payment rate equal to or greater than the facility-specific minimum payment rate. An incentive payment earned under the Nursing Facility Quality Incentive Program described in Exhibit DD(2) shall be in addition to the facility-specific minimum payment rate required under this subsection.

7. Coverage for Participants in an IMD

The Department will make Capitation payments for a Participant aged twenty-one through sixty-four (21 – 64) residing in a freestanding Institution for Mental Diseases (IMD) and the Participant's condition is not related to Substance Use Disorder (SUD) based on the following criteria:

- If the stay is no more than fifteen (15) cumulative days during the period of the monthly capitation payment and the provision of inpatient psychiatric treatment in a freestanding IMD meets the requirements for in lieu of services in 42 C.F.R. 438.3 (e) (2)(i) through (iv), payment will be full capitation in which a Participant is enrolled in the CHC-MCO.
- If the stay is at least sixteen (16) cumulative days during the period of the monthly capitation payment and the provision of inpatient psychiatric treatment in a freestanding IMD meets the requirements for in lieu of services in 42 C.F.R. 438.3 (e) (2)(i) through (iv), the payment will be based as follows: per diem rate identified in Section VII.B.1 multiplied by the number of days the Participant is both enrolled in the CHC-MCO and not residing in a freestanding IMD.

8. Liability during an Active Grievance or Appeal

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

9. Financial Responsibility for Dual Eligible Participants

The CHC-MCO must pay Medicare deductibles and coinsurance amounts relating to any Medicare-covered service for Dual Eligible Participants in accordance with Section 4714 of the Balanced Budget Act of 1997.

If Medicare's payment exceeds the CHC-MCOs contracted rates for a particular Medicare service, the CHC-MCO does not make a payment. When the CHC-MCOs contracted rate exceeds the amount paid by Medicare, the CHC-MCO must pay the difference between the amount paid by Medicare and the CHC-MCO contracted rate. The CHC-MCO will not be responsible for copayments or cost-sharing for Medicare Part D prescriptions.

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

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

The CHC-MCO, its subcontractors and Providers are prohibited from balance billing Participants for Medicare deductibles or coinsurance. Participants who are dually eligible for Medicare and Medicaid are allowed to continue using their Medicare PCP even if the PCP is not MA enrolled. The CHC-MCO must provide a Dual Eligible Participant access to Medicare products and services from the Medicare Provider of his or her choice. The CHC-MCO is responsible to pay any Medicare coinsurance and deductible amount, whether or not the Medicare Provider is included in the CHC-MCO's Provider Network, is a participating provider in Medicaid, and whether or not the Medicare Provider has complied with the Prior Authorization requirements of the CHC-MCO.

The Commonwealth enters into a Coordination of Benefits Agreement with Medicare. Consistent with 42 C.F.R. §438.3(t), the CHC-MCO must enter into individual Coordination of Benefits Agreements with Medicare for members dually eligible for Medicaid and Medicare and participate in the automated claims crossover process.

10. Confidentiality

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

11. Audits

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

12. Restitution for Overpayments

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

13. Penalty Periods

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

14. Prohibited Payments

The CHC-MCO shall not pay for an item or service (other than an emergency item or service, not including items or services furnished in an emergency room of a hospital), that is furnished:

- a. by, or at the medical direction or prescription of, any individual or entity during any period that the individual or entity is excluded from participation in Medicare, Medicaid, the federal Maternal and Child Health Services Block Grant program or the federal Social Services Block Grant program; or
- b. by any individual or entity during any period when there is a pending

investigation of a credible allegation of fraud against the individual or entity, unless the Department determines in accordance with then-applicable federal regulations there is good cause not to suspend such payments.

The CHC-MCO must not pay any amount for which funds may not be used under the federal Assisted Suicide Funding Restriction Act of 1997, including payments for items or services furnished for the purpose of causing, or for the purpose of assisting in causing, the death of any individual, such as by assisted suicide, euthanasia or mercy killing.

The CHC-MCO must not pay for any item or service for road bridges, stadiums, or any other item or service not provided for under this Agreement.

15. Payment for Personal Assistance Services

The Department requires CHC-MCOs to pay for Personal Assistance Services at no less than the HCBS MA fee schedule rate. Nothing in this provision should be construed to prohibit the CHC-MCO and the provider to agree to a higher payment rate.

16. Value-Based Purchasing (VBP)

Value-based purchasing (VBP) is the Department's initiative to transition providers to being paid for the value of the services provided, rather than simply the volume of services. VBP Payment Strategies and VBP Models are critical for improving quality of care, efficiency of services, reducing cost, and addressing Social Determinants of Health.

The Department has developed an aligned VBP framework that consists of both VBP Payment Strategies and VBP Models. VBP Payment Strategies define the mechanism by which the providers are paid by the MCO. VBP Payment Strategies are tiered by three levels of risk: low, medium, and high.

VBP Models define a way to organize and deliver care and may incorporate one or more VBP Payment Strategies as ways to pay providers. The Department is categorizing VBP Models into recommended models and required models.

CHC-MCOs, BH-MCOs, PH-MCOs, and CHIP-MCOs can form integrated VBP models. MCOs should work towards integrating VBP models, because addressing all service and supports needs will improve health outcomes.

a. VBP Payment Strategies

The MCO must enter into VBP Payment Arrangements with Providers that incorporate approved VBP Payment Strategies. The Department retains the ability to accept or reject any proposals to count toward the required VBP medical spend percentage. The approved VBP Payment Strategies are tiered as low risk (performance-based contracting), medium risk (shared savings, shared risk, bundled payments), and high risk (global payments).

Each arrangement must include quality benchmarks, financial incentives, penalties, or both, without which the Department will reject the arrangement as counting towards the required VBP medical or LTSS spend percentage. MCOs can also layer additional non-financial incentives as long as financial incentives are also in the arrangement.

Approved payment strategies:

- i. Performance-based contracting (low-risk strategy): FFS contracts in which incentives payments and/or penalties are linked to Network Provider performance. The MCO must measure Network Providers against quality benchmarks or incremental improvement benchmarks and must include in the contract incentives or penalties or both based upon meeting these benchmarks.
- ii. Shared Savings (medium-risk strategy): Supplemental payments to Network Providers if they can reduce health care spending relative to an annual cost benchmark, either for a defined Participant sub-population or the total Participant population served by a Network Provider. The cost benchmark should be developed prospectively, based at least in part on historical claims, and be risk adjusted if needed. The supplemental payment is a percentage of the net savings generated by the Network Provider.
- iii. Shared Risk (medium-risk strategy): Supplemental payments to Network Providers if they can reduce health care spending relative to a cost benchmark, either for a defined Participant sub-population or the total Participant population served by a Network Provider. The cost benchmark should be developed prospectively, based at least in part on historical claims, and risk adjusted if needed. The payment is a percentage of the net savings generated by the Network Provider. These arrangements also include shared losses with Network Providers if costs are higher relative to a benchmark.

- iv. Bundled payments (medium-risk strategy): Bundled payments include all payments for services rendered to treat a Participant for an identified condition during a specific time period. The payments may either be made in bulk or be paid over regular predetermined intervals. DHS may specify certain services that must be paid through bundled payments.
- v. Global payment (high-risk strategy): Population-based payments that cover all services rendered by a Network Provider, hospital, or health system by the participating MCO.

- i. An annual global budget is developed prospectively. These payments can either be made in bulk, delivered over regular predetermined intervals, or based on fee-for-service payments with retrospective reconciliation to the global budget. If these payments are subject to retrospective reconciliation, at least a portion of the payment must be prospective to allow Network Providers to make upfront investments in population health infrastructure.

- ii. Global payments should link payments to both improved physical health and behavioral health quality measures and provide incentive to reduce potentially avoidable utilization and address social determinants of health. Global payments must also take into consideration market shift on an annual basis, to ensure that Network Providers are not simply decreasing the amount of care provided.

- iii. Network Providers who are paid via global payments are excluded from participating in separate bundled payment, shared savings, and shared risk arrangements with the same MCO, because this would be a duplication of payment for services rendered.

b. VBP Models:

VBP Models are divided into Recommended Models, which the Department encourages MCOs to adopt, and Required Models, which are models that MCOs must adopt if they decide to contract with participating Network Providers. MCOs may also implement VBP payment arrangements outside of the recommended models and required models.

Recommended Model:

- i. Accountable Care Organization (ACO): An ACO Model integrates the financing arm with the delivery arm within the same organization, such that both are collectively responsible for the Participant. ACO models may include shared savings, shared risk, or global payments.

- ii. Patient Centered Medical Home (PCMH): MCOs may include PCMH models as defined by NCQA, current existing Medicare PCMH programs, current D-SNP PCMH programs, and the HealthChoices PCMH program to have the arrangement qualify as a PCMH. Note that payments to PCMHs must be categorized as one of the VBP payment arrangements listed in Section A, and still include quality benchmarks, with incentives or penalties or both based upon meeting these benchmarks, without which the payments will not count towards the required VBP medical spend percentage.
- iii. Performance-based Contracting (PBC): Fee-for-Service (FFS) contracts in which incentives payments and/or penalties are linked to Network Provider performance. The MCO must measure Network Providers against quality benchmarks or incremental improvement benchmarks and must include in the contract incentives or penalties or both based upon meeting these benchmarks.
- iv. Shared Savings: Supplemental payments to Network Providers if they can reduce health care spending relative to an annual cost benchmark, either for a defined Participant sub-population or the total Participant population served by a Network Provider. The cost benchmark should be developed prospectively, based at least in part on historical claims and be risk adjusted if needed. The supplemental payment is a percentage of the net savings generated by the Network Provider.
- v. Shared Risk: Supplemental payments to Network Providers if they can reduce health care spending relative to a cost benchmark, either for a defined Participant sub-population or the total Participant population served by a Network Provider. The cost benchmark should be developed prospectively, based at least in part on historical claims and risk adjusted if needed. The payment is a percentage of the net savings generated by the Network Provider. These arrangements also include shared losses with Network Providers if costs are higher relative to a benchmark.

- vi. **Bundled Payments:** Bundled payments include all payments for services rendered to treat a Participant for an identified condition during a specific time period. The payments may either be made in bulk or be paid over regular predetermined intervals. The Department of Human Services (DHS) may specify certain services that must be paid through bundled payments.
- vii. **Global Payment:** Population-based payments that cover all services rendered by a Network Provider, hospital, or health system by the participating MCO.
 - 1) An annual global budget is developed prospectively. These payments can either be made in bulk, delivered over regular predetermined intervals, or based on FFS payments with retrospective reconciliation to the global budget. If these payments are retrospective, at least a portion of the payment must be prospective to allow Network Providers to make upfront investments in population health infrastructure.
 - 2) Global payments should link payments to both improved physical health and behavioral health quality measures and provide incentive to reduce potentially avoidable utilization and address social determinants of health. Global payments must also take into consideration market shift on an annual basis, to ensure that Network Providers are not simply decreasing the amount of care provided.
 - 3) Network Providers who are paid via global payments are excluded from participating in bundled payment arrangements, because this would make the Network Provider doubly liable for the services rendered. MCOs should consider reduction of prior authorization requirements for Network Providers who are paid via global payments.

Required Models:

MCOs must participate in required VBP payment models if specified by the Department and work with the Department on the development of new models.

c. Financial Goals

The financial goals for the VBP strategies for each calendar year are based on a percentage of the CHC-MCO's expenditures to the medical portion of the risk adjusted capitation revenue without consideration of risk sharing risk pools, P4P or other revenue or revenue adjustments.

These goals apply collectively to all Community HealthChoices Agreements between the CHC-MCO and the Department in all Community HealthChoices Zones. For the purpose of this requirement, Capitation revenue is gross of premiums for risk sharing or risk pool arrangements without adjustment for risk sharing or risk pool results. The CHC-MCO must achieve the following percentages through VBP arrangements:

- i. Calendar year 2026 – fifteen percent (15%) of the medical portion of the capitation must be expended through VBP. The fifteen percent (15%) may be from any combination of strategies 8.a.i through 8.a.v., and twenty five percent (25%) of LTSS payments through a value-based payment arrangement. A minimum of ten percent (10%) of the total LTSS spend must be in the Medium or High Financial Risk categories.

d. Reporting

The Department will measure compliance through required reports that have been developed by the Department. By October 1st of each calendar year, the CHC-MCO must submit its proposed VBP plan to the Department in the format required by the Department that outlines and describes its plan for compliance in that calendar year. The Department will review and provide feedback on the plan to the CHC-MCO. The CHC-MCO must submit a progress report by the last workday of every quarter, excluding the quarter ending December 31.

By May 1st of the subsequent calendar year, the CHC-MCO must submit a preliminary report as directed by the Department on accomplishments from the prior year. This annual report must include a listing of the VBP arrangements by provider; and an explanation of each arrangement; and the dollar amount spent for medical services and LTSS provided during the previous year through these arrangements. By June 30th, the CHC-MCO must submit a final version of the aforementioned report. The dollar amounts that qualify toward meeting the VBP goals are as follows:

- i. Performance based contracting – dollar value of performance (bonus) payments and direct payments made to the Provider for Participants attributed to the provider's panel during the calendar year.

- ii. The CHC-MCOs will use the Nursing Facility Quality Measurement Program to evaluate nursing homes and develop a valued based incentive arrangement as detailed in Exhibit DD(2) Pay for Performance Nursing Facility Quality Measurement Program.
- iii. Shared savings— dollar value of any performance (bonus) payments, direct payments made to the provider and total medical costs incurred by the CHC-MCO for Participants of the provider's panel during the time period of the calendar year the Participant was attributed to the provider's panel.
- iv. Shared risk – dollar value of any performance (bonus) payments and penalty payments, direct payments made to the provider total medical costs incurred by the CHC-MCO for Participants of the provider's panel during the time period of the calendar year the Participant was attributed to the provider's panel.
- v. Bundled payments— dollar value of bundled payments made to providers. The Department may add additional reporting requirements depending on the services being bundled.
- vi. Global payments – dollar value of any performance (bonus) payments, direct payments made to the provider and total medical costs incurred by the CHC-MCO for Participants of the provider's panel inclusive of any previous (bonus) payments during the time period of the calendar year the Participant was attributed to the provider's panel.

e. New Agreements

If a new CHC-MCO Agreement is executed and effective during a calendar year, the reporting requirements are applicable to the calendar year that crosses Agreements, and the Department will determine compliance for the complete calendar year.

f. Assessment

This section provides for an assessment against the CHC-MCO's revenue if an annual goal is not met.

Not later than sixty (60) calendar days after receipt from the CHC-MCO of the annual report on VBP accomplishments, the Department will notify the

CHC-MCO of its determination about compliance with the goal for the preceding year. The CHC-MCO may provide a response within 30 calendar days. After considering the response from the CHC-MCO, if any, the Department will notify the CHC-MCO of its final determination of compliance.

If the CHC-MCO fails to provide a timely and adequate report on VBP accomplishments, the Department may determine that the CHC-MCO is not compliant with the goal of the preceding year.

If the determination results in a finding of non-compliance, the Department may reduce the next monthly capitation payment by an amount equivalent to .5 percent (.5%) of the capitation it paid to the CHC-MCO for December of the prior calendar year.

g. Data Sharing

The CHC-MCOs must provide timely and actionable data to its providers participating in VBP arrangements. This data should include, but is not limited to, the following:

- i. Identification of high risk patients;
- ii. Comprehensive care gaps inclusive of gaps related to quality metrics used in the VBP arrangement; and
- iii. Service utilization and claims data across clinical areas such as inpatient admissions, non-inpatient facility (Short Procedure Unit/Ambulatory Surgical Center), emergency department, radiology services, lab services, durable medical equipment and supplies, specialty physician services, home health services, nursing facilities, HCBS services and prescriptions,
- iv. Care management information such as initial assessments and care plans, reassessments, and updated care plans, as well as transition of care information from nursing home to the community.

17. Payments for Dental Services

- a. The CHC-MCO must apply a twenty seven percent (27%) uniform percent increase for dental services provided and billed by Medicaid enrolled dentists, in addition to the greater of the MCO and provider negotiated rates effective on or after July 1, 2024.
- b. The CHC-MCO must apply the uniform percent increase to

the following codes:

Dental Code	Description	Dental Code	Description
D0120	Periodic Oral Evaluation – Established Patient	D2392	Resin-based Composite – Two Surfaces, Posterior
D0150	Comprehensive Oral Evaluation	D2393	Resin-based Composite – Three Surfaces, Posterior
D0220	Intraoral – Periapical First Radiographic Image	D2751	Crown-porcelain Fused to Predominantly Base Metal
D0230	Intraoral – Periapical Each Additional Radiographic Image	D2930	Prefabricated Stainless Steel Crown – Primary Tooth
D0272	Bitewings – Two Radiographic Images	D2933	Prefabricated Stainless Steel Crown with Resin Window
D0274	Bitewings – Four Radiographic Images	D3220	Therapeutic Pulpotomy (Excluding Final Restoration)
D0330	Panoramic Radiographic Image	D3230	Pulpal Therapy (Resorbable Filling) – Anterior, Primary Tooth
D1110	Prophylaxis – Adult	D4341	Periodontal Scaling and Root Planing
D1120	Prophylaxis – Child	D5110	Complete Denture – Maxillary
D1206	Topical Fluoride Varnish	D5120	Complete Denture – Mandibular
D1208	Topical Application of Fluoride – Excluding Varnish	D5213	Maxillary Partial Denture
D1351	Sealant – Per Tooth	D5214	Mandibular Partial Denture
D2140	Amalgam – One Surface, Primary or Permanent	D7140	Extraction, Erupted Tooth or Exposed Root
D2150	Amalgam – Two Surfaces, Primary or Permanent	D8080	Comprehensive Orthodontic Treatment of the Adolescent Dentition
D2331	Resin-based Composite – Two Surfaces, Anterior	D9230	Inhalation of Nitrous Oxide/Analgesia, Anxiolysis
D2391	Resin-based Composite – One Surface, Posterior		

- c. The requirements in 8.a. and 8.b. apply to any Subcontractor of the CHC-MCO, as required by Section V.X.2

18. Perinatal Doulas

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

F. Third Party Liability

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

1. Cost-Avoidance Activities

- a. The CHC-MCO will have primary responsibility for cost avoidance through the COB relative to federal and private health insurance-type resources, including, but not limited to, Medicare, private health insurance, ERISA plans, and workers compensation. Except as provided in subparagraph ii, the CHC-MCO must attempt to avoid initial payment of Claims, whenever possible, where federal or private health insurance-type resources are available.

The CHC-MCO must report all funds that are cost-avoided by the CHC-MCO to the Department via Encounter Data submissions. The number of claims cost avoided by the CHC-MCO's claims system should be reported in Financial Report #8A, "Claims Cost Avoided." The use of the appropriate HIPAA 837 Loop(s) for Medicare and Other Insurance Paid shall indicate that TPL has been pursued and the amount which has been cost-avoided. The CHC-MCO shall not be held responsible for any TPL errors in EVS or the Department's TPL file. The CHC-MCO must sign a Coordination of Benefits Agreement and participate in the automated claims crossover process administered by Medicare.

- b. The CHC-MCO may not deny, or delay approval of otherwise covered treatment or services based upon TPL considerations. The CHC-MCO may neither unreasonably delay payment nor deny payment of Claims unless the probable existence of TPL is established at the time the Claim is adjudicated.

2. Post-Payment Recoveries

- a. Post-payment recoveries are categorized by (a) health-related insurance resources, and (b) Other Resources. Health-related insurance resources are ERISA health benefit plans, Blue Cross/Blue Shield subscriber contracts, Medicare, private health insurance, workers' compensation, and health insurance contracts. Other Resources include but are not limited to recoveries from personal injury claims, liability insurance, first-party automobile medical insurance and accident indemnity insurance.
- b. The Department's Division of TPL retains the sole and exclusive right to investigate, pursue, collect, and retain all Other Resources. The CHC-MCO assigns to the Department the CHC-MCO's subrogation rights to collect the Other Resources covered by this provision. The CHC-MCO must immediately forward to the Division of TPL any correspondence or Inquiry received by the CHC-MCO (by an attorney, Provider of service, insurance carrier, etc.) relating to a personal injury accident or trauma-related medical service, or which in any way indicates that there is, or may be, legal involvement regarding the Participant and the services which were provided. The CHC-MCO may neither unreasonably delay payment nor deny payment of Claims because they involve an injury stemming from

an accident such as a motor vehicle accident, where the services are otherwise covered. Those funds recovered by the Department under the scope of these “Other Resources” shall be retained by the Department.

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

- c. The CHC-MCO is responsible for pursuing, collecting, and retaining recoveries of a claim involving Workers’ Compensation.
- d. Due to potential time constraints involving casualty cases subject to litigation as well as estate cases, and due to the large dollar value of many claims which are potentially recoverable by the Department’s Division of TPL, the Department must ensure that it identifies these cases and establishes its claim before a settlement has been negotiated for a casualty case or a final accounting has been approved for an estate. Should the Department fail to identify and establish a claim prior to settlement due to the CHC-MCO’s untimely submission of notice of legal involvement where the CHC-MCO has received such notice, the amount of the Department’s actual loss of recovery shall be assessed against the CHC-MCO. The Department’s actual loss of recovery shall not include the attorney’s fees or other costs which would not have been retained by the Department. If the Department fails to identify and establish a casualty or estate claim prior to settlement due to the CHC-MCO’s untimely submitting of notice of legal involvement where the CHC-MCO has received such notice, the Department’s actual loss of recovery shall be assessed against the CHC-MCO. The Department’s assessment will not include the attorney’s fees or other costs that the Department would not have retained from the recovery.
- e. The CHC-MCO has the sole and exclusive responsibility and right to pursue, collect and retain all health-related insurance resources for a period of nine (9) months from the date of service or six (6) months after the date of payment, whichever is later. The CHC-MCO must indicate its intent to recover on health-related insurance by providing to the Department an electronic file of those cases it will pursue. The cases must be identified, and a file provided to the Department by the CHC-MCO within the window of opportunity afforded by the nine (9) months from the date of service or six (6) months after the date of payment unless otherwise

permitted by the Department. The Department's Division of TPL may pursue, collect and retain recoveries of all health-related insurance cases which are not identified by the CHC-MCO for recovery, after the later of nine (9) months from the date of service or six (6) months after the date of payment. Notification of intent to pursue, collect and retain health-related insurance is the sole responsibility of the CHC-MCO, and cases not identified for recovery will become the sole and exclusive right of the Department to pursue, collect and retain. In such cases where the CHC-MCO has identified the cases to be pursued, the CHC-MCO shall retain the exclusive responsibility for the cases for a period not to exceed eighteen (18) months. The calculation of the eighteen (18) month period shall commence with receipt of the file from the CHC-MCO identifying the cases to be pursued. Any case not completed within the eighteen (18) month period will become the sole and exclusive right of the Department to pursue, collect and retain. The CHC-MCO is responsible for notifying the Department through the prescribed electronic file process of all outcomes for those cases identified for pursuit. Cases included in Encounter files that were suspended will not be able to be included in the flagging process because the Claims cannot be adjusted in the Department's automated processing system.

With respect to any third-party payment received by the CHC-MCO from a Provider, the CHC-MCO shall ensure that the funds are within their right of recovery. If the funds are outside the allowable recovery window, the funds shall be returned to the Department. These third-party payments shall not be held by the MCO for more than thirty (30) calendar days. If the provider funds received by the Department from the CHC-MCO must be returned to the CHC-MCO for any reason, for example, an outdated check or the amount of the check does not match supporting documentation, then the CHC-MCO shall have sixty (60) calendar days to return all provider funds to the Department using the established format.

- f. Should the Department lose recovery rights to any Claim due to late or untimely filing of a Claim with the liable third party, and the untimeliness in filing that specific Claim is directly related to untimely submission of Encounter Data or additional records under special request, or inappropriate denial of Claims for accidents or emergency care in casualty related situations, the amount of the unrecoverable claim shall be assessed against the CHC-MCO. The same will apply in any situation where the Department loses recovery rights on an estate due to the CHC-MCO's failure to timely supply the data necessary to perfect the Department's claim and meet the forty-five (45) day regulatory mandate.
- g. Encounter Data that is not submitted to the Department in accordance with the data requirements and/or timeframes identified in this Agreement can possibly result in a loss of revenue to the Department. Strict compliance

with these requirements and timeframes shall therefore be enforced by the Department and could result in the assessment of sanctions against the CHC-MCO.

- h. Health Insurance Premium Payment (HIPP) Program. The HIPP Program pays for employment-related health insurance for Participants when it is determined to be cost effective.

3. Requests for Additional Data

The CHC-MCO must provide, at the Department's request, such information not included in the Encounter Data submissions that may be necessary for the administration of TPL activity, specifically casualty and estate recoveries. The CHC-MCO must provide casualty information within fifteen (15) calendar days of the Department's request. The CHC-MCO must provide information for urgent requests involving casualty and Encounter data for estate cases within forty-eight (48) hours. Such information may include, but is not limited to, individual medical records for the express purpose of determining TPL for the services rendered. Confidentiality of the information must be maintained as required by Federal and State regulations.

4. Accessibility to TPL Data

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

5. Third Party Resource Identification

The CHC-MCO must supply the Department with TPL information identified by the CHC-MCO or its subcontractors, which does not appear on the Department's TPL database, as well as information on coverage for other household members, addition of a coverage type, changes to existing resources, including termination of coverage and changes to coverage dates. The method of reporting must be by electronic file or by any alternative method approved by the Department. TPL resource information must be submitted within two (2) weeks of its receipt by the CHC-MCO. A web-based referral is only to be submitted in the following instances: the CHC-MCO is no longer the Participant's CHC-MCO; the Contract /Policy ID number is longer than 12 digits; or the referral is from the Pennsylvania Health Insurance Premium Payment Program. For web-based referrals, the CHC-MCO must use an exact replica of the TPL resource referral form supplied by the Department. For electronic submissions, the CHC-MCO must follow the required report format, data elements, and specifications supplied by the Department.

The Department will contact the CHC-MCO when the validity of a resource is in question. The CHC-MCO shall verify inconclusive resource information within two (2) business days of notification by the Department that the

resource information is in dispute. However, if the verification notification is requested on the last business day of the week, the CHC-MCO must respond by the close of business that day to avoid a potential access to care issue for its Participant.

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

6. Estate Recovery

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

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

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

SECTION VIII: REPORTING REQUIREMENTS

A. Department Monitoring Requirements

To demonstrate compliance with 42 CFR § 438.66, State Monitoring Requirements, the Department must have in effect a monitoring system for CHC. The Department's system must address all aspects of the managed care program, including the performance of each CHC-MCO as required in § 438.66 (b). The Department must use the data collected from its monitoring activities to improve the performance of its managed care program, including, at a minimum the areas noted in § 438.66 (c).

In addition, § 438.66 (e) requires the Department to submit to CMS, no later than 180 days after each contract year, a report on its managed care programs. The annual report for CHC is due to CMS no later than June 29, 2026 for the 2025 calendar year. The annual program report must provide information on and an assessment of the operation of CHC on, at a minimum, the following areas:

- Financial performance of each CHC-MCO, including MLR experience.

- Encounter data reporting by each CHC-MCO.
- Enrollment and service area expansion (if applicable) of each CHC-MCO.
- Modifications to, and implementation of, MCO benefits covered under the contract with the Department.
- Grievance, appeals, and State fair hearings for CHC.
- Availability and accessibility of covered services within the CHC-MCO agreements, including network adequacy standards.
- Evaluation of the CHC-MCO's performance on quality measures, including as applicable, consumer report card, surveys, or other reasonable measures of performance.
- Results of any sanctions or corrective action plans imposed by the Department or other formal or informal intervention on a CHC-MCO to improve performance.
- Activities and performance of the beneficiary support system.
- Any other factors in the delivery of LTSS not otherwise addressed in § 438.66 (e)(2)(i)-(ix) as applicable.

The CHC-MCO must comply with all state and federal reporting requirements that are set forth in this Agreement and provided through Guidance from the Department. If the CHC-MCO fails to submit the required reports within timeframes specified, the Department shall assess sanctions upon the CHC-MCO as specified in Section VIII.I, Sanctions, and Section VII D.2, Sanctions, and Exhibits T, X, BB of this Agreement.

B. General

The CHC-MCO must comply with state and federal reporting requirements that are set forth in this section and throughout this Agreement and in any guidance issued by the Department.

The CHC-MCO must submit data to the Department as specified under 42 C.F.R. § 438.604 and certify the data, documentation, and information as required by 42 C.F.R. § 438.606. Such certifications must:

- Be submitted concurrently with the data.
- Attest that based on best information, knowledge and belief, the data is accurate, complete, and truthful.
- Be based on the best knowledge, information, and belief of the CEO, CFO, or an individual with delegated authority to sign for the CEO or CFO and who reports directly to the CEO or CFO.

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

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

The CHC-MCO must cooperate with the Department in all activities related to compliance with federal mental health parity requirements. The CHC-MCO must provide all information requested by the Department related to these activities within ten (10) days of the Department's request.

For critical and urgent issues, the CHC-MCO is required to respond to the Department the same day or within 12 hours. The CHC-MCO is required to respond to the Department's questions and issues within three business days of receiving questions and requests for clarification. The Department will determine the appropriate contact method, (e.g., phone call or email to the CHC-MCO Government Liaison or other CHC-MCO contact).

C. Systems Reporting

The CHC-MCO must submit electronic data as specified by the Department. Whenever possible, the Department will provide reasonable advance notice of modifications or additions to required electronic data submissions.

Information on the submission of the Department's data files is available on the Pennsylvania HealthChoices Extranet.

1. Encounter Data Reporting

The CHC-MCO must record Encounter Data for internal use and submit timely, complete, and accurate Encounter Data to the Department. The CHC-MCO shall only submit Encounter Data for Participants enrolled in its CHC plan on the date of service and must not submit duplicate records.

The CHC-MCO must maintain appropriate systems and mechanisms to obtain all data from its Providers needed to comply with Encounter Data and TMSIS reporting requirements.

The Department will provide a minimum of sixty (60) days advance written notice to the CHC-MCO regarding changes to Encounter Data requirements.

Failure of Providers or Subcontractors to submit Claims and Encounter Data to the CHC-MCO in a complete, timely, and accurate manner shall not excuse the CHC-MCO's noncompliance with this requirement.

The CHC-MCO must comply with all sections of 42 C.F.R. § 438.242, including, but not limited to, compliance with Section 6504(a) of the Affordable Care Act, which requires that Claims processing and retrieval systems collect data elements necessary to meet the requirements of section 1903(r)(1)(F) of

the Act.

a. Data Format

The CHC-MCO must submit Encounter Data to the Department using established protocols. Prior to submission of production data, the CHC-MCO must pass Encounter Data certification for all transaction types.

- i. The CHC-MCO must adhere to Encounter Data file specifications, including the collection and maintenance of sufficient Participant Encounter Data to identify the Provider who delivers any items or services to Participants.
- ii. The CHC-MCO must adhere to the file size, format specifications, and file submission schedule provided by the Department. The CHC-MCO must submit Participant Encounter Data to the Department at a frequency and level of detail specified by CMS and the Department, based on program administration, oversight, and program integrity needs.

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

- 837P
 - Professional
 - Professional Crossover
 - Professional Drug
- 837I
 - Inpatient
 - Inpatient Crossover
 - Outpatient
 - Outpatient Crossover
 - Covered Drug
 - Long Term Care (LTC)
- 837D
 - Dental
- NCPDP D.0
 - NCPDP Pharmacy
 - Compound Pharmacy

b. Timing of Data Submittal

- i. Provider Claims

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

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

ii. Encounter Submissions

All Encounter Data except NCPDP transactions must be submitted by the CHC-MCO and approved by the Department on or before the last calendar day of the third (3rd) month after the adjudication calendar month in which the CHC-MCO adjudicated the Claim.

NCPDP transactions must be submitted by the CHC-MCO and approved in the Department's MMIS within thirty (30) days following the adjudication date.

Encounter Data sent to the Department is considered approved when all Department edits are passed.

A file with Encounter Data records that deny due to Department edits will be returned to the CHC-MCO. These records must be corrected and resubmitted as "new" Encounter records within the timeframe referenced above.

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

When Error Status Code (ESC) denials occur due to CHC-MCO, Subcontractor, or Provider system faults or limitations, it is the responsibility of the CHC-MCO to make every attempt to remediate the systems concerns within a reasonable amount of time. Based on the impact of the errors and the length of time to implement a solution, the CHC-MCO may be subject to assessments, Corrective Action, or both.

iii. Response Files

The CHC-MCO's Encounter Data system must be able to receive, process, and reconcile the U277, NCPDP, and ESC Supplemental response files. The CHC-MCO must also store the Department's MMIS ICN associated with each processed Encounter Data record returned

on the files.

c. Data Completeness

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

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

Upon request of the Department, the CHC-MCO must submit a Data Completeness Plan for advance written review and approval. This Plan must include the three (3) elements listed above.

d. Financial Sanctions

The CHC-MCO must provide complete, accurate, and timely Encounter Data to the Department. In addition, the CH-MCO must maintain complete medical service history data.

The Department will request the CHC-MCO submit a Corrective Action Plan when areas of noncompliance are identified.

The Department may assess financial sanctions as provided in Exhibit X, Encounter Data Submission Requirements and Damages Applications, based on the identification of instances of non-compliance.

e. Data Validation

The CHC-MCO must assist the Department in its validation of Encounter Data by making medical records and Claims data available as requested. The validation may be completed by Department staff, independent external review organizations, or both.

f. Release of Encounter Data

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

Program under this Agreement.

g. Drug Rebate Supplemental File

The CHC-MCO must submit a complete, accurate, and timely monthly file containing supplemental data for NCPDP, 837P Professional Drug, and 837I Covered Drug transactions used for the purpose of drug rebate dispute resolution. The file must be submitted by the fifteenth (15th) day of the month following the month in which the drug transaction was processed in the Department's MMIS as specified on the Pennsylvania HealthChoices Extranet.

The MCO Supplemental Data Status Report will be provided by the Department to the CHC-MCO on or after the 20th of each month following receipt of the Drug Rebate Supplemental File. CHC-MCOs must use this report to reconcile and correct any errors on Drug Rebate data that was submitted.

2. Third-Party Liability Reporting

Third Party Resources identified by the CHC-MCO or its subcontractors, which do not appear on the Department's TPL database, must be supplied to the Department's Division of TPL within two (2) weeks of its receipt by the CHC-MCO. The Department will contact the CHC-MCO when the validity of a resource is in question. The CHC-MCO shall verify inconclusive resource information within two (2) business days of notification by the Department that the resource information is in dispute. However, if the verification notification is requested on the last business day of the week, the CHC-MCO must respond by the close of business that day to avoid a potential access to care issue for its member. The method of reporting shall be by electronic submission via a batch file or by hardcopy document, whichever is deemed most convenient and efficient by the CHC-MCO for its individual use. For electronic submissions, the CHC-MCO must follow the required report format, data elements, and specifications supplied by the Department. For hardcopy submissions, the CHC-MCO must use an exact replica of the TPL resource referral form supplied by the Department.

Submissions lacking information key to the TPL database update process will be considered incomplete and will be returned to the CHC-MCO for correction and subsequent resubmission.

3. PCP Assignment

The CHC-MCO must provide a weekly file (EVS-PCP) to the Department's MMIS containing PCP assignments for all its Participants other than those who have a Medicare PCP. This file is used to update the Department's Eligibility Verification System.

The CHC-MCO must provide this file at least weekly or more frequently if requested by the Department. The CHC-MCO must confirm that the PCP assignment information is consistent with all requirements specified by the Department by utilizing the response report provided by the Department. The CHC-MCO must comply with the file submission requirements found on the Pennsylvania HealthChoices Extranet.

4. Provider Network

The CHC-MCO must provide a monthly Network Provider File (PRV640M) to the Department. The initial file must contain records for its entire Provider Network, including Subcontractors. Subsequent monthly files should contain only updates.

The CHC-MCO must confirm the information is consistent with all requirements by utilizing the response report (PRM640M) provided by the Department. The CHC-MCO must use this report to reconcile and correct any errors. The CHC-MCO must comply with file submission requirements found on the Pennsylvania HealthChoices Extranet.

5. Alerts

The CHC-MCO must report the following to the Department on a Weekly Enrollment/Disenrollment/Alert File: pregnancy (not in eCIS), death (not in eCIS), and returned mail.

The CHC-MCO must confirm the information is consistent with all requirements specified on the HealthChoices Extranet.

D. Operations Reporting

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

1. Operations and Quality Reporting Requirements

As a condition of approval of the Waivers for the operation of CHC, CMS has imposed specific reporting requirements related to the Home and Community Based Waiver and overall CHC monitoring. OLTL has also established additional Operations and Quality Management Reports to oversee CHC. Required reports are identified on the Operations and Quality Management Reporting Requirements Submission Schedule. CHC-MCOs are required to meet identified due dates, submit accurate data, and provide requested documentation.

2. Fraud, Waste, and Abuse

The CHC-MCO must submit to the Department quarterly and annual statistical reports which relate to its Fraud, Waste and Abuse detection and sanctioning activities regarding Providers. The CHC-MCO must include information for all situations where a Provider action caused an overpayment to occur and must identify cases under review (including approximate dollar amounts), Providers terminated due to Medicare/Medicaid preclusion, provider terminations for good cause or best interest, overpayments recovered and cost avoidance issues related to identifying and/or identified fraud, waste, and abuse (42 CFR §438.608(a)(2)). The CHC-MCO must comply with all requirements regarding Operations Report format and timeframes provided on the DHS/CHC-MCO docuShare Reporting pages and on the HealthChoices Extranet at Managed Care Program/Fraud and Abuse.

E. Financial Reports

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

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

F. Equity

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

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

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

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

G. Claims Processing Reports

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

The Department may impose the following sanction for the CHC-MCO's failure to submit a timely Claims processing report that is accurate and fully compliant with the reporting requirements: Two Hundred Dollars (\$200.00) per day for the first ten (10) calendar days from the date that the report is due, and One Thousand Dollars (\$1,000.00) per day for each calendar day thereafter.

H. Presentation of Findings

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

I. Sanctions

1. The Department may impose sanctions for noncompliance with the requirements under this Agreement and failure to meet applicable requirements in Sections 1932, 1903(m), and 1905(t) of the SSA in accordance with 42 C.F.R §§ 438.700; 438.702 and 438.704 in addition to any sanctions described in Exhibit B of this Agreement, Standard Terms and Conditions for Services, and in Exhibit B(1) of this Agreement, DHS Addendum to Standard Contract Terms and Conditions. The sanctions which can be imposed shall depend on the nature and severity of the breach, which the Department, in its reasonable discretion, will determine as follows:
 - a. Imposing civil monetary penalties of a minimum of One Thousand Dollars (\$1,000.00) per day for noncompliance;
 - b. Requiring the submission of a corrective action plan;
 - c. Suspending or Limiting Enrollment of new Participants;
 - d. Suspension of payments;
 - e. Preclusion or exclusion of the CHC-MCO, its officers, managing employees or other individuals with direct or indirect ownership or control interest in accordance with 42 U.S.C. § 1320a-7, 42 C.F.R. Parts 1001 and 1002; 62 P.S. § 1407 and 55 Pa. Code §§ 1101.75 and 1101.77;

- f. Temporary management subject to applicable Federal or State law; and/or
 - g. Termination of the Agreement
- 2. Where this Agreement provides for a specific sanction for a defined infraction, the Department may, at its discretion, apply the specific sanction provided for the noncompliance or apply any of the general sanctions set forth in this Section VIII.I, Sanctions. Specific sanctions contained in this Agreement include the following:
 - a. Claims Processing: Sanctions related to Claims processing are provided in Section VII D.2 of this Agreement, Sanctions.
 - b. Report or File, exclusive of Audit Reports: If the CHC-MCO fails to provide any report or file that is specified by this Agreement by the applicable due date, or if the CHC-MCO provides any report or file specified by this Agreement that does not meet established criteria, a subsequent payment to the CHC-MCO may be reduced by the Department. The reduction shall equal the number of days that elapse between the due date and the day that the Department receives a report or file that meets established criteria, multiplied by the average Per-Member, Per-Month Capitation rate that applies to the first (1st) month of the Agreement year. If the CHC-MCO provides a report or file on or before the due date, and if the Department notifies the CHC-MCO after the fifteenth (15th) calendar day after the due date that the report or file does not meet established criteria, no reduction in payment shall apply to the sixteenth (16th) day after the due date through the date that the Department notifies the CHC-MCO.
 - c. Encounter Data Reporting: The sanctions related to the submission of Encounter Data are set forth in Section VIII.C of this Agreement, Systems Reports, and Exhibit X, Encounter Data Submission Requirements and Sanction Applications.
 - d. Marketing: The sanctions for engaging in unapproved marketing practices are described in Section V.O.3 of this Agreement, CHC-MCO Outreach Activities.
 - e. Access Standard: The sanction for noncompliance with the access standard is set forth in Exhibit T, Provider Network Composition/ Service Access.
 - f. Covered Drug Encounters: The sanctions for non-compliance with covered drug encounter data timeliness is set forth in Exhibit D, Drug Services.

J. Non-Duplication of Financial Penalties

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

SECTION IX: REPRESENTATIONS AND WARRANTIES OF THE CHC-MCO

A. Accuracy of Proposal

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

B. Disclosure of Interests

The CHC-MCO must provide, on its behalf and for its subcontractors, written disclosure to the Department of information on ownership and control, business transactions, and persons convicted of crimes in accordance with 42 C.F.R. § 438.608 and with 42 C.F.R. Part 455, Subpart B.

The CHC-MCO shall make the disclosures required by 42 C.F.R. § 438.608 and by 42 C.F.R. Part 455, Subpart B at the following times:

1. when the CHC-MCO may submit a proposal in accordance with the Department's procurement process, if any;
2. when the CHC-MCO executes this Agreement; or
3. when the CHC-MCO may renew or extend this Agreement; or
4. within thirty-five (35) days after any change in ownership of the CHC-MCO.

The CHC-MCO must report to the Department a description of transactions between the CHC-MCO and a party in interest (as defined in 42 U.S.C. § 300e-17(b)), including the following transactions:

1. Any sale or exchange or leasing of any property between the CHC-MCO and such a party.

2. Any furnishing for consideration of goods, services (including management services), or facilities between the CHC-MCO and such a party, but not including salaries paid to employees for services provided in the normal course of their employment.
3. Any lending of money or other extension of credit between the CHC-MCO and such a party.

The CHC-MCO shall make the forgoing information available to Participants upon reasonable request.

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

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

C. Disclosure of Change in Circumstances

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

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

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

Affiliate or Related Party; and

4. Any lawsuits or investigations by any federal or state agency involving CHC-MCO, CHC-MCO's parent(s), or any Affiliate or Related Party.

SECTION X: TERMINATION AND DEFAULT

A. Termination by the Department

1. Termination for Convenience upon Notice

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

2. Termination for Cause

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

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

3. Termination Due to Unavailability of Funds or Approvals

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

- a. Notification by the US DHHS of the withdrawal or disapproval of Federal Financial Participation in all or part of the cost for CHC Covered Services;
- b. Notification of the unavailability of funds for the CHC Program; or
- c. Notification that the federal approvals necessary to operate the CHC Program are not obtained or not retained; or
- d. Notification by the PID or DOH that the authority under which the CHC-

MCO operates is subject to suspension or revocation proceedings or sanctions, has been suspended, limited, or curtailed, has been revoked, or has expired and shall not be renewed.

B. Responsibilities of the CHC-MCO upon Termination

1. Continuing Obligations

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

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

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

- g. Arrange for the orderly transfer of Participant care and records to those Providers who will be assuming care for the Participants.

2. Notice to Participants and Network Providers

If this Agreement is terminated, or expires without a new Agreement in place, the CHC-MCO must notify all Participants and Network Providers of such termination or expiration at least forty-five (45) days in advance of the effective date of termination or expiration, if practical. The CHC-MCO must make notices available in an accessible format and in the relevant language as required for Vital Documents. The CHC-MCO must coordinate the continuation of care prior to termination or expiration for Participants who are undergoing treatment for an acute condition.

3. Submission of Invoices

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

4. Termination Requirements

Within one year (365 days) of expiration or termination of the Agreement, the CHC-MCO must provide the Department with all outstanding Encounter Data and Maternity Care Claims. The Department will withhold ten percent (10%) of one (1) month's Capitation payment until the Department determines that the CHC-MCO has complied with this requirement. The Department will not unreasonably delay or deny a determination of compliance.

The Department will provide its determination to the CHC-MCO by the first (1st) day of the fifth (5th) month after the Agreement ends. If the Department determines that the CHC-MCO has not complied, the Department will provide subsequent determinations by the first (1st) day of each subsequent month.

C. Transition at Expiration or Termination of Agreement

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

months in duration.

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

SECTION XI: RECORDS

A. Financial Records Retention

1. The CHC-MCO must maintain and must cause its subcontractors to maintain all books, records, and other evidence pertaining to revenues, expenditures, and other financial activity pursuant to this Agreement in accordance with the standards and procedures specified in this Agreement, including Section V.X.3, Records Retention and Exhibit O, CHC Audit Clause.
2. The CHC-MCO will include the requirements set forth in Section XII, Subcontractual Relationships, in all Subcontracts it enters for the CHC Program, and will monitor subcontractors for compliance with these requirements.

B. Operational Data Reports

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

C. Medical Records and Comprehensive Medical and Service Records Retention

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

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

D. Review of Records

1. The CHC-MCO must make all records relating to the CHC Program, including, but not limited to, the records referenced in this Section, available for audit, review, or evaluation by the Department, the Pennsylvania Office of Attorney General Medicaid Fraud Control Section, federal agencies, or their designees. Such records shall be made available on site, subject to the Department's approval, at any time or through the mail. The Department will, to the extent required by law, maintain as confidential any confidential information provided by the CHC-MCO.

2. In the event that the Department the Pennsylvania Office of Attorney General Medicaid Fraud Control Section, or federal agencies request access to records, subject to this Agreement, after the expiration or termination of this Agreement or at such time that the records no longer are required by the terms of this Agreement to be maintained at the CHC-MCO's location, but in any case, before the expiration of the period for which the CHC-MCO is required to retain such records, the CHC-MCO, at its own expense, must send copies of the requested records to the requesting entity within thirty (30) days of such request.

SECTION XII: SUBCONTRACTUAL RELATIONSHIPS

A. Compliance with Program Standards

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

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

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

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

1. A requirement for cooperation with the submission of all Encounter Data for all services provided within the timeframes required in Section VIII, Reporting Requirements, regardless of whether reimbursement for these services is made by the CHC-MCO either directly or indirectly through capitation.
2. Language which requires compliance with all applicable Federal and State laws, including applicable sub-regulatory guidance and contract provisions.
3. Language which prohibits gag clauses which would limit the subcontractor from disclosure of Medically Necessary or appropriate healthcare information or alternative therapies to Participants, other LTSS Providers, or to the

Department.

4. Provides for access for Federal and State agencies and their designees to any and all documents and records of transactions, computer, or other electronic systems pertaining to the provision of services to Participants or determinations of amounts payable under this Agreement.
5. The definition of Medically Necessary as outlined in Section II, Definitions.
6. The CHC-MCO must require, if applicable, that its Subcontractors adhere to the standards for Network composition and adequacy.
7. Should the CHC-MCO use a subcontracted utilization review entity, the CHC-MCO must require that its subcontractors process each request for benefits in accordance with Section V.B, General Prior Authorization Requirements.
8. Should the CHC-MCO subcontract with an entity to provide any information systems services, the Subcontract must include provisions for a transition plan in the event that the CHC-MCO terminates the Subcontract or enters into a Subcontract with a different entity. This transition plan must include information on how the data shall be converted and made available to the new subcontractor. The data must include all historical Claims and service data.
9. Language regarding mandatory reporting requirements under both the Adult Protective Services Act (APS) (35 P.S. § § 10210.101—10210.704) and the Older Adult Protective Services Act (OAPSA) (35 P.S. § § 10225.101—10225.5102).
10. Prohibitions on engaging in marketing activities associated with enrollment into a specific CHC-MCO.

B. Consistency with Regulations

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

SECTION XIII: CONFIDENTIALITY

- A. The CHC-MCO must comply with all applicable Federal and State laws regarding the confidentiality of Participant records, including medical records. The CHC-MCO must also require each of its subcontractors to comply with all applicable Federal and State laws regarding the confidentiality of medical records.

- B. The CHC-MCO will be liable for any State or Federal fines, sanctions, financial penalties, or damages levied upon the Department for a breach of confidentiality due to the negligent or intentional conduct of the CHC-MCO in relation to the CHC-MCO's systems, staff, or other area of responsibility.
- C. The CHC-MCO will return all data and material obtained in connection with this Agreement and the implementation thereof, including confidential data and material, at the Department's request. The CHC-MCO is not permitted to use this material for any purpose after the expiration or termination of this Agreement.
- D. The CHC-MCO is entitled to receive all information relating to the health status of its Participants in accordance with applicable confidentiality laws.

SECTION XIV: INDEMNIFICATION AND INSURANCE

A. Indemnification

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

B. Insurance

The CHC-MCO must maintain for itself and each of its employees, agents, and

representatives, general liability, and all other types of insurance in such amounts as reasonably required by the Department and all applicable laws. In addition, the CHC-MCO must require that each of the Network Providers with which the CHC-MCO contracts maintains professional malpractice and all other types of insurance in such amounts as required by all applicable laws. The CHC-MCO must provide to the Department, upon the Department's request, certificates evidencing such insurance coverage.

SECTION XV: DISPUTES

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

SECTION XVI: GENERAL

A. Suspension from Other Programs

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

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

B. Rights of the Department and the CHC-MCO

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

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

C. Invalid Provisions

Any provision of this Agreement which is in violation of any Federal or State law or

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

D. Notice

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

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

With a Copy to:

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

To the CHC-MCO

E. Counterparts

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

F. Headings

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

G. No Third-Party Beneficiaries

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

APPENDIX 3a

Explanation of Capitation Payments

I. Base Waiver Capitation Rates

The schedule of Base Waiver Capitation Rates will be provided to the CHC-MCOs. The Department will provide the CHC-MCO with information on methodology and data used to develop the schedule of Base Waiver Capitation Rates.

II. Risk Adjusted Rates (RAR)

A. Applicability of RAR

The Department will risk adjust the Base Waiver Capitation Rates using an actuarially sound method to reflect differences in functional status and demographics of the Members enrolled in each CHC-MCO's program.

The Department may elect to terminate the risk adjustment of any or all Base Waiver Capitation Rates. If the Department makes this election, the Department will notify the CHC-MCO and will provide an effective date for this change. If the Department makes this election, the Department will enter into negotiations with the CHC-MCO on the subject of Base Waiver Capitation Rates that will apply on and after the effective date of the change.

B. RAR CHC-MCO Plan Factors

If Base Waiver Capitation Rates are risk adjusted, the Department and its actuarial consultant will develop each RAR CHC-MCO Plan Factor to reflect the functional status and demographics of Participants enrolled in the CHC-MCO's program within one Rate Cell and one Rating Region or combinations thereof.

The Department and its actuaries will recalculate the RAR CHC-MCO Plan Factors in accordance with a schedule determined by the Department.

C. MCO Assessment Amount

The Base Waiver Capitation Rates include an MCO Assessment Amount. The MCO Assessment Amount is the amount included in the Base Waiver Capitation Rates for the MCO Assessment fee inclusive of a multiplier that accounts for the CHC-MCO's responsibility to pay the MCO Assessment fee for partial member months.

D. Risk-Adjusted Portion of the Base Waiver Capitation Rate

If the Base Waiver Capitation Rate is higher than the lowest Base Waiver Capitation Rate that the Department has calculated for a given Rate Cell and Rating Region for the applicable program month among all CHC-MCOs that operate in a zone, the difference is referred to as Amount A.

For each CHC-MCO, the following calculation will be made for each Rate Cell and Rating Region:

	Base Waiver Capitation Rate
MINUS	Acute Services Portion of Rate
MINUS	MCO Assessment Amount
MINUS	Amount A
TIMES	RAR CHC-MCO Plan Factor
EQUALS	Risk-Adjusted Portion of the Base Waiver Capitation Rate

E. Revised Base Waiver Capitation Rate

For each CHC-MCO, the following calculation will be made for each Rate Cell and Rating Region:

	Risk-Adjusted Portion of the Base Waiver Capitation Rate
PLUS	Acute Services Portion of Rate
PLUS	MCO Assessment Amount
PLUS	Amount A
EQUALS	Revised Base Waiver Capitation Rate

III. Capitation Payment Rate

The Capitation Payment Rate will include a Participant Enrollment Mix Adjustment, which is described in Appendix 3e. The Participant Enrollment Mix Adjustment calculation will utilize the Revised Base Waiver Capitation Rate.

In accordance with Section VII.B.2.ii of this Agreement, the Department will make capitation payments at per diem equivalents of the Capitation Payment Rates that are calculated and issued by the Department.

APPENDIX 3b

Medical Loss Ratio (MLR) Reporting and Remittance Requirements

This appendix establishes requirements for the CHC-MCO's responsibility to calculate and report their medical loss ratio (MLR) to the Department consistent with the 2016 Medicaid/CHIP Managed Care Final Rule requirements at 42 CFR §438.8. This appendix also establishes a requirement for remittance to the Department.

The reporting requirements apply collectively to all Agreements the CHC-MCO has with the Department to operate Community HealthChoices (CHC) programs during a CY. The CHC-MCO must provide one report inclusive of all zones, rating periods and Agreements within a CY. The CHC-MCO must not include revenue or costs that are not specific to the CHC program.

I. Timing

The CHC-MCO must submit the annual MLR report to the Department by November 30 of the following CY.

II. MLR Reporting Year

Consistent with 42 CFR §438.8, the MLR reporting year is a 12-month period that aligns with the Department's CHC rating period. The Department's current, standard rating period is a 12-month CY.

III. Contents of Annual MLR Report

The CHC-MCO is to submit their MLR report containing at least the information outlined herein for the current MLR reporting year, consistent with the requirements in 42 CFR §438.8(k) or subsequently modified by CMS. The Department reserves the right to request additional information and/or require the use of a MLR report template.

1. Total incurred claims (including fraud reduction efforts)
2. Expenditures on quality improving activities
3. Expenditures on fraud prevention activities (not applicable)
4. Non-claim costs
5. Premium revenue
6. Premium related taxes, licensing, and regulatory fees
7. Methodologies for allocation of expenditures
8. Any credibility adjustment applied
9. The calculated MLR (including numerator and denominator)
10. Any remittance potentially owed to the Department
11. A comparison of the MLR report information to the CHC-MCO's audited financial report(s)
12. The number of member months
13. A description of the aggregation method used to aggregate data for all Medicaid eligibility groups covered under this Agreement

IV. New Community HealthChoices CHC-MCOs

The Department, at its discretion, may exclude a CHC-MCO that did not previously have a CHC Agreement from these requirements for the first year of the CHC-MCO's operations. However, the new CHC-MCO will be required to comply with these requirements during the next MLR reporting year even if the first year of operations was not a full 12 months. For example, if a CHC-MCO is new on July 1, 2026, the Department may exclude the new CHC-MCO from completing and submitting the CY 2026 MLR report. The new CHC-MCO will be required to complete the subsequent CY 2027 MLR report. If a CHC-MCO exits CHC, a report will still be required, even if it is less than twelve months of experience.

V. MLR Numerator and Denominator

Detail of what is included and how the MLR numerator and denominator are computed can be found in 42 CFR §438.8(e) and (f) respectively. If an expenditure related to Social Determinants of Health is an "activity that improves health care quality" as specified in 42 CFR § 438.8(e)(3), the CHC-MCO may include the costs in the numerator of the MLR. The CHC-MCO is expected to comply with any additional requirements, guidance or instructions released by CMS that relate to the computation of the MLR as required in 42 CFR §438.8.

VI. Aggregate Medicaid Eligibility Groups

The Department requires the CHC-MCO's MLR report to be calculated as a single aggregated group across all populations. This aggregated group must represent all CHC Medicaid/Title XIX rate cells/populations and rating regions/zones combined that are covered under the CHC Agreements.

VII. Credibility Adjustment

Per 42 CFR §438.8(h), the CHC-MCO may add a credibility adjustment to the reported MLRs per Aggregate Medicaid Eligibility Group in section VI of this appendix if the CHC-MCO has sufficient member months to be partially credible, but not enough member months to be fully credible. The credibility adjustment is required for any remittance calculations. CMS will publish the table of credibility adjustments to be used. Fully credible plans may not use a credibility adjustment.

VIII. Remittance

Per 42 CFR §438.8(c) the Department has chosen a minimum MLR of 90.00 percent (90.00%). The Department will require a remittance in accordance with 42 CFR §438.8(j) for each Aggregate Medicaid Eligibility Group listed in section VI above. Settlement of any remittance obligation will be due 75 calendar days after the Department has issued a remittance notification to the CHC-MCO.

IX. Attestation

The CHC-MCO must provide an attestation of the accuracy of the information provided in their submitted MLR report as required in 42 CFR §438.8(n) and consistent with 42 CFR §438.606. The attestation is due on the report due date.

X. Sub-Regulatory Guidance and Capitation Adjustments

These requirements are subject to change as CMS releases sub-regulatory guidance. If there are retroactive capitation adjustments these MLR reports may need to be updated. For more information about MLR calculations, please see 42 CFR §438.8.

XI. Continuation

If CMS issues regulation that revises or replaces the citations in this appendix, the revised or replacement citations will apply.

APPENDIX 3c

Capitation Rates

This Appendix will be used for specifying the capitation rates that will be paid by the Department to the CHC-MCO.

APPENDIX 3d

Overview of Methodologies for Rate Setting

I. Rate Setting Methodology #1 – Use of Historical Fee-For-Service Data and Managed Care Encounter Data

To develop capitation rates on an actuarially sound basis for the Community HealthChoices (CHC) program using historical fee-for-service (FFS) data and managed care encounter data, the following general steps are performed:

- Summarize the FFS claims, managed care encounter and eligibility data
- Combine the Multiple Years of Data Together, If Applicable
- Project the Base Data Forward
- Include the Effect of Program/Policy Changes
- Adjust the FFS Data to Reflect Managed Care Principles
- Add an Appropriate Administration/Underwriting Gain Load
- Add an Amount for Taxes/Assessments

Summarize the FFS Claims, Managed Care Encounter and Eligibility Data — The Department provides summarized FFS claims, encounters and eligibility data for the recipients and services to be covered under the CHC program. Normally, multiple years of data are made available for rate-setting purposes; however, the actuary may choose one or more years of data to base rates upon. This data is then adjusted to account for items not included in the initial data collection process. These adjustments (positive and negative) generally include, but are not limited to: completion factors, legal settlements, gross adjustments, graduate medical education payments, pharmacy rebates, and other adjustments needed to improve the accuracy of the data.

Combine the Multiple Years of Each Data Source Together, If Applicable — To arrive at a single year of each data source to serve as the basis for rate setting, the multiple years of each data source can be combined together if more than one year of data was selected for the base. The blending of the base years of data may be on Participant months or other weighting factors selected by the actuary.

Project the Base Data Forward — The base data is then projected forward to the time period for which the capitation rates are to be paid. Trend factors are used to estimate the future costs of the services for the populations covered by the managed care program. These trend factors normally vary by service and/or population group.

Include the Effect of Program/Policy Changes — Changes from Commonwealth and/or federal policy may occur to the services or populations covered under the CHC program (e.g., expands dental care, restricts enrollment, or encourages innovations in service or workforce recruitment and retention). Material program changes are included in the capitation rates by either increasing or decreasing the base data by an appropriate adjustment.

Adjust the FFS Data to Reflect Managed Care Principles — Because Community HealthChoices is a managed care program and not FFS, the projected FFS data needs to be adjusted to reflect the typical changes that occur when changing from a FFS program to a managed care program. This generally involves increasing the cost/use of preventive services and decreasing hospital and emergency room cost/use. It may also include increasing the use of community services and transitioning individuals out of nursing facilities, as applicable.

Add an Appropriate Administration/Underwriting Gain Load — After the base data has been trended to the appropriate time period, adjusted for program/policy changes and adjusted to reflect managed care principles, an administration/underwriting gain load will be added to the service claims cost component to determine the overall capitation rates applicable to each population group. The administration/underwriting gain load may be applied as a percentage of the total capitation rate (i.e., percent of premium) and includes all reasonable and appropriate administrative expenses expected for a health plan operating the program in an efficient and effective manner. The underwriting gain component of the load includes consideration for the cost of capital and a risk margin.

Add an Amount for Taxes/Assessments — The final capitation rate, after all other components have been completed, is further adjusted to reflect legislatively mandated taxes/assessments as applicable. These taxes/fees can be applied as a percent of final premium or a PMPM adjustment added to the original final capitation rate. The Department will adjust the payment to the CHC-MCOs for the Medicaid portion of the MCO assessment cost based upon changes to the assessment fee in accordance with Act 92 of 2015 and any amendments thereto.

II. Rate Setting Methodology #2 – Use of Managed Care Data

To develop capitation rates on an actuarially sound basis for the CHC program using actual CHC program-specific managed care data, the following general steps are performed:

- Summarize, Analyze, and Adjust the Managed Care Data
- Project the Managed Care Base Data Forward
- Include the Effect of Program/Policy Changes
- Add an Appropriate Administration/Underwriting Gain Load
- Add an Amount for Taxes/Assessments
- Optional Rate Update

Summarize, Analyze, and Adjust the Managed Care Data — The Department collects data from each of the managed care organizations (MCOs) participating in the CHC program. This data is summarized, analyzed, and adjustments (positive and negative) are applied as needed to account for underlying differences between each MCO's management of the program. These adjustments can account for items such as collection of TPL/COB, over- or under- reserving of unpaid claims, management efficiency, and Provider contracting relations. After adjusting each MCO's data, each plan's specific service claim costs are aggregated together to arrive at a set of base data for each population group.

Project the Managed Care Base Data Forward — The aggregate base of managed care data is projected forward to the time period for which the capitation rates are to be paid. Trend factors are used to estimate the future costs of the services that the covered population would generate in the managed care program. These trend factors normally vary by service and/or population group.

Include the Effect of Program/Policy Changes — The Commonwealth occasionally changes, or Federal statutes or regulations will impact, the services or populations covered under the CHC (e.g., expands dental care, restricts enrollment). Any new, material program/policy changes that were not already reflected in the managed care data are included in the capitation rates by either increasing or decreasing the managed care data by an appropriate adjustment.

Add an Appropriate Administration/Underwriting Gain Load — After the base data has been trended to the appropriate time period, adjusted for program/policy changes, adjusted to reflect managed care principles, and blended into one data source, an administration/underwriting gain load will be added to the service claim cost component to determine the overall capitation rates applicable to each population group. The administration/underwriting gain load may be applied as a percentage of the total capitation rate (i.e., percent of premium) and includes all reasonable and appropriate administrative expenses expected for a health plan operating the program in an efficient and effective manner. The underwriting gain component of the load includes consideration for the cost of capital and a risk margin.

Add an Amount for Taxes/Assessments — The final capitation rate, after all other components have been completed, is further adjusted to reflect legislatively mandated taxes/assessments as applicable. These taxes/fees can be applied as a percent of final premium or a PMPM adjustment added to the original final capitation rate.

Optional Rate Update — In lieu of rebasing rates on newer experience base data, it is possible to update the prior year's rates for new, material program changes, trends and other adjustments following a similar process outlined above.

III. Rate Setting Methodology #3 – Blending of Prior Year's Rates and Managed Care Data

When updated FFS data is unavailable and actual CHC managed care experience first becomes available, capitation rates for the program can be developed on an actuarially sound basis using a blending of both data sources using the following two-track approach:

- Project the Prior Year's Rates Forward (Track 1)
- Summarize and Adjust the CHC Managed Care Data (Track 2)
- Include the Effect of New Program/Policy Changes (Track 1 and Track 2)

- Apply Credibility Factors to Each Track and Blend Together
- Add an Appropriate Administration/Underwriting Gain Load
- Add an Amount for Taxes/Assessments

Project the Prior Year's Rates Forward (Track 1) — The first step of Track 1 is to begin with the previous year's capitation rates. This data is projected forward to the time period for which the new capitation rates are to be paid. Trend factors are used to estimate the future costs of the services the covered population would generate under managed care. These trend factors normally vary by service and/or population group.

Include the Effect of New Program/Policy Changes (Track 1) — In Track 1, any new, material program/policy changes implemented by the Department or required by the federal government, which were not already accounted for in the previous year's rates, are included in the new capitation rates by either increasing or decreasing the rates by an appropriate adjustment.

Summarize and Adjust the CHC Managed Care Data (Track 2) — The more recent managed care data is collected from the MCOs, summarized, and analyzed to support rate setting. Adjustments (positive and negative) are applied to the managed care data as needed to account for underlying differences between each MCO's management of the CHC program. These adjustments can account for items such as collection of TPL/COB, over- or under-reserving of unpaid claims, management efficiency, and Provider contracting relations.

Include the Effect of Trend and New Program/Policy Changes (Track 2) — In Track 2, the managed care data is projected forward to the time period the capitation rates are to be paid. Trend factors may vary by service and/or population group and are used to estimate the future costs of the services that the covered population would generate under managed care. Any new, material program/policy changes that were not already reflected in the managed care data are included in the rates by either increasing or decreasing the data by an appropriate adjustment.

Apply Credibility Factors to Each Track and Blend Together — After separately developing capitation rates using Track 1 and Track 2, the two sets of rates are combined together. This blending involves applying a credibility weight to each track and adding the two components together. The credibility weights may vary between the population groups.

Add an Appropriate Administration/Underwriting Gain Load — After the data has been trended to the appropriate time period, adjusted for program/policy changes, adjusted to reflect managed care principles, and blended into one data source, an administration/underwriting gain load will be added to the service claim cost component to determine the overall capitation rates applicable to each population group. The administration/underwriting gain load may be applied as a percentage of the total capitation rate (i.e., percent of premium) and includes all reasonable and appropriate administrative expenses expected for a health plan operating the program in an efficient and effective manner. The underwriting gain component of the load includes consideration for the cost of capital and a risk margin.

Add an Amount for Taxes/Assessments — The final capitation rate, after all other components have been completed, is further adjusted to reflect legislatively mandated taxes/assessments as applicable. These taxes/fees can be applied as a percent of final premium or a PMPM adjustment added to the original final capitation rate. The Department will adjust the payment to the CHC-MCOs for the Medicaid portion of the MCO assessment cost based upon changes to the assessment fee in accordance with Act 92 of 2015 and any amendments thereto.

IV. Additional Information on Rate Development

The reimbursement provided under this Agreement is intended for Medically Necessary services covered under the Commonwealth's State Plan. For NFCE individuals, the reimbursement is also intended to cover HCBS services determined necessary based on the individual's assessed need. The MCO has the option to utilize this reimbursement to provide alternatives to the Medically Necessary services covered under the State Plan in order to meet the needs of the individual Participant in the most efficient manner. However, an adjustment may be required in the rate development process to incorporate only the cost of state plan and HCBS waiver services which would have been provided in the absence of alternative services. Cost effective in lieu of services may be addressed differently than other non-cost effective in lieu of services. The CHC-MCO may be required to provide documentation, supporting analyses and data related to the provision and justification of non-state plan services.

APPENDIX 3e

Participant Enrollment Mix Adjustment

The Department will apply a budget-neutral Participant Enrollment Mix Adjustment (PEMA) to adjust capitation payments based on the CHC-MCO's enrollment mix of nursing facility Participants and NFCE HCBS Participants.

I. Covered Participants

The PEMA applies collectively to all Participants for which the Department has made or will make a capitation payment under one of the eligible NFCE rate cells identified in Appendix 3c for the applicable rate period or rate year.

II. Timing of the PEMA Process

The Department will calculate the PEMA in accordance with a schedule determined by the Department. Until the Department, in its sole discretion, either determines that the PEMA is no longer necessary or implements a substitute mechanism, the Department will apply the PEMA prospectively for each rate year.

III. Data and Computation

The PEMA is a budget neutral mix adjustment applied to the CHC-MCO payments for every CHC-MCO in a given zone.

The Department will adjust payment by a PEMA based on Participant eligibility data on a schedule determined by the Department.

APPENDIX 3f

Peer Group 13 Risk Pool

Overview

Starting 12 months after the Implementation Date, the Department will establish, administer, and distribute funds from three quarterly Peer Group 13 Risk Pools per zone for costs associated with Peer Group 13 facilities.

The CHC-MCO will fund the quarterly risk pool based on Peer Group 13 Risk Pool Allocation Amounts developed annually by the Department's actuary. To determine the CHC-MCO-specific quarterly distributions based on the Peer Group 13 facility service costs, the Department will utilize encounter data, unless it notifies the CHC-MCO that it will utilize files submitted by the CHC-MCO with information on Participants and associated costs for Peer Group 13 facility services during the twelve-month period defined below. For each CHC zone, the Department will sum the amount spent by each CHC-MCO on Peer Group 13 facilities for the Defined Twelve-Month Period in order to determine what portion of the risk pool each CHC-MCO will receive. The Department will distribute the funds in the Peer Group 13 Risk Pool in proportion to each CHC-MCO's adjusted Peer Group 13 expenditures on all Covered Participants for the Defined Twelve-Month Period. The Department's payment to each CHC-MCO will be net of the CHC-MCO's Peer Group 13 Risk Pool Allocation Amount obligation for the quarter. If the CHC-MCO's Peer Group 13 Risk Pool Allocation Amount obligation exceeds its share of the Peer Group 13 Risk Pool, the Department will reduce a subsequent payment to the CHC-MCO by the amount of the difference.

Medicaid Eligible Group (MEG)

The Department will administer one budget-neutral risk pool per quarter per zone for each of the following groups, starting twelve months after CHC implementation in a zone:

- Nursing Facility Clinically Eligible (NFCE) Dual Eligibles (Duals)
- NFCE Non-Dual Eligibles
- Nursing Facility Ineligible (NFI) Dual Eligibles (Duals)

CHC-MCO Inclusion/exclusion in the Peer Group 13 Risk Pool

The Peer Group 13 Risk Pool threshold for Peer Group 13 facility claims is \$0.00 for each of the above noted MEGs.

A CHC-MCO will participate in the quarterly Peer Group 13 Risk Pool if both of the following criteria are met:

- The Department has made or will make capitation payments to the CHC-MCO in the zone for all three months during the quarter; and
- The Department has made or will make capitation payments to the CHC-MCO for the zone for all three months of each of the four previous quarters.

If the CHC-MCO does not meet the criteria for inclusion in the quarterly Peer Group 13 Risk Pool, then:

- The CHC-MCO has no Peer Group 13 Risk Pool Allocation Amount obligation for that quarter; and
 - The CHC-MCO has no opportunity to receive a distribution from that quarterly Peer Group 13 Risk Pool; and

- The CHC-MCO will not be required to contribute to that quarterly Peer Group 13 Risk Pool through a reduction to a subsequent payment.

The Department will determine each quarter which of the CHC-MCOs meet the criteria for inclusion in that quarter's Peer Group 13 Risk Pool.

DHS Calculation of Quarterly Funds in the Peer Group 13 Risk Pool

After each quarter has ended, the Department will determine the sum of the CHC-MCO's Peer Group 13 Risk Pool Allocation Amount obligation for the quarter, by multiplying the Peer Group 13 Risk Pool Allocation Amount by the number of member months included in the CHC-MCO during the quarter. The Department will use Participant data compiled as of one date for the purpose of determining each CHC-MCO's Peer Group 13 Risk Pool Allocation Amount obligation for the quarter. The Department will provide documentation to the CHC-MCO and will consider any issues the CHC-MCO brings to the Department's attention.

The sum of the Peer Group 13 Risk Pool Allocation Amount obligation for every CHC-MCO in the zone will be the total amount allocated to the Peer Group 13 Risk Pool for that quarter.

Covered Services

The CHC-MCO may include all claims paid by the CHC-MCO for Peer Group 13 facility services received by an enrolled Participant during the Defined Twelve-Month Period on files submitted to the Department unless the service is eligible in another risk sharing program. The Department may reprice each Peer Group 13 facility claim to the amount the Department would have paid for the same claim. The Department may elect to use CHC-MCO encounter data in lieu of Peer Group 13 Risk Pool-specific files submitted by the CHC-MCO, in whole or in part. The Department will apply the same criteria if it elects to use CHC-MCO encounter data in lieu of Peer Group 13 Risk Pool-specific files submitted by the CHC-MCOs.

For members for which a Peer Group 13 Risk Pool Allocation Amount was collected, this Arrangement covers services provided by Peer Group 13 facilities.

Defined Twelve-Month Period

The Defined Twelve-Month Period is the twelve months that ended the day before the quarter for which the Peer Group 13 Risk Pool is allocated to the quarterly risk pool.

Example: The Defined Twelve-Month Period for the Southwest zone for the January – March 2020 Peer Group 13 Risk Pool quarter is January 2019 – December 2019.

The Defined Twelve-Month Period encompasses dates of service, not the dates claims are paid.

The Defined Twelve-Month Period may include months that are covered by a different CHC-MCO agreement that applies to the same zone.

Data Source

The Department will use the Commonwealth's MMIS approved encounter data, unless the Department notifies the CHC-MCO that it will use different data. The Department will provide the run dates for extraction of encounter data to the CHC-MCO.

If the Department decides not to use encounter data, upon notification from the Department, the CHC-MCO will submit files in a format specified by the Department for the administration of the risk pool in lieu of encounter data.

For purposes of risk pool allocation, the Department will utilize information on Participants whose costs exceed the Peer Group 13 Risk Pool threshold during the Defined Twelve-Month Period, after repricing and other adjustments.

Calculation of Quarterly Distributions

The Department will utilize the Commonwealth's MMIS approved encounter data to administer the steps outlined in this Appendix and to determine the adjusted amount each CHC-MCO paid in excess of the Peer Group 13 threshold for each Participant for Covered Services provided during the Defined Twelve-Month Period. The CHC-MCO-specific sum will be the numerator in the calculation for the risk pool distribution. The denominator will be the applicable sum for all CHC-MCOs in the CHC zone. The resulting percentage figure will be multiplied by the amount in the risk pool. The CHC-MCO's uncollected Peer Group 13 Risk Pool Allocation Amount obligation for the quarter will be subtracted from this amount. If the result is a positive number, the Department will pay the amount to the CHC-MCO. If the result is a negative number, the Department will reduce a subsequent payment to the CHC-MCO by this amount.

Early Payment of a CHC-MCO's Peer Group 13 Risk Pool Allocation Amount Obligation

If the Department notifies the CHC-MCO of termination of this Agreement; or if the CHC-MCO notifies the Department of termination of this CHC Agreement; or if this Agreement expires within four months; or if an CHC-MCO fails to submit a required report or file to support the administration of a risk pool or risk-sharing arrangement within fifteen workdays of the final due date:

- The Department may elect to reduce a subsequent monthly capitation payment by the total amount of the outstanding Peer Group 13 Risk Pool Allocation Amount obligation for current and previous program months; and
- The Department may reduce each subsequent monthly capitation payment by the CHC-MCO's Peer Group 13 Risk Pool Allocation Amount obligation for the same month.

Appendix 4

Community HealthChoices Revenue Sharing

This Appendix establishes a requirement for remittance to the Department of any Realized Revenue, as defined in this Appendix, earned by a CHC-MCO in excess of three (3) percent.

The reporting requirements apply collectively to all Community HealthChoices (CHC) zone(s) in which the CHC-MCO operates under this Agreement or a previous Agreement with the Department during the applicable time period. This requirement is specific to the CHC program only and does not include revenue from any other MA managed care program in which the CHC-MCO may operate.

I. Time Period

The time period for purposes of reporting CHC program revenue aligns with the Department's CHC program year and the CHC program rating period. The applicable Time Period included in this Appendix will be CHC program year CY2026.

II. Extent of Calculation

Revenue sharing calculations will be based on CHC revenue and corresponding costs for all Rate Cells for each rating region and zone as identified in Appendix 3c. The CHC-MCO may not include revenue or costs that are not specific to the CHC program.

III. Calculation Process

The revenue sharing calculation will utilize information reported in each applicable annual Medical Loss Ratio Report (Annual Financial Report) for the Time Period. The Department will utilize the Department reviewed and approved Annual Financial Report for each applicable program year within the Time Period and will combine the reported amounts in each referenced section on the Annual Financial Report for each Aggregated Medicaid Eligibility Group for the applicable Time Period.

The following items reference Sections within the Annual Financial Report:

- a. **Capitation Revenue** will be based on "Total Premium Revenue" as reported in Section 4 as follows:
 - i. Capitation revenue will not include CHC-MCO quality incentive payments, such as any received CHC-MCO Nursing Facility Quality Incentive Program funds, as detailed in Exhibit DD(2), or any future Pay-for-Performance initiatives.
 - ii. The MCO Assessment will be deducted from Capitation Revenue.
 - iii. Applicable Federal and Pennsylvania State taxes will be deducted from Capitation Revenue.
 - iv. If the CHC-MCO paid a MLR Remittance amount to the Department as calculated on the Annual Financial Report, the MLR Remittance

amount paid by the CHC-MCO will be deducted from the Capitation Revenue.

- b. **Medical Expenses** will include paid claims and alternative method payments made by the CHC-MCO for allowable covered services rendered to Participants during the Time Period. Medical Expenses will be based on “Total Incurred Claims” as reported in Section 1. The Department may review a portion of or all of the reported Medical Expenses and may exclude Medical Expenses that do not constitute payment for State Plan services and/or allowed in lieu of services, including but not limited to:
 - i. Any allowance for Unpaid Claim Liability (UCL). The Department has full discretion to modify UCL allowances that, in the professional judgment of the Department’s Actuary, overstate projected liabilities; and
 - ii. Payments to Related Parties.
- c. **Activities that improve health care quality** are reported in Section 2 and will be considered in the revenue sharing calculation in a manner consistent with the Medical Loss Ratio calculation in Appendix 3b, as long as they meet one or more of the following criteria:
 - i. CHC-MCO activity that meets requirements of 45 CFR § 158.150(b) and is not excluded under 45 CFR § 158.150(c).
 - ii. CHC-MCO activity related to any External Quality Review related activity as described in 45 CFR § 438.358(b) and (c).
 - iii. CHC-MCO expenditure that is related to Health Information Technology and meaningful use, under 45 CFR § 158.151.
- d. **Administrative Expenses** will include those administrative expenses as reported in Section 6 and determined by the Department to be an allowable program expense.
 - i. The Department will review all payments to parent companies and reserves the right to limit consideration for these payments in the profit calculation.
 - ii. The Department reserves the right to limit total Administrative Expenses to an amount based on assumptions used in the capitation rate development process for this Agreement Period.
- e. **Taxes and assessments** imposed on the CHC-MCO pursuant to law are to be included in Section 5.
- f. **Prohibited Expenses** – the following expenses will not be included as expenses under this Appendix:
 - i. Outreach activities as described in Section V.O.3 of this Agreement
 - ii. Payments described in Section VII.E.14: Prohibited Payments of this Agreement

- iii. Claims payments covered under a non-risk arrangement(s) included in this CHC Agreement
 - iv. Premium Deficiency Reserves
 - v. Cost of advertisements in mass media
 - vi. Start-up, development or RFA expenses incurred before the Start Date on which the CHC-MCO is responsible for the provision of services to Participants
 - vii. Any expense related to exiting or terminating operations in a given zone/region under this Agreement
 - viii. Donations
 - ix. Excessive allocation of corporate overhead, as determined by the Department (see also item IV.d.i).
- g. **Percent Limit** will be the maximum retained percentage of certain CHC revenue, which is three (3) percent.
- h. **Maximum Retained Revenue**, or the amount of revenue that may be retained by the CHC-MCO, will be calculated by multiplying Capitation Revenue by the Percent Limit.
- i. **Realized Revenue** - the Department will calculate the Realized Revenue for the Time Period as follows:
- | | |
|---------|--|
| | Capitation Revenue |
| LESS: | Medical Expenses |
| LESS: | Expenses for Activities that improve health care quality |
| LESS: | Administrative Expenses |
| EQUALS: | Realized Revenue |
- j. **Revenue Recovery Amount** - If the Realized Revenue is greater than the Maximum Retained Revenue, the Revenue Recovery Amount will be the difference between the Realized Revenue and Maximum Retained Revenue. If this amount is greater than zero (0), then the Revenue Recovery Amount is an obligation due from the CHC-MCO to the Department. The Department will recover this obligation due from the CHC-MCO by offsetting a future payment due to the CHC-MCO under this Agreement. The Department will notify the CHC -MCO of the future payment that will be offset in advance of that scheduled payment.
- k. **Retention of Excess Revenue** – The CHC-MCO may retain fifty percent (50%) of the Realized Revenue in excess of the Maximum Retained Revenue with express written approval from the Department if the CHC-MCO agrees to expend the remaining fifty percent (50%) of funds in excess of the Maximum Retained Revenue on initiatives that align with the Department's goals of improving access and provider retention; investments in social determinants of health such as housing, employment and food insecurity; achieving health equity; and programs that focus on community development.

- i. A CHC-MCO shall submit to the Department a written expenditure proposal for any funds in excess of the Maximum Retained Revenue.
- ii. This proposal shall be submitted within thirty (30) days of receiving the preliminary calculation per Section V, below.
- iii. After the Department accepts the CHC-MCO's proposal, the Department will decrease the Revenue Recovery Amount to zero (0).

IV. Risk of Insolvency

If the CHC-MCO decides not to invest excess revenue as described in Section III.k of this Appendix, and the Department determines that payment of a Revenue Recovery Amount by the CHC-MCO would result in the CHC-MCO being put at significant risk of insolvency, the Department may at the Department's discretion, waive all or a portion of the Revenue Recovery Amount owed by the CHC-MCO.

V. Communication and Timing of Revenue Sharing Administration

The Department will notify each CHC-MCO of the preliminary revenue sharing calculation and associated Revenue Recovery Amount within ninety (90) days following the date the Department completes the review and approves the Annual Financial Report for CY2026. The CHC-MCO will have thirty (30) days from the notification date to provide additional documentation or supplemental information to the Department regarding the calculation, including the reported amounts in the Annual Financial Report. The Department will have up to sixty (60) days to review the additional documentation and supplemental information submitted by the CHC-MCO and to finalize the Revenue Recovery Amount calculation. If the Revenue Recovery Amount is greater than zero (0), the Department will recover this amount per Section IV of this Appendix.

VI. Final Revenue Sharing Notification and Remittance

The Department will provide the CHC-MCO with written notification of the final Revenue Recovery Amount and the date when the amount due to the Department will be recovered, if applicable.

VII. Documentation of CHC-MCO Expenses

At the request of the Department, the CHC-MCO shall make available all books, accounts, documents, files and information that relate to the CHC-MCO's transactions within ten (10) business days after the request was made. The CHC-MCO shall cooperate with the Department and any representatives of the Department.

VIII. Continuation

If CMS issues regulation(s) that revises or replaces the requirements in this appendix, the revised or replacement requirements will apply. The Department

at its discretion may choose to waive any or all requirements of this Appendix. If the requirements of this Appendix are waived in full or in part, the Department will notify the CHC-MCO in writing of the waived Sections.

Appendix 5

In Lieu of Services (ILOS)

ILOS Definition. ILOS is a cost-effective, medically necessary service or setting that is offered to a Participant as a substitute for a State Plan service or setting in accordance with 42 CFR § 438.3(e)(2) and all future regulations and sub-regulatory federal guidance. All ILOS must be allowable under Medicaid State Plan or Section 1915(c) waiver rules and approved by the Department in advance.

Compliance With Federal Requirements. ILOSs must not violate any applicable federal requirements, including 42 CFR § 438.3(e)(2), general prohibitions on payment for room and board costs under Title XIX of the Social Security Act, the Americans with Disabilities Act, Section 504 of the Rehabilitation Act, and the Emergency Medical Treatment and Labor Act.

Department Approved ILOS. The services or settings listed below are determined by the Department to be a medically appropriate and cost-effective substitute for the named covered services or settings under the State Plan for the following clinically defined target populations. The CHC-MCO may provide ILOS only from this approved list to Participants during the contract year.

Pursuant to 42 CFR 438.3, CHC-MCOs may not provide ILOS without first applying to the Department and obtaining approval to offer the ILOS by demonstrating all requirements will be met. If the CHC-MCO identifies a potential ILOS that they would like to offer during a future contract period, the CHC-MCO must follow the process described in the ILOS development guidelines and request form documents as detailed in the In Lieu of Services Operations Memorandum.

ILOS Name	ILOS Definition	Substituted State Plan Service or Setting	Procedure Code(s) (e.g., HCPCS or CPT) That Identify ILOS	Clinically Defined Target Population(s)
Assisted Living	A group living situation, licensed under 55 PA Code Chapter 2800, for NFCE members that provides food, shelter, assistance with personal care and activities of daily living, health assessment and monitoring, and assistance or supervision of supplemental health care services.	Nursing Facility Services	T2030 and T2031	NFCE individuals in a nursing facility who are interested in transition to a less restrictive setting, or individuals at risk of nursing facility placement who are interested in diversion from placement in a Nursing Facility.

CHC-MCOs must demonstrate through the PCSP and Assisted Living Support Plans that all of the Participants needs will be addressed and services will be provided in the Assisted Living setting in accordance with the CHC-MCO and OLTL ILOS Agreement, and current year CHC Agreement. CHC-MCOs must adhere to all applicable 55 Pa. Code § 2800 regulations (Assisted Living Residences) for Participants that choose assisted living ILOS.

Assisted Living Facilities impacted by the discontinuance of Assisted Living as an ILOS must be notified by the CHC-MCO of the intent to discontinue services at least sixty (60) calendar days in advance.

Encounter Data. The CHC-MCO must utilize identified codes to submit encounter data on ILOS.

Clinical Determination of Appropriateness. For each approved ILOS, the Department determined a clinically defined target population as individuals who are medically appropriate for the ILOS and for whom the use of the ILOS is likely to result in lower costs than utilization of the substituted State Plan service and setting.

For a Participant to receive an ILOS, a determination of medical appropriateness must be made by the CHC-MCO using their professional judgement and assessing the Participant's presenting medical condition, preferred course of treatment, and current or past medical treatment. Prior to offering the ILOS, the CHC-MCO must develop a policy and procedure for determining whether an ILOS is medically necessary, and the individual meets the targeted population to receive an ILOS and submit to the Department for review and approval.

The CHC-MCO shall document the determination of medical appropriateness within the Participant's records, which could include the Participant's PCSP, medical record (paper or electronic), or another record that details the Participant's level of care. The documentation must include how each ILOS is expected to address the Participant's needs. The Department must approve the CHC-MCO's documentation process before the CHC-MCO elects to provide the ILOS.

CHC-MCO Responsibilities:

1. **ILOS Option for the CHC-MCO.** The CHC-MCO is not required to offer an ILOS to Participants.
2. **Public Disclosure of ILOS Provided.** The CHC-MCO shall include in its Participant handbook the protections available to participants who receive ILOS, including a description of the process to determine eligibility for specific ILOS, the voluntary nature of ILOS, and the right to file a Complaint, Grievance or Fair Hearing with regards to the denial or receipt of an ILOS.
3. **Calculation of Cost of ILOS.** CHC-MCO shall supply any information needed by the Department to assist in calculating cost projections for approved or potential ILOS, including but not limited to, specific claims, cost information, encounter data, and other Participant data that will assist the Department in meeting and current or future CMS documentation requirements. The CHC-MCO will also comply with any standards detailed in the Community HealthChoices Financial Reporting Requirements documenting ILOS expenditures.
4. **Provision of ILOS Encounter Data to the Department.** Encounter data must be submitted to the Department by the CHC-MCO in accordance with Section VIII.A.1 for ILOS and, when available, include data necessary for the State to stratify ILOS utilization by sex (including sexual orientation and gender identity), race, ethnicity, disability status, and language spoken to inform health equity initiatives and efforts to mitigate health disparities.

To the extent that existing health care codes do not accurately identify ILOS, the Department will provide specific codes and modifiers that the CHC-MCO shall use to ensure consistent use.
5. **Operations and Quality Reporting Requirements.** The CHC-MCO is required to comply with Operations and Quality Management Reporting requirements as specified in Section VIII:D.1 to enable the Department to monitor the CHC-MCO's in-lieu of program.

Participant Rights

1. **ILOS Option for Participants.** The CHC-MCO shall not require Participants to use an ILOS as a substitute for a State Plan Service.
2. **Participant Rights and Protections.** When receiving an ILOS, Participants retain all of the rights afforded to them in 42 CFR Part 438, including, for example, the right to make informed decisions about their health care and to receive information on available treatment options and alternatives per 42 CFR § 438.100(b)(2). In accordance with 42 CFR § 438.3(e)(2)(ii), the CHC-MCO shall not require Participants to utilize ILOS or from mandating replacement of a State Plan Service for an ILOS. ILOS may not be used to reduce, discourage, or jeopardize Participants' access to covered State Plan Services or Settings. If a Participant chooses not to receive an ILOS, they always retain their right to receive the covered State Plan Service or Setting on the same terms as would apply if an ILOS were not an option. The CHC-

MCO is not permitted to deny a Participant a medically appropriate State Plan Service or Setting on the basis that a Participant has been offered an ILOS, is currently receiving an ILOS, or has received an ILOS in the past.

In accordance with 42 CFR § 438.10(g)(2)(ix), all of the CHC-MCO's Participant handbooks must contain information on Participant rights and responsibilities, including the Complaint, Grievance, and fair hearings requirements outlined in Exhibit G. Regardless of a Participant's utilization of an ILOS, the Participant retains all rights and privileges under Exhibit G. The Department will review and approve the ILOS language included in the Participant handbooks annually.

Oversight

Performance Monitoring The Department will include any ILOSs the CHC-MCO elects to provide in the overall quality monitoring structure detailed in Exhibit F- Quality Management and Utilization Management Program Requirements, to ensure that all ILOS received by Participants are medically appropriate, cost effective, and used at the option of the Participant and CHC-MCO.

Utilization and Cost The utilization and actual cost of ILOSs shall be taken into account in developing the component of the capitation rates that represents the covered State Plan services, unless a federal statute or regulation explicitly requires otherwise.

Network Adequacy The CHC-MCO must develop and maintain a network of ILOS providers that have the capacity and capability to deliver medically appropriate and cost effective ILOSs selected by the Participant.

Discontinuation of ILOS by the CHC-MCO The CHC-MCO may discontinue offering an approved ILOS with notice to the Department at least sixty (60) calendar days prior to the discontinuation date. The CHC-MCO must ensure that any ILOS that were authorized for a Participant prior to the discontinuation of that specific ILOS are not disrupted by a change in ILOS offerings, either by completing the authorized service or by seamlessly transitioning the Participant into other medically necessary services or programs that meet the Participant's needs. The CHC-MCO's transition plan must be provided to the Department as part of the ILOS discontinuation process. The transition plan must identify the total number of Participants utilizing the ILOS through the discontinuation date and the alternative services that will be offered (either State Plan services or other approved ILOS). The CHC-MCO must not offer the ILOS after the date of discontinuation.

At least 45 calendar days before discontinuing an ILOS, the CHC-MCO must notify Participants affected by the discontinuation of the ILOS of the following:

- The discontinuance of the ILOS and the last date the Participant can receive the ILOS, and
- How the CHC-MCO will ensure that the Participant will receive the ILOS as authorized or the plan to transition the Participant to other comparable medically necessary services.

Discontinuation of ILOS by the Department In the event the Department or CMS determines an ILOS not to be medically appropriate or cost effective, the CHC-MCO will

assist the Department in preparing a transition plan to phase out the applicable ILOS while ensuring access for affected Participants to contractually required services with minimal disruption of care. The transition plan will include a process to notify Participants of the termination of the ILOS that they are currently receiving as expeditiously as required by the Participants' health condition. If the Department discontinues an ILOS, the Department will amend the Agreement to remove the applicable ILOS.

EXHIBIT A

COVERED SERVICES LIST

In the event that a conflict arises between this Agreement and the content of the CHC Waivers approved by CMS, the CHC waivers shall take precedence.

CHC Covered Physical Health Services	
Category	Category
Inpatient Hospital Services	Clinic Services
Inpatient Acute Hospital	Independent Clinic
Inpatient Rehab Hospital	Maternity – Physician, Certified Nurse Midwives, Birth Centers
Outpatient Hospital Clinic	Renal Dialysis Services
Outpatient Hospital Clinic	Ambulatory Surgical Center (ASC) Services
Outpatient Hospital Short Procedure Unit	Dental Services
Federally Qualified Health Center / Rural Health Clinic	Physical Therapy, Occupational Therapy, and Services for Individuals with Speech, Hearing, and Language Disorders
Other Laboratory and X-ray Service	Prescribed Drugs, Dentures, and Prosthetic Devices; and eyeglasses prescribed by a physician skilled in diseases of the eye or by an optometrist
Laboratory	Prescribed Drugs
Radiology (For example: X- rays, MRIs, CTs)	Dentures
Nursing Facility Services	Prosthetic Devices
	Eyeglasses
Family Planning Clinic Services, and Supplies	Diagnostic, Screening, Preventive, and Rehabilitative Services
Physician Services	Tobacco Cessation
Primary Care Provider	Therapy (Physical, Occupational, Speech) - Rehabilitative
Physician Services and Medical and Surgical Services provided by a Dentist	Certified Registered Nurse Practitioner Services
Medical care and any other type of remedial care	Any other medical care and any other type of remedial care recognized under state law, specified by the Secretary
Podiatrist Services	Ambulance Transportation

Optometrist Services	Non-Emergency Medical Transport
Chiropractor Services	Emergency Room
Home Health Services	Hospice Care
Home Healthcare Including Nursing, Aide and Therapy	Limited Abortions*
Medical Supplies	
Durable Medical Equipment Including home accessibility durable medical equipment	
Therapy (Physical, Occupational, Speech)	Definitions for Physical Health Services may be found in the Pennsylvania Medicaid State Plan at: http://www.dhs.state.pa.us/publications/medicaidstateplan/
Personal Protective Equipment (PPE)	
CHC LTSS Benefits	
Nursing Facility Services	
Nursing Facility Services are professionally supervised nursing care and related medical and other health services furnished by a healthcare facility licensed by the Pennsylvania Department of Health as a long-term care nursing facility under Chapter 8 of the Healthcare Facilities Act (35 P.S. §§ 448.801-448.821) and certified as a nursing facility provider in the MA Program (other than a facility owned or operated by the Federal or State government or agency thereof). Nursing facility services include services that are skilled nursing and rehabilitation services under the Medicare Program and health-related care and services that may not be as inherently complex as skilled nursing or rehabilitation services but which are needed and provided on a regular basis in the context of a planned program or healthcare and management. A Participant must be NFCE to receive nursing facility services under the CHC Program. Nursing Facility Services includes at least the items and services specified in 42 CFR 483.10(f)(11)(i). Nursing facility services are covered as defined in 55 Pa. Code § 1187.51.	
Exceptional DME for CHC Participants Residing in a Nursing Facility.	
Home and Community-Based Services	
Adult Daily Living	Non-Medical Transportation
Assistive Technology	Nutritional Consultation
Behavior Therapy	Occupational Therapy

Benefits Counseling	Participant-Directed Community Supports
Career Assessment	Participant-Directed Goods and Services
Chore Services	Personal Assistance Services
Cognitive Rehabilitation	Personal Emergency Response System
Community Integration	Pest Eradication
Community Transition Services	Physical Therapy
Counseling	Residential Habilitation
Employment Skills Development	Respite
Financial Management Services	Specialized Medical Equipment and Supplies
Home Adaptations	Speech and Language Therapy
Home Delivered Meals	Structured Day Habilitation
Home Health Aide	Telecare
Job Coaching	Teleservices- Cognitive Rehabilitation Therapy
Job Finding	Teleservices- Counseling
Nursing	Teleservices- Nutritional Consultation
	Vehicle Modifications

*Some services are included on the CHC Covered Physical Health Services list and the CHC LTSS Benefits list. The CHC LTSS Benefits are available only after the Participant's State Plan, Medicare or private insurance limitations have been reached, or the service is not covered under the State Plan, Medicare or private insurance.

Definitions for the LTSS listed above can be found in the 1915(c) Home and Community Based Services Waiver, and may be amended from time to time, found at:

<https://www.dhs.pa.gov/HealthChoices/HC-Services/Pages/CHC-Supporting-Documents.aspx>

***An Abortion is a Covered Service only when a physician has found, and certified in writing to the Medicaid agency that, on the basis of that physician's professional judgment, the life of the mother would be endangered if the fetus were carried to term (which is in accordance with 42 CFR 441.202).**

EXHIBIT B
STANDARD TERMS AND CONDITIONS

1. TERM

The term of this Agreement shall commence on the effective date and shall end on the expiration date identified in the Agreement, subject to the other provisions of the Agreement. The Agreement shall not be a legally binding Agreement until fully executed by the CHC-MCO and by the Commonwealth and all approvals required by Commonwealth and federal procurement procedures have been obtained. No agency employee has the authority to verbally direct the commencement of any work under this Agreement. The Commonwealth may, upon notice to the CHC-MCO, extend the term of the Agreement for up to three (3) months upon the same terms and conditions, which will be utilized to prevent a lapse in Agreement coverage and only for the time necessary, up to three (3) months, to enter into a new Agreement.

2. PARTY RELATIONSHIP

In performing the services required by the Agreement, the CHC-MCO will act as an independent contractor and not as an employee or agent of the Commonwealth.

3. Reserved.

4. ENVIRONMENTAL PROVISIONS

In the performance of the Agreement, the CHC-MCO shall minimize pollution and shall strictly comply with all applicable environmental statutes and regulations.

5. Reserved.

6. COMPENSATION/EXPENSES

The CHC-MCO shall be required to perform the specified services at the prices provided for in the Agreement. All services shall be performed within the time periods specified in the Agreement. The CHC-MCO shall be compensated only for work performed to the satisfaction of the Commonwealth. The CHC-MCO shall not be paid travel or per diem expenses.

7. Reserved.

8. OFFSET

The Commonwealth may set off the amount of any state tax liability or other obligation of the CHC-MCO, or its subsidiaries, owed to the Commonwealth against any payments due the CHC-MCO under any Agreement between the Commonwealth and CHC-MCO.

9. TAXES

The Commonwealth is exempt from all excise taxes imposed by the Internal Revenue Service and has accordingly registered with the Internal Revenue Service to make tax-free purchases under Registration No. 23740001-K. With the exception of purchases of the following items, no exemption certificates are required, and none will be issued: undyed diesel fuel, tires, trucks, gas guzzler emergency vehicles, and sports fishing equipment. The Commonwealth is also exempt from Pennsylvania state sales tax, local sales tax, public

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

10. WARRANTY

The CHC-MCO warrants that all services performed by the CHC-MCO, its employees, representatives, agents, and subcontractors shall be performed in a professional and workmanlike manner and in accordance with prevailing professional and industry standards. Unless otherwise stated in this Agreement, all services are warranted for a period of one (1) year following completion of performance by the CHC-MCO and acceptance by the Commonwealth. The CHC-MCO shall correct any problem with the service without any additional cost to the Commonwealth.

11. PATENT, COPYRIGHT, AND TRADEMARK INDEMNITY

The CHC-MCO warrants that it is the sole owner or author of, or has entered into a suitable legal agreement concerning either: a) the design of any product or process provided or used in the performance of the Agreement which is covered by a patent, copyright, or trademark registration or other right duly authorized by Federal or State law, or b) any copyrighted matter in any report document or other material provided to the Commonwealth. The CHC-MCO shall defend any suit or proceeding brought against the Commonwealth on account of any alleged patent, copyright, or trademark infringement in the United States of any of the products provided or used in the performance of the Agreement. This is upon condition that the Commonwealth shall provide prompt notification in writing of such suit or proceeding; full right, authorization, and opportunity to conduct the defense thereof; and full information and all reasonable cooperation for the defense of same. As principles of governmental or public law are involved, the Commonwealth may participate in or choose to conduct, in its sole discretion, the defense of any such action. If information and assistance are furnished by the Commonwealth at the CHC-MCO's written request, it shall be at the CHC-MCO's expense, but the responsibility for such expense shall be only that within the CHC-MCO's written authorization. The CHC-MCO shall indemnify and hold the Commonwealth harmless from all damages, costs, and expenses, including attorney's fees that the CHC-MCO or the Commonwealth may pay or incur by reason of any infringement or violation of the rights occurring to any holder of copyright, trademark, or patent interests and rights in any products provided or used in the performance of the Agreement. If any of the products provided by the CHC-MCO in such suit or proceeding are held to constitute infringement and the use is enjoined, the CHC-MCO shall, at its own expense and at its option, either procure the right to continue use of such infringement products, replace them with non-infringement equal performance products or modify them so that they are no longer infringing. If the CHC-MCO is unable to do any of the preceding, it will remove all the equipment or software which are obtained contemporaneously with the infringing product, or, at the option of the Commonwealth, only those items of equipment or software which are held to be infringing, and to pay the Commonwealth: 1) any amounts paid by the Commonwealth towards the purchase of the product, less straight line depreciation; 2) any license fee paid by the Commonwealth for the use of any software, less an amount for the period of usage; and 3) the pro rata portion of any maintenance fee representing the time remaining in any period of maintenance paid for. The obligations of

the CHC-MCO under this paragraph continue without time limit. No costs or expenses shall be incurred for the account of the CHC-MCO without its written consent.

12. OWNERSHIP RIGHTS

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

13. ASSIGNMENT OF ANTITRUST CLAIMS

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

14. INDEMNIFICATION

The CHC-MCO shall indemnify and defend the Commonwealth against all third-party claims, suits, demands, losses, damages, costs, and expenses, including without limitation, litigation expenses, attorneys' fees, and liabilities, arising out of or in connection with any activities performed by the CHC-MCO or its employees and agents pursuant to this Agreement, as determined by the Commonwealth in its sole discretion.

15. AUDIT PROVISIONS

In addition to its other audit requirements, the Commonwealth shall have the right, at reasonable times and at a site designated by the Commonwealth, to audit, review, or inspect the books, documents, and records of the CHC-MCO to the extent that the books, documents, and records relate to costs or pricing data for the Agreement. The CHC-MCO will maintain records which will support the prices charged and costs incurred for the Agreement. The CHC-MCO shall preserve books, documents, and records that relate to costs or pricing data for the Agreement for a period of five (5) years from date of final payment. The CHC-MCO shall give full and free access to all records to the Commonwealth and its authorized employees, agents, representatives, or designees.

16. DEFAULT

- a. The Commonwealth may, subject to the provisions of Paragraph 17, Force Majeure, and in addition to its other rights under the Agreement, declare the CHC-MCO in default by written notice to the CHC-MCO, and terminate as provided in Paragraph 18, Termination Provisions, the whole or any part of this Agreement for any of the following reasons:
 - 1) Failure to begin services within the time specified in the Agreement or as otherwise specified;
 - 2) Failure to perform the services with sufficient labor, equipment, or material to ensure the completion of the specified work in accordance with the Agreement terms;

- 3) Unsatisfactory performance of services;
 - 4) Discontinuance of services without approval;
 - 5) Failure to resume services, which has been discontinued, within a reasonable time after notice to do so;
 - 6) Insolvency or bankruptcy;
 - 7) Assignment made for the benefit of creditors;
 - 8) Failure or refusal within ten (10) days after written notice, to make payment or show cause why payment should not be made, of any amounts due for materials furnished, labor supplied or performed, for equipment rentals, or for utility services rendered;
 - 9) Failure to protect, to repair, or to make good any damage or injury to property;
 - 10) Theft, fraud, waste, or abuse involving the Commonwealth or the federal government;
 - 11) An adverse material change in circumstances as described in Section IX of the Agreement;
 - 12) Notification by PID or DOH that the CHC-MCO's authority to operate has been suspended, limited or revoked or has expired and will not be renewed;
 - 13) Failure to obtain NCQA certification; or
 - 14) Breach of any provision of the Agreement.
- b. In the event that the Commonwealth terminates this Agreement in whole or in part, the Commonwealth may procure, upon such terms and in such manner as it determines, services similar or identical to those so terminated, and the CHC-MCO shall be liable to the Commonwealth for any reasonable excess costs for such similar or identical services included within the terminated part of the Agreement.
- c. If the Agreement is terminated, the Commonwealth, in addition to any other rights provided in this paragraph, may require the CHC-MCO to transfer title and deliver immediately to the Commonwealth in the manner and to the extent directed by the Department, such partially completed work, including, where applicable, reports, working papers and other documentation, as the CHC-MCO has specifically produced or specifically acquired for the performance of such part of the Agreement as has been terminated. Except as provided below, payment for completed work accepted by the Commonwealth shall be at the Agreement price. Except as provided below, payment for partially completed work including, where applicable, reports and working papers, delivered to and accepted by the Commonwealth shall be in an amount agreed upon by the CHC-MCO and the Department. The Commonwealth may withhold from amounts otherwise due the CHC-MCO for such completed or partially completed works such sum as the Department determines to be necessary to protect the Commonwealth against loss.
- d. The rights and remedies of the Commonwealth provided in this paragraph are not exclusive and are in addition to any other rights and remedies provided by law or under the Agreement.

17. FORCE MAJEURE

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

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

In the event of a declared emergency by competent governmental authorities, the Commonwealth by notice to the CHC-MCO, may suspend all or a portion of the Agreement.

18. TERMINATION PROVISIONS

a. The Commonwealth has the right to terminate the Agreement for any of the following reasons. Termination shall be effective upon written notice to the CHC-MCO and in accordance with the Agreement terms.

- 1) TERMINATION FOR CONVENIENCE:** Upon one hundred twenty (120) days written notice, the Commonwealth may terminate the Agreement for its convenience if the Commonwealth determines termination to be in its best interest. The effective date of the termination will be the last day of the month in which the one hundred-twentieth (120th) day fall. The CHC-MCO shall be paid for services satisfactorily completed prior to the effective date of the termination, but in no event shall the CHC-MCO be entitled to recover loss of profits.
- 2) NON-APPROPRIATION:** The Commonwealth's obligation to make payments during any Commonwealth fiscal year succeeding the current fiscal year shall be subject to availability and appropriation of funds. When funds (state and/or federal) are not appropriated or otherwise made available to support continuation of performance in a subsequent fiscal year period, the Commonwealth shall have the right to terminate the Agreement. The CHC MCO shall be reimbursed for the reasonable value of any nonrecurring costs incurred but not amortized in the price of the supplies or services delivered under this Agreement. Such reimbursement shall not include loss of profit, loss of use of money, or administrative or overhead costs. The reimbursement amount may be paid for any appropriations available for that purpose.
- 3) TERMINATION FOR CAUSE:** The Commonwealth may terminate the

Agreement for default under Paragraph 16, Default, or other cause as specified in the Agreement or by law, by providing written notice of default to the CHC-MCO. Except as provided in Section X.A.2 of the Agreement, the Commonwealth will provide forty-five (45) days written notice setting forth the grounds for termination and provide the CHC-MCO with forty-five (45) days or such longer time as approved by the Commonwealth in which to implement a corrective action plan and cure the deficiency. If corrective action is not implemented to the satisfaction of the Commonwealth within the approved cure period, the termination shall be effective at the expiration of the approved cure period. If it is later determined that the Commonwealth erred in terminating the Agreement for cause, then, at the Commonwealth's discretion, the Agreement shall be deemed to have been terminated for convenience under the Subparagraph 18.a.

19. Reserved.

20. ASSIGNABILITY AND SUBGRANTING

- a. Subject to the terms and conditions of this Paragraph 20, this Agreement shall be binding upon the parties and their respective successors and assigns.
- b. The CHC-MCO shall not subcontract with any person or entity to perform all or any part of the services to be performed without the prior written consent of the Department, which consent may be withheld at the sole and absolute discretion of the Department.
- c. The CHC-MCO may not assign, in whole or in part, the Agreement or its rights, duties, obligations, or responsibilities hereunder without the prior written consent of the Department, which consent may be withheld at the sole and absolute discretion of the Department.
- d. The CHC-MCO may, without the consent of the Department, assign its rights to payment to be received under the Agreement, provided that the CHC-MCO provides written notice of such assignment to the Department together with a written acknowledgement from the assignee that any such payments are subject to all of the terms and conditions of the Agreement.
- e. For the purposes of this Agreement, the term "assign" shall include, but shall not be limited to, the sale, gift, assignment, pledge, or other transfer of any ownership interest in the CHC-MCO, provided, however, that the term shall not apply to the sale or other transfer of stock of a publicly traded company.
- f. Any assignment consented to by the Department shall be evidenced by a written assignment Agreement executed by the CHC-MCO and its assignee in which the assignee agrees to be legally bound by all of the terms and conditions of the Agreement and to assume all duties, obligations, and responsibilities being assigned.
- g. A change of name, following which the CHC-MCO's federal identification number remains unchanged, shall not be considered to be an assignment. The CHC-MCO shall give the Department written notice of any such change of name.

21. NONDISCRIMINATION/SEXUAL HARASSMENT

- a. **Representations.** The CHC-MCO represents that it is presently in compliance with and will remain in compliance with all applicable federal, state, and local laws, regulations, and policies relating to nondiscrimination

and sexual harassment for the term of the agreement. The CHC-MCO shall, upon request and within the time periods requested by the Commonwealth, furnish all necessary employment documents and records, including EEO-1 reports, and permit access to its books, records, and accounts by the Commonwealth for the purpose of ascertaining compliance with provisions of this Nondiscrimination/Sexual Harassment Clause.

b. **Nondiscrimination/Sexual Harassment Obligations.** The CHC-MCO shall not:

- i. in any manner discriminate in the hiring of any employee(s) for the performance of the activities required under this agreement or any subgrant agreement, contract, or subcontract, by reason of race, gender, creed, color, sexual orientation, gender identity or expression, or in violation of the Pennsylvania Human Relations Act ("PHRA") and applicable federal laws, against any citizen of this Commonwealth who is qualified and available to perform the work to which the employment relates.
- ii. in any manner discriminate by reason of race, gender, creed, color, sexual orientation, gender identity or expression, or in violation of the PHRA and applicable federal laws, against or intimidate any of its employees.
- iii. in any manner discriminate by reason of race, gender, creed, color, sexual orientation, gender identity or expression, or in violation of the PHRA and applicable federal laws, in the provision of services under this agreement or any subgrant agreement, contract, or subcontract.
- iv. in any manner discriminate by reason of race, gender, creed, color, sexual orientation, gender identity or expression, or in violation of PHRA and applicable federal laws, against any subgrantee, contractor, subcontractor, or supplier who is qualified to perform the work to which this agreement relates.
- v. in any manner discriminate against employees by reason of participation in or decision to refrain from participating in labor activities protected under the Public Employee Relations Act, Pennsylvania Labor Relations Act, or National Labor Relations Act, as applicable, and to the extent determined by entities charged with the Acts' enforcement and shall comply with any provision of law establishing organizations as employees' exclusive representatives.

c. **Establishment of CHC-MCO Policy.** The CHC-MCO shall establish and maintain a written nondiscrimination and sexual harassment policy that complies with the applicable law and these Nondiscrimination/Sexual Harassment provisions and shall inform its employees in writing of the policy. The policy must contain a provision that states that sexual harassment will not be tolerated and employees who practice it will be disciplined. For the entire period of this agreement, the CHC-MCO shall: (1) post its written

nondiscrimination and sexual harassment policy or these Nondiscrimination/Sexual Harassment provisions conspicuously in easily accessible and well-lighted places customarily frequented by employees at or near where the grant activities are performed; or (2) provide electronic notice of the policy or this clause to its employees not less than annually.

- d. **Notification of Violations.** The CHC-MCO's obligations pursuant to these provisions are ongoing from the effective date and through the termination date of the agreement. Accordingly, the CHC-MCO shall notify the Commonwealth if, at any time during the term of this agreement, it becomes aware of any actions or occurrences that would result in violation of these provisions.
- e. **Cancellation or Termination of Agreement.** The Commonwealth may cancel or terminate this agreement and all money due or to become due under this agreement may be forfeited for a violation of the terms and conditions of these Nondiscrimination/Sexual Harassment provisions. In addition, the Department may proceed with debarment or suspension and may place the CHC-MCO in the Contractor Responsibility File.
- f. **Subgrant Agreements, Contracts, and Subcontracts.** The CHC-MCO shall include these Nondiscrimination/Sexual Harassment provisions in its subgrant agreements, contracts, and subcontracts with all subgrantees, contractors, and subcontractors providing goods or services under this agreement. The incorporation of these provisions in the Department's subgrants, contracts, or subcontracts does not create privity of contract between the Commonwealth and any subgrantee, contractor, or subcontractor, and no third-party beneficiaries are created by those provisions. If the CHC-MCO becomes aware of a subgrantee's, contractor's, or subcontractor's violation of these provisions, the CHC-MCO shall use its best efforts to ensure the subgrantee's, contractor's, or subcontractor's compliance with these provisions.

22. CHC-MCO INTEGRITY

- a. **Definitions.** For purposes of these CHC-MCO Integrity Provisions, the following definitions apply:
 - i. "Affiliate" means two or more entities where (a) a parent entity owns more than 50% of the voting stock of each of the entities; (b) a common shareholder or group of shareholders owns more than 50% of the voting stock of each of the entities; or (c) the entities have a common proprietor or general partner.
 - ii. "CHC-MCO" means the individual or entity, that has entered into this agreement with the Commonwealth.
 - iii. "CHC-MCO Related Parties" means any Affiliates of the CHC-MCO and the CHC-MCO's executive officers, Pennsylvania officers and directors, or owners of five percent or more interest in the CHC-MCO.

- iv. “Financial Interest” means ownership of more than a five percent interest in any business or holding a position as an officer, director, trustee, partner, employee, or holding any position of management.
- v. “Gratuity” means tendering, giving, or providing anything of more than nominal monetary value including, but not limited to, cash, travel, entertainment, gifts, meals, lodging, loans, subscriptions, advances, deposits of money, services, employment, or contracts of any kind. The exceptions set forth in the [Governor’s Code of Conduct, Executive Order 1980-18](#), as may be amended, 4 Pa. Code §7.153(b), apply.
- vi. “Non-Solicitation Award Process” means a method of awarding grants based on predetermined criteria, without the solicitation of grant applications.

b. Representations and Warranties.

- i. **CHC-MCO Representation and Warranties.** The CHC-MCO represents, to the best of its knowledge and belief, and warrants that within the last five years neither the CHC-MCO nor CHC-MCO Related Parties have:
 - 1. been indicted or convicted of a crime involving moral turpitude or business honesty or integrity in any jurisdiction;
 - 2. been suspended, debarred, or otherwise disqualified from entering into any contract with any governmental agency;
 - 3. had any business license or professional license suspended or revoked;
 - 4. had any sanction or finding of fact imposed as a result of a judicial or administrative proceeding related to fraud, extortion, bribery, bid rigging, embezzlement, misrepresentation or anti-trust; and
 - 5. been, and are not currently, the subject of a criminal investigation by any federal, state, or local prosecuting or investigative agency or civil anti-trust investigation by any federal, state, or local prosecuting or investigative agency.
- ii. **Contractor Explanation.** If the CHC-MCO cannot make the representations and warranties set forth above at the time of its submission of its grant application or if the agreement is awarded pursuant to a Non-Solicitation Award Process at the time of the execution of the agreement, the CHC-MCO shall submit a written explanation outlining the reasons why it cannot make those representations and warranties. The Commonwealth may, based on its evaluation of the explanation provided, determine whether it is in the Commonwealth’s best interest to execute the agreement.
- iii. **Further Representations.** By submitting any bills, invoices, or requests for payment pursuant to the agreement, the CHC-MCO further represents that it has not violated any of these CHC-MCO

Integrity Provisions during the term of the agreement.

- iv. **Notice.** The CHC-MCO shall immediately notify the Commonwealth, in writing, if at any time during the term of the agreement it becomes aware of any event that would cause the Contractor's certification or explanation to change. The CHC-MCO acknowledges that the Commonwealth may, in its sole discretion, terminate the agreement for cause if it learns that any of the certifications made in these CHC-MCO Integrity Provisions are currently false or misleading due to intervening factual circumstances or were false or misleading or should have been known to be false or misleading when entering into the agreement.
- c. **CHC-MCO Responsibilities.** During the term of this agreement, the CHC-MCO shall:
- i. maintain the highest standards of honesty and integrity.
 - ii. take no action in violation of any applicable laws, regulations, or other requirements applicable to the CHC-MCO that govern Commonwealth contracting or grant administration.
 - iii. establish and implement a written business integrity policy that includes, at a minimum, the requirements of these CHC-MCO Integrity Provisions as they relate to the CHC-MCO's activity with the Commonwealth and Commonwealth employees and ensure that its employees comply with the policy.
 - iv. not accept, agree to give, offer, confer, agree to confer, or promise to confer, directly or indirectly, any gratuity or pecuniary benefit to any person, or to influence or attempt to influence any person in violation of any federal or state law, regulation, executive order, statement of policy, management directive, or bulletin applicable to the award of grants or the administration of this agreement.
 - v. not have a financial interest in any other subgrantee, contractor, subcontractor, or supplier providing services, labor, or material under this agreement, unless the financial interest is disclosed to the Commonwealth in writing and the Commonwealth consents to CHC-MCO's financial interest. The CHC-MCO must disclose the financial interest to the Commonwealth at the time of submission of its grant application, or if a Non-Solicitation Award Process is used, no later than the date the CHC-MCO signs the agreement. The Commonwealth shall be deemed to have consented if the required disclosure is received and all of the required Commonwealth signatures are affixed.
 - vi. comply with the requirements of the Lobbying Disclosure Act (65 Pa.C.S. § 13A01 et seq.) regardless of the method of award.
 - vii. comply with the requirements of Section 1641 of the Pennsylvania Election Code (25 P.S. § 3260a) if this agreement was awarded

pursuant to a Non-Solicitation Award Process.

- viii. immediately notify the Commonwealth or the Office of the State Inspector General, in writing, when the CHC-MCO has reason to believe that any breach of ethical standards as set forth in law, the Governor's Code of Conduct, or these CHC-MCO Integrity Provisions has occurred or may occur, including, but not limited to, contact by a Commonwealth officer or employee, which, if acted upon, would violate the ethical standards.
- d. **Investigations.** If a State Inspector General investigation is initiated, the CHC-MCO shall:
- i. reimburse the Commonwealth for the reasonable costs of investigation incurred by the Office of the State Inspector General for investigations of the CHC-MCO's compliance with the terms of this or any other agreement between the CHC-MCO and the Commonwealth that results in the suspension or debarment of the CHC-MCO. The CHC-MCO shall not be responsible for investigative costs for investigations that do not result in the CHC-MCO's suspension or debarment.
 - ii. cooperate with the Office of the State Inspector General in its investigation of any alleged Commonwealth agency or employee breach of ethical standards and any alleged CHC-MCO non-compliance with these CHC-MCO Integrity Provisions and make identified CHC-MCO employees and volunteers available for interviews at reasonable times and places.
 - iii. upon the inquiry or request of an Inspector General, provide, or if appropriate, make promptly available for inspection or copying, any information of any type or form deemed relevant by the Office of the State Inspector General to CHC-MCO's integrity and compliance with these provisions. This information may include, but is not limited to, the CHC-MCO's business or financial records, documents or files of any type or form that refer to or concern this agreement.
- e. **Termination.** For violation of any of these CHC-MCO Integrity Provisions, the Commonwealth may terminate this agreement and any other contract with the CHC-MCO, claim liquidated damages in an amount equal to the value of anything received in breach of these CHC-MCO Integrity provisions, claim damages for all additional costs and expenses incurred in obtaining another grantee to complete performance under this agreement, and debar and suspend the CHC-MCO from doing business with the Commonwealth. These rights and remedies are cumulative, and the use or non-use of any one does not preclude the use of all or any other. These rights and remedies are in addition to those the Commonwealth may have under law, statute, regulation, or otherwise.
- f. **Subcontracts.** The CHC-MCO shall include these CHC-MCO Integrity Provisions in its subgrant agreements, contracts, and subcontracts with all

subgrantees, contractors, and subcontractors providing goods or services under this agreement. The incorporation of this provision in the CHC-MCO's subgrant agreements, contracts, and subcontracts shall not create privity of contract between the Commonwealth and any subgrantee, contractor, or subcontractor, and no third-party beneficiaries are created by the inclusion of these provisions. If the CHC-MCO becomes aware of a subgrantee's, contractor's, or subcontractor's violation of these provision, the CHC-MCO shall use its best efforts to ensure their compliance with these provisions.

23. CONTRACTOR RESPONSIBILITY PROVISIONS

- a. **Definition.** For the purpose of these provisions, the term "Contractor" means as any person, including, but not limited to, a bidder, offeror, loan recipient, grantee or lessor, who has furnished or performed or seeks to furnish or perform, goods, supplies, services, leased space, construction or other activity, under a contract, grant, lease, purchase order or reimbursement agreement with the Commonwealth. The term also includes a permittee, licensee, or any agency, political subdivision, instrumentality, public authority, or other public entity in the Commonwealth.
- b. **Contractor Representations.**
 - i. The Contractor represents for itself and its subgrantees, contractors, and subcontractors required to be disclosed or approved by the Commonwealth, that as of the date of its execution of this agreement, that neither the Contractor, nor any of its subgrantees, contractors, and subcontractors, are under suspension or debarment by the Commonwealth or any governmental entity, instrumentality, or authority and, if the Contractor cannot make this representation, the Contractor shall submit, along with the agreement, a written explanation of why the certification cannot be made.
 - ii. The Contractor represents that, as of the date of its execution of this agreement, it has no tax liabilities or other Commonwealth obligations, or has filed a timely administrative or judicial appeal, if any liabilities or obligations exist, or is subject to a duly approved deferred payment plan if any liabilities exist.
- c. **Notification.** The Contractor shall notify the Commonwealth if, at any time during the term of the agreement, it becomes delinquent in the payment of taxes, or other Commonwealth obligations, or if it or, to the best of its knowledge, any of its subgrantees, contractors, or subcontractors are suspended or debarred by the Commonwealth, the federal government, or any other state or governmental entity. The Contractor shall provide this notification within 15 days of the date of suspension or debarment.
- d. **Default.** The Contractor's failure to notify the Commonwealth of its suspension or debarment by the Commonwealth, any other state, or the federal government constitutes an event of default of the agreement with the Commonwealth.
- e. **Reimbursement.** The Contractor shall reimburse the Commonwealth for the reasonable costs of investigation incurred by the Office of State Inspector General for investigations of the Contractor's compliance with the terms of this agreement or any other agreement between the Contractor and the Commonwealth that results in

the suspension or debarment of the Contractor. These costs include, but are not limited to, salaries of investigators, including overtime; travel and lodging expenses; and expert witness and documentary fees. The Contractor shall not be responsible for investigative costs for investigations that do not result in the Contractor's suspension or debarment.

- f. **Suspension and Debarment List.** The Contractor may obtain a current list of suspended and debarred Commonwealth contractors by visiting the eMarketplace website at <http://www.emarketplace.state.pa.us> and clicking the Debarment list tab.

24. AMERICANS WITH DISABILITIES ACT

- a. **No Exclusion.** Pursuant to the Americans with Disabilities Act, 42 U.S. Code § 12101, et seq., no qualified individual with a disability may, on the basis of the disability, be excluded from participation in this contract or from activities provided for under this agreement.
- b. **Compliance.** For all goods and services provided pursuant to this agreement, the CHC-MCO shall comply with Title II of the Americans with Disabilities Act, the "General Prohibitions Against Discrimination" set forth in 28 C. F. R. § 35.130, and all other regulations promulgated under Title II of the Americans with Disabilities Act that apply to state and local governments.
- c. **Indemnification.** The CHC-MCO shall indemnify the Commonwealth against all third-party claims, suits, demands, losses, damages, costs, and expenses, including without limitation, litigation expenses, attorneys' fees, and liabilities, arising out of or in connection with the CHC-MCO's failure or its employee's or agent's failure to comply with the provisions of paragraph a, as determined by the Commonwealth in its sole discretion.

25. Reserved.

26. COVENANT AGAINST CONTINGENT FEES

The CHC-MCO warrants that no person or selling agency has been employed or retained to solicit or secure this Agreement upon an agreement or understanding for a commission, percentage, brokerage, or contingent fee, except bona fide employees or bona fide established commercial or selling agencies maintained by the CHC-MCO for the purpose of securing business. For breach or violation of this warranty, the Commonwealth may terminate this Agreement without liability or in its discretion to deduct from the Agreement price or consideration, or otherwise recover the full amount of such commission, percentage, brokerage, or contingent fee.

27. APPLICABLE LAW AND FORUM

This Agreement is governed by and must be interpreted and enforced in accordance with the laws of the Commonwealth of Pennsylvania (without regard to any conflict of laws provisions) and the decisions of the Pennsylvania courts. The Contractor consents to the jurisdiction of any court of the Commonwealth of Pennsylvania and any federal courts in Pennsylvania and waives any claim or defense that such forum is not convenient or proper. Any Pennsylvania court or tribunal has in personam jurisdiction over the Contractor, and the Contractor consents to service of process in any manner authorized by Pennsylvania law. This provision may not be interpreted as a waiver or limitation of the

Commonwealth's rights or defenses.

28. INTEGRATION

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

29. CHANGE ORDERS

The Commonwealth may issue change orders at any time during the term of the Agreement or any renewals or extensions thereof: 1) to increase or decrease the quantities resulting from variations between any estimated quantities in the Agreement and actual quantities; 2) to make changes to the services within the scope of the Agreement; 3) to notify the CHC-MCO that the Commonwealth is exercising any renewal or extension option; or 4) to modify the time of performance that does not alter the scope of the Agreement to extend the completion date beyond the Expiration Date of the Agreement or any renewals or extensions thereof. Any such change order shall be in writing signed by the Project Officer. The change order shall be effective as of the date appearing on the change order, unless the change order specifies a later effective date. Such increases, decreases, changes, or modifications will not invalidate the Agreement, nor, if performance security is being furnished in conjunction with the Agreement, release the security obligation. The CHC-MCO will provide the service in accordance with the change order.

30. RIGHT TO KNOW LAW

- a. **Applicability.** The Pennsylvania Right-to-Know Law, 65 P.S. §§ 67.101-3104, ("RTKL") applies to this Agreement.
- b. **CHC-MCO Assistance.** If the Commonwealth needs the CHC-MCO's assistance in any matter arising out of the RTKL related to this Agreement, the Commonwealth shall notify the CHC-MCO that it requires the CHC-MCO's assistance, and the CHC-MCO shall provide to the Commonwealth:
 - i. access to, and copies of, any document or information in the CHC-MCO's possession (Requested Information) arising out of this Agreement that the Commonwealth reasonably believes is a public record under the RTKL, within ten calendar days after receipt of written notification; and
 - ii. any other assistance as the Commonwealth may reasonably request, in order to comply with the RTKL with respect to this Agreement.

- c. **Trade Secret or Confidential Proprietary Information.** If the CHC-MCO considers the Requested Information to include a Trade Secret or Confidential Proprietary Information, as those terms are defined by the RTKL, or other information that the Contractor considers exempt from production under the RTKL, the CHC-MCO shall notify the Commonwealth and provide, within seven calendar days of receipt of the written notice a written statement, signed by a representative of the CHC-MCO, that explains why the requested material is exempt from public disclosure under the RTKL. If the Commonwealth determines that the Requested Information is clearly not exempt from disclosure, the CHC-MCO shall provide the Requested Information to the Commonwealth within five business days of receipt of written notice of the Commonwealth's determination.
- d. **Reimbursement**
 - i. **Commonwealth Reimbursement.** If the CHC-MCO fails to provide the Requested Information and the Commonwealth is ordered to produce the Requested Information, the CHC-MCO shall reimburse the Commonwealth for any damages, penalties, or costs that the Commonwealth may incur as a result of the CHC-MCO's failure, including any statutory damages assessed against the Commonwealth.
 - ii. **Contractor Reimbursement.** The Commonwealth will reimburse the CHC-MCO for any costs that the CHC-MCO incurs as a direct result of complying with these provisions only to the extent allowed under the fee schedule established by the Office of Open Records or as otherwise provided by the RTKL.
- e. **Challenges of Commonwealth Release.** The CHC-MCO may file a legal challenge to any Commonwealth decision to release a record to the public with the Office of Open Records, or in the Pennsylvania Courts, however, the CHC-MCO shall reimburse the Commonwealth for any legal expenses incurred by the Commonwealth as a result of the challenge, including any damages, penalties or costs that the Commonwealth may incur as a result of the CHC-MCO's legal challenge, regardless of the outcome.
- f. **Waiver.** As between the parties, the CHC-MCO waives all rights or remedies that may be available to it as a result of the Commonwealth's disclosure of Requested Information pursuant to the RTKL.
- g. **Survival.** The CHC-MCO's obligations contained in this Section survive the termination or expiration of this Agreement.

31. WORKER PROTECTION AND INVESTMENT

The CHC-MCO shall comply with all applicable Pennsylvania state labor laws and worker safety laws including, but not limited to, the following:

- a. Construction Workplace Misclassification Act;

- b. Employment of Minors Child Labor Act;
- c. Minimum Wage Act;
- d. Prevailing Wage Act;
- e. Equal Pay Law;
- f. Employer to Pay Employment Medical Examination Fee Act;
- g. Seasonal Farm Labor Act;
- h. Wage Payment and Collection Law;
- i. Industrial Homework Law;
- j. Construction Industry Employee Verification Act;
- k. Act 102: Prohibition on Excessive Overtime in Healthcare;
- l. Apprenticeship and Training Act; and
- m. Inspection of Employment Records Law.

EXHIBIT B(1)
DEPARTMENT OF HUMAN SERVICES
ADDENDUM TO STANDARD CONTRACT
TERMS AND CONDITIONS

A. APPLICABILITY

This Addendum is intended to supplement the Standard Terms and Conditions. To the extent any of the terms contained herein conflict with terms contained in the Standard Contract Terms and Conditions, the terms in the Standard Contract Terms and Conditions shall take precedence. Further, it is recognized that certain terms contained herein may not be applicable to all the services which may be provided through Department contracts.

B. CONFIDENTIALITY

The parties shall not use or disclose any information about a Participant of the services to be provided under this Agreement for any purpose not connected with the parties' Agreement responsibilities except with written consent of such Participant, Participant's attorney, or Participant's parent or legal guardian.

C. INFORMATION

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

D. CERTIFICATION AND LICENSING

CHC-MCO agrees to obtain all licenses, certifications and permits from Federal, State and Local authorities permitting it to carry on its activities under this Agreement.

E. PROGRAM SERVICES

Definitions of service, eligibility of recipients of service and other limitations in this Agreement are subject to modification by amendments to Federal, State, and local statutes, regulations, and program requirements without further notice to the CHC-MCO hereunder.

F. CHILD PROTECTIVE SERVICE LAWS

In the event that the Agreement calls for services to minors, the CHC-MCO shall comply with the provisions of the Child Protective Services Law (Act of November 26, 1975, P.L. 438, No. 124; 23 P.S. §§ 6301-6384, and all regulations promulgated thereunder at 55 Pa. Code chapter 3490.

G. PRO-CHILDREN ACT OF 1994

The CHC-MCO agrees to comply with the requirements of the Pro-Children Act of 1994, as amended; Public Law 103- 277, Part C-Environment Tobacco Smoke (also known as the Pro-Children Act of 1994), which requires that smoking not be permitted in any portion of any indoor facility owned or leased or

contracted by an entity and used routinely or regularly for the provision of healthcare services, day care and education to children under the age of 18, if the services are funded by Federal programs whether

directly or through State and Local governments. Federal programs include grants, cooperative agreements, loans or loan guarantees and contracts. The law does not apply to children's services provided in private residences, facilities funded solely by Medicare or Medicaid funds, and portions of facilities used for inpatient drug and alcohol treatment.

H. MEDICARE/MEDICAID REIMBURSEMENT

1. To the extent that services are furnished by contractors, subcontractors, or organizations related to the CHC-MCO and such services may in whole or in part be claimed by the Commonwealth for Medicare/Medicaid reimbursements, the CHC-MCO agrees to comply with 42 C.F.R. Part 420, including:
 - a. Preservation of books, documents, and records until the expiration of four (4) years after the services are furnished under this Agreement.
 - b. Full and free access to (i) the Commonwealth, (ii) the US Comptroller General, (iii) the US DHHS, and their authorized representatives.
2. The CHC-MCO's authorized representative's signature on the proposal certifies under penalty of law that the CHC-MCO has not been suspended or terminated from the Medicare or Medicaid Program and will notify the contracting DHS Facility or DHS Program Office immediately should a suspension or termination occur during the Agreement period.

I. TRAVEL AND PER DIEM EXPENSES

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

J. INSURANCE

1. The CHC-MCO shall accept full responsibility for the payment of premiums for Workers' Compensation, Unemployment Compensation, Social Security, and all income tax deductions required by law for its employees who are performing services under this Agreement. As required by law, an independent contractor is responsible for Malpractice Insurance for healthcare personnel. CHC-MCO shall provide the insurance Policy Number and Provider Name, or a copy of the policy with all renewals for the entire Agreement period.
2. The CHC-MCO shall, at its expense, procure and maintain during the term of the Agreement the following types of insurance, issued by companies acceptable to the Department and authorized to conduct such business under the laws of the Commonwealth of Pennsylvania:
 - a. Worker's Compensation Insurance for all of the CHC-MCO's employees and those of any subcontractor engaged in work at the site of the project as required by law.
 - b. Public liability and property damage insurance to protect the Commonwealth, the CHC-MCO, and any and all subcontractors from claim for damages for personal injury (including bodily injury), sickness or disease, accidental death and damage to property, including loss of use resulting from any property damage, which may arise from the activities performed under this Agreement or the failure to perform under this Agreement whether such performance or nonperformance be by the CHC-MCO, by any subcontractor, or by anyone directly or indirectly employed by either. The limits of such insurance shall be in an amount not less than \$500,000 each person and \$2,000,000 each occurrence, personal injury and property damage combined. Such policies shall be occurrence

rather than claims-made policies and shall name the Commonwealth of Pennsylvania as an additional insured. The insurance shall not contain any endorsements, or any other form designated to limit or restrict any action by the Commonwealth, as an additional insured, against the insurance coverage in regard to work performed for the Commonwealth.

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

K. PROPERTY AND SUPPLIES

1. The CHC-MCO agrees to obtain all supplies and equipment for use in the performance of this Agreement at the lowest practicable cost and to purchase by means of competitive bidding whenever required by law.
2. Title to all property furnished in-kind by the Department shall remain with the Department.
3. The CHC-MCO has title to all personal property acquired by the CHC-MCO, including purchase by lease/purchase agreement, for which the CHC-MCO is to be reimbursed under this Agreement. Upon cancellation or termination of this Agreement, disposition of such purchased personal property which has a remaining useful life shall be made in accordance with the following provisions.
 - a. The CHC-MCO and the Department may agree to transfer any item of such purchased property to another contractor designated by the Department. Cost of transportation shall be borne by the CHC-MCO receiving the property and will be reimbursed by the Department. Title to all transferred property shall vest in the designated CHC-MCO. The Department will reimburse the CHC-MCO for its share, if any, of the value of the remaining life of the property in the same manner as provided under subclause b of this paragraph.
 - b. If the CHC-MCO wishes to retain any items of such purchased property, depreciation tables shall be used to ascertain the value of the remaining useful life of the property. The CHC-MCO shall reimburse the Department in the amount determined from the tables.
 - c. When authorized by the Department in writing, the CHC-MCO may sell the property and reimburse the Department for its share. The Department reserves the right to fix the minimum sale price it will accept.
4. All property furnished by the Department or personal property acquired by the CHC-MCO, including purchase by lease/purchase contract, for which the CHC-MCO is to be reimbursed under this Agreement shall be deemed "Department Property" for the purposes of subsection 5, 6 and 7 of this section.
5. The CHC-MCO shall maintain and administer in accordance with sound business practice a program for the maintenance, repair, protection, preservation, and insurance of Department Property so as to assure its full availability and usefulness.
6. Department property shall, unless otherwise approved in writing by the Department, be used only for the performance of this Agreement.
7. In the event that the CHC-MCO is indemnified, reimbursed or otherwise compensated for any loss, destruction or damage to Department Property, it shall use the proceeds to replace, repair or renovate the property involved, or shall credit such proceeds against the cost of the work covered by the Agreement, or shall reimburse the Department, at the Department's direction.

L. DISASTERS

If, during the terms of this Agreement, the Commonwealth's premises are so damaged by flood, fire or other Acts of God as to render them unfit for use; then the Agency shall be under no liability or obligation to the

CHC-MCO hereunder during the period of time there is no need for the services provided by the CHC-MCO except to render compensation which the CHC-MCO was entitled to under this Agreement prior to such damage.

M. SUSPENSION OR DEBARMENT

In the event of suspension or debarment, 4 Pa. Code Chapter 60, as it may be amended, shall apply.

N. COVENANT AGAINST CONTINGENT FEES

The CHC-MCO warrants that no person or selling agency has been employed or retained to solicit or secure this Agreement upon an Agreement or understanding for a commission, percentage, brokerage, or contingent fee (excepting bona fide employees or bona fide established commercial or selling agencies maintained by the CHC-MCO for the purpose of securing business). For breach or violation of this warranty, the Department shall have the right to annul this Agreement without liability or, in its discretion, to deduct from the consideration otherwise due under the Agreement, or otherwise recover, the full amount of such commission, percentage, and brokerage or contingent fee.

O. CHC-MCO'S CONFLICT OF INTEREST

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

P. INTEREST OF THE COMMONWEALTH AND OTHERS

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

Q. CONTRACTOR RESPONSIBILITY TO EMPLOY CASH ASSISTANCE BENEFICIARIES
(Applicable to contracts Twenty-Five Thousand Dollars (\$25,000.00) or more)

1. The CHC-MCO, within ten (10) days of receiving the notice to proceed, must contact the Department's Contractor Partnership Program (CPP) to present, for review and approval, the CHC-MCO's plan for recruiting and hiring recipients currently receiving cash assistance. If the contract was not procured via Request for Proposal (RFP); such plan must be submitted on Form PA-778. The plan must identify a specified number (not percentage) of hires to be made under this Agreement. If no employment opportunities arise as a result of this Agreement, the CHC-MCO must identify other employment opportunities available within its organization that are not a result of this Agreement. The entire completed plan (Form PA-778) must be submitted to the Bureau of Employment and Training Programs (BETP): Attention CPP Division. (Note: Do not keep the pink copy of Form PA-778). The approved plan will become a part of the Agreement.
2. The CHC-MCO's CPP approved recruiting and hiring plan shall be maintained throughout the term of the Agreement and through any renewal or extension of the Agreement. Any proposed change must be submitted to the CPP Division, which will make a recommendation to the Contracting Officer regarding course of action. If an Agreement is assigned to another CHC-MCO, the new CHC-MCO must maintain the CPP recruiting and hiring plan of the original Agreement.
3. The CHC-MCO, within (10) days of receiving the notice to proceed, must register in the Commonwealth Workforce Development System (CWDS). In order to register, the CHC-MCO must provide business, location, and contact details by creating an Employer Business Folder for review and approval, within

CWDS at <https://www.cwds.state.pa.us>. Upon CPP review and approval of Form PA-778 and the Employer Business Folder in CWDS, the CHC-MCO will receive written notice (via the pink CHC-MCO's copy of Form PA-778) that the plan has been approved.

4. Hiring under the approved plan will be monitored and verified by Quarterly Employment Reports (Form PA-1540) submitted by the CHC-MCO to the Central Office of Employment and Training – CPP Division. A copy of the submitted Form PA-1540 must also be submitted by the CHC-MCO to the Department's Contract Monitor (i.e., Contract Officer). The reports must be submitted on the DHS Form PA-1540. The form may not be revised, altered, or re-created.
5. If the CHC-MCO is non-compliant, CPP Division will contact the Contract Monitor to request corrective action. The Department may cancel this Agreement upon thirty (30) days written notice in the event of the CHC-MCO's failure to implement or abide by the approved plan.

R. TUBERCULOSIS CONTROL

Recommendations of the Centers for Disease Control and Prevention (CDC), United States Department of Health and Human Services (HHS) shall be followed in screening, testing and surveillance for TB and in treating and managing persons with confirmed or suspected TB. Currently the CDC recommends:

1) TB screening with an individual risk assessment and symptom evaluation at baseline (preplacement); 2) TB testing with an interferon-gamma release assay (IGRA) or a tuberculin skin test (TST) for persons without documented prior TB disease or latent TB infection (LTBI); 3) no routine serial TB testing at any interval after baseline in the absence of a known exposure or ongoing transmission; 4) encouragement of treatment for all health care personnel with untreated LTBI, unless treatment is contraindicated; 5) annual symptom screening for health care personnel with untreated LTBI; and 6) annual TB education of all health care personnel. In the event that a CHC-MCO employee is unwilling to submit to the test due to previous positive reading, allergy to testing material, or refusal, the risk assessment questionnaire must be completed. If a CHC-MCO employee refuses to be tested in accordance with this policy, the facility will not be able to contract with this provider and will need to procure the services from another source.

S. ACT 13 APPLICATION TO CHC-MCO

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

1. Pursuant to 18 Pa. C.S. Chap. 91 (relating to criminal history record information), a report of criminal history information from the Pennsylvania State Police or a statement from the State Police that its central repository contains no such information relating to that person. The criminal history record information shall be limited to that which is disseminated pursuant to 18 Pa. C.S. § 9121(b)(2) (relating to general regulations).
2. Where the applicant is not, and for the two (2) years immediately preceding the date of application has not been, a resident of this Commonwealth, the Department shall require the applicant to submit with the application a report of Federal criminal history record information pursuant to the Federal Bureau of Investigation's under Department of State, Justice, and Commerce, the Judiciary, and Related Agencies Appropriation Act, 1973 (Public Law 92-544, 86 Stat. 1109). For the purpose of this paragraph, the applicant shall submit a full set of fingerprints to the State Police, which shall forward them to the Federal Bureau of Investigation for a national criminal history check. The information obtained from the criminal record check shall be used by the Department to determine the applicant's eligibility. The Department shall ensure confidentiality of the information.
3. The Pennsylvania State Police may charge the applicant a fee of not more than \$10 to conduct the criminal record check required under subsection 1. The State Police may charge a fee of not more than the established charge by the Federal Bureau of Investigation for the criminal history record check required under subsection 2.

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

T. LOBBYING CERTIFICATION AND DISCLOSURE
(applicable to agreements \$100,000 or more)

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

U. AUDIT CLAUSE
(applicable to Agreements \$100,000 or more)

This Agreement is subject to audit in accordance with Exhibit O, the Audit Clause.

EXHIBIT C

MANAGED LONG-TERM SERVICES AND SUPPORTS REGULATORY COMPLIANCE GUIDELINES

The CHC-MCO must comply with all applicable Federal and State laws (including, but not limited to, applicable regulations found in 55 Pa. Code Chapters 52, 1101 through 1249) and policy bulletins issued, by the Department.

As a general manner, regulatory provisions that no longer apply relate to Early and Periodic Screening, Diagnosis, and Treatment requirements (EPSDT) and to the calculation of MA provider payment rates and fees.

The following is a non-exhaustive outline of regulations in Title 55 of the Pennsylvania Code and policy bulletins relating to those regulations that do not apply to the CHC-MCO:

Chapter 52. Long-term Living Home and Community-Based Services

- Subsection 52.26(e) (relating to service coordination entity as Organized Healthcare Delivery System (OHCDS))
- Section 52.27 (relating to service coordinator qualifications and training)
- Sections 52.41 and 52.42 (relating to billing and payment policies)
- Section 52.45 (relating to fee schedule rates)
- Sections 52.51 and 52.52 (relating to vendor goods and services)
- Section 52.53 (relating to OHCDS)
- Section 52.64 (relating to payment sanctions)

Chapter 1101. General Provisions

- Section 1101.21 (relating to the following definitions: Prior Authorization; Shared Health Facility)
- Subsection 1101.31(b)(13) (relating to dental services)
- Subsection 1101.31(f) (relating to program exception process)
- Subsection 1101.33(a) (relating to recipient eligibility)
- Subsection 1101.33(b) (relating to a single-provider exception)
- Section 1101.51(a) (relating to freedom of choice)
- Section 1101.61 (relating only to fees and payments)
- Section 1101.62 (relating to maximum fees)
- Subsections 1101.63(b)(1) through (9) (relating to cost payments)
- Subsection 1101.63(c) (relating to MA deductibles)
- Subsection 1101.64(b) (only as to the reference to rates and fees)
- Section 1101.65 (relating to method of payment)
- Section 1101.67 (relating to prior authorization)
- Section 1101.68 (relating to invoices)
- Section 1101.69 (relating to overpayments and underpayments)
- Section 1101.72 (relating to invoice adjustments)
- Section 1101.83 (relating to restitution and repayment)

Chapter 1121. Pharmaceutical Services

- Section 1121.2 (relating to the definitions of: CAP; Compounded Prescription; Pricing Service; Federal Upper Limit; CMS Multisource Drug; State MAC; and Usual and Customary Charge)
- Subsections 1121.52(a)(6) and (b) (relating to payment conditions)
- Subsections 1121.53(a), (b)(1), (b)(2), (c), and (f) (relating to limitations on payment)
- Section 1121.55 (relating to the Department's payment to pharmacies)
- Section 1121.56 (relating to Drug Cost Determination)

Chapter 1123. Medical Supplies

- Section 1123.1 (only as to the reference to MA Fee Schedule)
- Subsections 1123.13(a) and (b) (relating to inpatient services)
- Subsection 1123.22(1) and (2) (relating to medical supplies which have been prescribed through the school medical program and EPSDT)
- Section 1123.51 (only as to the reference to MA Fee)
- Section 1123.53 (relating to hemophilia products)
- Section 1123.54 (relating to Orthopedic shoes)
- Section 1123.55 (relating to oxygen and related equipment)
- Section 1123.56 (relating to vision aids)
- Section 1123.57 (relating to hearing aids)
- Subsections 1123.58 (relating to prostheses and orthoses)
- Section 1123.60 (relating to limitations on payment)
- Section 1123.61 (relating to non-compensable services and items)
- Section 1123.62 (relating to method of payment)
- MA Bulletin 05-86-02
- MA Bulletin 05-87-02
- MA Bulletin 1123-91-01

Chapter 1126. Ambulatory Surgical Center and Hospital Short Procedure Unit Services

- Subsections 1126.51(f) through (h), and (k) through (m) (relating to payment for same-day surgical services)
- Subsections 1126.52 (relating to maximum reimbursement and developed fees)
- Subsection 1126.53(b) (relating to limitations on covered procedures)
- Subsection 1126.54(a)(7) (relating to sex reassignment)
- Subsections 1126.54(b) (relating to non-compensable services and items)

Chapter 1127. Birth Center Services

- Subsection 1127.51(d) (relating to claims submissions)
- Subsections 1127.52(a) through (c) (relating to fees and payment methodology)
- Subsection 1127.52(d) (relating to termination of birth center services during prenatal care)
- Subsection 1127.52(e) (relating to payment if complications develop during labor and patient is transferred to a hospital)
- Subsection 1127.53(c) (relating to limitations on payment)

Chapter 1128. Renal Dialysis Facilities

- Subsection 1128.51(a) – (d) (only as it relates to payment provisions)
- Subsection 1128.51(f) through (m) (only as it relates to fees)
- Subsection 1128.51(n) (relating to payment to Out-of-State dialysis facilities)
- Section 1128.52 (relating to payment criteria)
- Subsection 1128.53(a) through (e) (relating to limitations on payment)
- Subsection 1128.53(f) (only as it relates to payment for back up visits)
- Subsection 1128.53(g) (relating to limitations on payment)

Chapter 1129. Rural Health Clinic Services

- Subsection 1129.51(b) and (c) (only as it relates to billings to, and payments from, the Department to payment to Rural Health Clinics)
- Sections 1129.52 and 1129.53 (relating to payment policies for Rural Health Clinics)

Chapter 1130. Hospice Services

- Subsections 1130.22(4), 1130.41(a), 1130.41(c) and Subsection 1130.42(a) (only as it relates to the use of the specific form; however, the provider must have a form that is substantively the same)
- Subsection 1130.63(b) (relating to limitations on coverage)
- Subsection 1130.63(c) (to the extent it provides that bereavement counseling is not reimbursable)
- Subsection 1130.63(e) (relating to limitations on coverage)
- Subsection 1130.71(d) through (h) (as those provisions relate to MA payments process)
- Section 1130.72 (relating to services performed by hospice physicians)
- Section 1130.73 (relating to additional payment to nursing facility residents)

Chapter 1140. Healthy Beginnings Plus Program

- Subsections 1140.52(2), 1140.53 and 1140.54(1) (as those provisions relate to billing, payment process and non-compensable services and items)

Chapter 1141. Physicians' Services

- Subsection 1141.53(a) through (c) (relating to payment made in an approved short procedure unit only if the service could not appropriately and safely be performed in the physician's office, clinic or ED of a hospital; prior authorization requirements for specialists' examinations and consultations; and services provided to recipients in skilled and intermediate care facilities by the physician administrator or medical director)
- Subsection 1141.53(f) and (g) (relating to all covered outpatient physicians' services billed to the Department shall be performed by such physician personally or by a registered nurse, physician's assistant, or a midwife under the physician's direct supervision; and payment by the Department of a Ten Dollar (\$10.00) per month fee to physicians who are approved by the Department to participate in the restricted recipient program)
- Subsection 1141.54(a)(1) through (3) (relating to when a physician is eligible to bill the Department for services provided to a hospitalized recipient)

- Subsection 1141.54(f) (relating to inpatient physicians' services billed to the Department shall be performed by the physician, an RN, physician's assistant or midwife under the physician's direct supervision)
- Subsection 1141.55(b)(1) (only as it relates to the Department's forms)
- Subsections 1141.55(c), 1141.55(c)(2) and Subsection 1141.55(c)(3) and 1141.56(a)(3) (to the extent those provisions referenced the Provider Handbook)
- Subsection 1141.57(a)(2) (only to the extent that the incident must be reported within seventy-two (72) hours)
- Subsection 1141.57(a)(1)(i) (to the extent of the invoice and report)
- Subsection 1141.57(a)(2)(i) (to the extent of the invoice and report)
- Subsections 1141.59(1) through (5), 1141.59(7) and (8), and 1141.59(10) and (11) and 1141.59(14) through (16) (relating to non-compensable services)
- Section 1141.60 (relating to payment for medications dispensed or ordered in the course of an office visit)

Chapter 1142. Midwives' Services

- Section 1142.51 (only as to MA payment fees)
- Subsection 1142.52(2) (only as to MA billing)
- Subsection 1142.55 (relating to non-compensable services)

Chapter 1143. Podiatrists' Services

- Section 1143.2 (only as to the definition of Medically Necessary)
- Section 1143.51 (only as to the MA fee schedule)
- Section 1143.53 (relating to payment conditions for outpatient services)
- Section 1143.54 (relating to payment conditions for inpatient hospital services)
- Subsection 1143.55 (relating to payment conditions for diagnostic services)
- Section 1143.56 (relating to payment conditions for orthopedic shoes, molded shoes and shoe inserts)
- Section 1143.57 (relating to limitations on payment for podiatrist visits and x-rays)
- Subsection 1143.58(a)(1) through (12) (relating to non-compensable services and items for podiatry services)
- Subsection 1143.58(b) (relating to non-compensable services and items)

Chapter 1144. Certified Registered Nurse Practitioner Services

- Subsection 1144.42(b) (only as to the reference to the Department)
- Subsection 1144.52 (relating to payment conditions)
- Subsection 1144.53 (relating to non-compensable services)

Chapter 1145. Chiropractor's Services

- Subsections 1145.11 through 1145.14 (relating to services and payment limitations)
- Section 1145.51 (only as to the MA fee schedules and billing)
- Section 1145.54 (relating to non-compensable services)

Chapter 1147. Optometrists' Services

- Section 1147.2 (only as to remove "untinted" from the definition of "Eyeglasses")
- Section 1147.11 (only as to MA)
- Section 1147.12 (only as to MA fee schedules)

- Section 1147.13 (only as to MA fee Schedules)
- Subsection 1147.14(1) (relating to orthoptic training)
- Section 1147.23 (to the extent of "only" and "They are not eligible for eyeglasses, low vision aids or eye prostheses. However, State Blind Pension recipients are eligible for eye prostheses if they are also categorically needy.")
- Section 1147.51 (relating to limitations on payment; and non-compensable services and items; Medical Assistance Program fee schedule; and Optometric services shall be billed in the name of the optometrist providing the service)
- Section 1147.53 (relating to limitations on payments for optometric services)
- Section 1147.54 (relating to non-compensable optometric services and items)

Chapter 1149. Dentists' Services

- Section 1149.1 (only as to MA fee schedule)
- Subsection 1149.43(6) (relating to radiographs are requested by the Department for prior authorization purposes)
- Subsection 1149.43(9) through (11) (relating to pathology reports are required for surgical excision services; pre-operative X-rays are required for surgical services; and postoperative X-rays are required for endodontic procedures)
- Section 1149.51 (relating to general payment policy)
- Section 1149.52 (relating to payment conditions for various dental services)
- Section 1149.54 (relating to payment policies for orthodontic services)
- Subsection 1149.55(1) and Subsections 1149.55(5) through (8) (relating to payment policies for orthodontic services)
- Section 1149.56 (relating to payment limitations for orthodontic services)
- Section 1149.57 (relating to non-compensable dental services and items)

Chapter 1150. Medical Assistance Program Payment Policies

- Section 1150.2 (only as to definitions of place of service review (PSR) and Second Opinion program)
- Subsections 1150.51 (relating to general Medical Assistance Program payment policies)
- Section 1150.52 (relating to payment for Anesthesia services)
- Section 1150.54 (relating to payment for surgical services)
- Section 1150.55 (relating to payment for obstetrical services)
- Section 1150.56 (relating to payment for medical services)
- Section 1150.56a (relating to payment policy for consultations)
- Section 1150.57 (relating to payment for diagnostic services and radiation therapy)
- Section 1150.58 (relating to prior authorization)
- Section 1150.59 (relating to the PSR Program)
- Section 1150.60 (relating to the Second Opinion Program)
- Section 1150.61 (relating to guidelines for fee schedule changes)
- Section 1150.62 (relating to payment levels and notices of rate setting changes)
- Section 1150.63 (only as to references to the Department and CAO)

Chapter 1151. (relating to inpatient psychiatric services)

Chapter 1153. (relating to outpatient psychiatric services)

Chapter 1163. Inpatient Hospital Services, Subchapter A, Acute Care General Hospitals under the Prospective Payment System

- Section 1163.32 (relating to hospital units excluded from the DRG prospective payment system)
- Subsections 1163.51 (relating to payment for hospital services)
- Sections 1163.52 through 1153.59 (relating to prospective payment methodology, assignment of DRG, prospective capital reimbursement system, payments for direct medical education, outliers, payment policy for readmissions and transfers, and non-compensable services and items and outlier days)
- Subsection 1163.60(b)(1), Subsection 1163.60(c)(2), and Subsection 1163.60(c)(3) (only as to references to the Provider Handbook)
- Subsections 1163.62(a)(2) through 1163.65 (relating to payment conditions for abortions , billing, cost reports, and payment for out-of-state services)
- Subsection 1163.66(b) through (g) (relating to third party liability)
- Section 1163.67 (relating to disproportionate share payments)
- Sections 1163.70 (relating to changes of ownership or control)
- Subsections 1163.72(a), (c) through (g) (relating to general utilization review, admissions, day and cost outliers)
- Sections 1163.73 (relating to hospital utilization review plan)
- Subsections 1163.75 (6) and (12) (relating to, the Department's forms and manual)
- Sections 1163.76 through 1163.77 (only as to the written plan of care within two (2) days of admission and admission review requirements within twenty-four (24) hours of admission)
- Section 1163.78a and 1163.78b (relating to review requirements for day outliers and cost outliers)
- Subsections 1163.92(a) through (f) (relating to administrative sanctions)
- Subsection 1163.101(a) (relating to right to appeal under Chapter 1101 (relating to general provisions))
- Section 1163.122 (relating to determination of DRG relative values)
- Section 1163.126 (relating to computation of hospital specific computation rates)

Chapter 1163. Inpatient Hospital Services, Subchapter B, Hospitals and Hospital Units Under Cost Reimbursement Principles

- Section 1163.402 (only as to definition of "certified day")
- Subsections 1163.451 (relating to general payment policies)
- Section 1163.452 (relating to payment methods and rates)
- Subsections 1163.453(a) and (c) (relating to allowable and non-allowable costs, allowable costs for inpatient services, payment not higher than hospital's customary charge)
- Subsections 1163.453(d) (2) through (9) (relating to costs not allowable under the

Medical Assistance Program)

- Subsections 1163.453(e) and (f) (relating to allowable costs)
- Section 1163.454 (relating to limitations on payment)
- Subsection 1163.455 (a)(1) through (5) and (7) through (16) (relating to non-compensable inpatient services)
- Subsection 1163.455 (b) and (c) (relating to non-compensable inpatient services)
- Section 1163.457 (relating to payment policies relating to out-of-state hospitals)
- Section 1163.458 (relating to payment policies relating to same calendar day admissions and discharges)
- Section 1163.459 (relating to disproportionate share payments)
- Section 1163.472 (relating to concurrent hospital review)
- Section 1163.476 and 1163.477 (only as to the written plan of care within two (2) days of admission and admission review requirements within twenty-four (24) hours of admission)
- Subsection 1163.481(b) and (c) (relating to utilization review sanctions)
- Section 1163.501 (relating to provider right to appeal)
- Section 1163.511 (relating to change of ownership or control)

Chapter 1181. Nursing Facility Care

- Subchapter A (related to nursing facility care)
- Subchapter B (related to manual for allowable cost reimbursement for skilled nursing and intermediate care facilities)

Chapter 1187. Private Nursing Facility Services

- Section 1187.2 (for definitions relating to payment calculation)
- Subsection 1187.21(4) (only as to "Payment will be based on criteria found in § 1187.101(b) (relating to general payment policy)")
- Section 1187.23 (relating to nursing facility incentives and adjustments)
- Subsections 1187.33(b)(1)-(3) (relating to sanctions)
- Subchapter E (relating to allowable program cost policies)
- Subchapter F, except for 1187.78 (relating to accountability requirements related to resident personal fund management) and 1187.79 (relating to auditing requirements related to resident personal fund management)
- Subchapter G
- Subsection 1187.102(e) (only as to reporting allowable Medicare Part B-type costs)
- Section 1187.103 (relating to cost finding and allocation of costs)
- Section 1187.104 (only as to payment rates)
- Section 1187.105 (relating to limitations on payment for prescription drugs)
- Section 1187.106 (relating to limitations on payment during strike or disaster situations requiring resident evacuation)
- Sections 1187.107 through 1187.117, including 1187.113a and 1187.113b (relating to payment provisions)
- Subchapter J (relating to NF right of appeal)
- Subchapter K (relating to exceptional payments for nursing facility services)

Chapter 1189. County Nursing Facility Services

- Sections 1189.1 and 1189.2 (relating to policy and definitions)
- Section 1189.2C (relating to payment calculations)
- Subchapter B (relating to allowable program costs and policies)
- Section 1189.75 (related to auditing requirements for MA Cost Reports)
- Subchapter D (relating to rate setting)
- Subsection 1189.102(e) (relating to reporting allowable Medicare Part B-type costs)
- Subsection 1189.71 (related to cost reporting) and 1189.72 (related to cost reporting for Medicare Part B type services)
- Section 1189.103 (only as to payment)
- Section 1189.104 (relating to limitations on payment during strike or disaster situations requiring resident evacuation)
- Section 1189.105 (relating to incentive payments)
- Section 1189.106 (relating to adjustments relating to sanctions and fines)
- Section 1189.107 (relating to adjustment relating to errors and corrections of NF payments)
- Section 1189.108 (relating to supplemental payments)
- Subchapter F (relating to county facility right of appeal)

Chapter 1221. Clinic and Emergency Room Services

- Sections 1221.43 through 1221.44 (relating to participation requirements for hospital clinics and emergency rooms for higher reimbursement rates, and additional participation requirements for independent clinics)
- Sections 1221.51 and 1221.52 (relating to general payment policy for clinic and emergency room services and payment conditions for various services)
- Subsection 1221.55(b)(1) (except that an informed consent form is required)
- Subsections 1221.57(a)(2) and 1221.57(c) (except that the CHC-MCO must comply with Medical Assistance Bulletin 99- 95-09)
- Sections 1221.58 and 1221.59 (relating to limitations on payments and non-compensable services and items)
- MA Bulletin 11-95-04
- MA Bulletin 11-95-10
- MA Bulletin 11-95-12

Chapter 1223. Outpatient Drug and Alcohol Clinic Services

Chapter 1225. Family Planning Clinic Services

- Sections 1225.1 and 1225.51 (only as to MA fees)
- Subsection 1225.54(2) (relating to non-compensable family planning services)

Chapter 1230. Portable X-Ray Services

- Sections 1230.1, 1230.51 and 1230.52(b) (only as to MA fees)
- Subsection 1230.53 (relating to portable x-ray services, provider maximum payment, payment for transportation of portable x-ray equipment, and electrocardiogram services)
- Subsection 1230.54 (relating to non-compensable)

Chapter 1239. Medical Assistance Case Management Services for Recipients under the Age of 21

- MA Bulletin 99-94-08

Chapter 1241. Early and Periodic Screening, Diagnosis, and Treatment Program

Chapter 1243. Outpatient Laboratory Services

- Section 1243.1 and 1243.51 (only as to MA fees)
- Subsection 1243.52(b) (only as to billing)
- Subsection 1243.53(a) (relating to limitations on payment)
- Subsection 1243.54(1)(2) (relating to non-compensable services)

Chapter 1245. Ambulance Transportation

- Section 1245.1 (only as to MA fees)
- Subsection 1245.52(1) (relating to payment conditions for ambulance services)
- Subsections 1245.52(3) through (5) (relating to transportation to the nearest appropriate medical facility and medical services/supplies invoice)
- Section 1245.53 (relating to limitations on payment for ambulance service when more than one patient is transported. Payment is made for transportation of the patient whose destination is the greatest distance. No additional payment is allowed for the additional person)
- Subsections 1245.54(1) through (7) (relating to non-compensable services)

Chapter 1249. Home Health Agency Services

- Section 1249.1 and 1249.51 (only as to MA fee schedule)
- Section 1249.52 (relating to payment conditions for various services.)
- Subsection 1249.55(a) (only as to MA fee schedule) and (b) (relating to reimbursement for supplies)
- Section 1249.57(a) (relating to payment conditions for maternal/child services) and 1249.57 (b).
- Section 1249.58 (relating to payment conditions for travel costs)
- Section 1249.59 (relating to limitations on payment)

EXHIBIT D

DRUG SERVICES

1. General Requirements

- a. All requirements in this Exhibit apply to all Covered Drugs regardless of the setting in which the drug is dispensed or administered the billing provider type, or how the CHC-MCO makes payment for the drug (pharmacy benefit and medical benefit).
- b. The amount, duration, and scope of Covered Drugs must be consistent with coverage under the Fee-for-Service (FFS) program. The CHC-MCO must cover all Covered Drugs listed on the CMS Quarterly Drug Information File when determined to be Medically Necessary, unless otherwise excluded from coverage. (See Section 2, Coverage Exclusions, below for exclusions.) This includes brand-name and generic drugs, and over-the-counter drugs (OTCs), prescribed by licensed Providers enrolled in the Medical Assistance program, and sold or distributed by drug manufacturers that participate in the Medicaid Drug Rebate Program.
- c. The CHC-MCO must provide coverage for all medically accepted indications, as described in Section 1927(k)(6) of the Social Security Act, 42 U.S.C.A. § 1396r-8(k)(6). This includes any use which is approved under the Federal Food, Drug, and Cosmetic Act, 21 U.S.C.A. §§ 301 et seq., or whose use is supported by the nationally recognized pharmacy compendia, or peer-reviewed medical literature.
- d. Unless financial responsibility is otherwise assigned, all Covered Drugs are the payment responsibility of the Participant's CHC-MCO. The only exception is that the behavioral health managed care organization (BH-MCO) is responsible for the payment of methadone when used in the treatment of substance abuse disorders and when prescribed and dispensed by BH-MCO Service Providers.
- e. All Covered Drugs must be dispensed through CHC-MCO Network Providers. This includes Covered Drugs prescribed by both the CHC-MCO and the BH-MCO Providers.
- f. Under no circumstances will the CHC-MCO permit the therapeutic substitution of a drug by a pharmacist without explicit authorization from the licensed prescriber.
- g. All proposed Covered Drug policies, programs, and drug Utilization Management programs, such as but not limited to Prior Authorization, Step Therapy, partial fills, specialty pharmacy, pill-splitting, mail order, 90-day supply programs, limited pharmacy networks, medication therapy management programs, etc., must be submitted to the Department for review and written approval prior to implementation, prior to implementation of any changes, and annually thereafter.

- h. The CHC-MCO must include in its written policies and procedures an assurance that all requirements and conditions governing coverage and payment for Covered Drugs, such as, but not limited to, Prior Authorization (including Step Therapy), medical necessity guidelines, age edits, drug rebate Encounter submission, reporting, notices of decision, etc., will:
 - i. Apply, regardless of whether the Covered Drug is provided as a drug benefit or as a “medical benefit” incident to a medical service and billed by the prescribing Provider using codes such as the Healthcare Common Procedure Coding System (HCPCS).
 - ii. Ensure access for all medically accepted indications as documented by package labeling, nationally recognized pharmacy compendia, peer-reviewed medical literature, Statewide Preferred Drug List (PDL) prior authorization guidelines, if applicable, and FFS guidelines to determine medical necessity of drugs that require Prior Authorization in the Medical Assistance FFS Program, when designated by the Department.
- i. The CHC-MCO must submit for review and approval a policy for each section of Exhibit D that includes the requirements in the respective section and the CHC-MCO’s procedures to demonstrate compliance.
- j. The CHC-MCO must agree to adopt the same requirements for prior authorization and some or all of the same guidelines to determine medical necessity of selected drugs or classes of drugs as those adopted by the Medical Assistance FFS Program when designated by the Department.
- k. The CHC-MCO must comply with Section 2117 of Article XXI of the Insurance Company Law of 1921, 40 P.S. § 991.2117 regarding continuity of care requirements and 28 Pa. Code Chapter 9. The CHC-MCO must also comply with the procedures outlined in Medical Assistance Bulletin # 99-03-13 and Medical Assistance Bulletin #99-96-01. The CHC-MCO policy and procedures for continuity of care for drugs, and all subsequent changes to the Department-approved policy and procedures, must be submitted to the Department for review and approval prior to implementation. The policy and procedures must address how the CHC-MCO will ensure no interruption in drug therapy and the course of treatment, and continued access to drugs that the Participant was prescribed before enrolling in the CHC-MCO.
- l. The CHC-MCO must allow access to all new drugs approved by the Food and Drug Administration (FDA) and meet the definition of a Covered Drug either by addition to the Statewide PDL or MCO Formulary or through prior authorization, within 10 days from their availability in the marketplace.
- m. The CHC-MCO must comply with 1902(a)(85); Section 1004 of the Substance Use Disorder Prevention that Promotes Opioid Recovery and Treatment for Patients and Communities Act (SUPPORT Act). The CHC-MCO will

implement prospective safety edits on subsequent fills of opioid prescriptions, as specified by the state, which may include edits to address days' supply, early refills, duplicate fills, and quantity limitations for clinical appropriateness.

2. Coverage Exclusions

- a. In accordance with Section 1927 of the Social Security Act, 42 U.S.C.A. § 1396r-8, the CHC-MCO must exclude coverage for any drug marketed by a drug company (or labeler) that does not participate in the Medicaid Drug Rebate Program. The CHC-MCO is not permitted to provide coverage for any drug product, brand name or generic, legend or non-legend, sold or distributed by a company that did not sign an agreement with the federal government to provide rebates to the Medicaid agency. This requirement does not apply to vaccines, compounding materials, certain vitamins and minerals or diabetic supplies.
- b. The CHC-MCO may not provide coverage for Drug Efficacy Study Implementation (DESI) drugs under any circumstances.
- c. The CHC-MCO must exclude coverage of non-compensable drugs in accordance with 55 Pa. Code § 1121.54

3. Formularies and Preferred Drug Lists (PDLs)

- a. The CHC-MCO must utilize the Statewide PDL developed by the Department's Pharmacy and Therapeutics (P&T) Committee.

If the CHC-MCO fails to meet Statewide PDL quarterly compliance of 95% (excluding TPL) a financial sanction consistent with the difference in net cost using CHC-MCO actual compliance rate and the net cost if compliance rate was 95%. The minimum penalty of \$25,000 per quarter will be imposed. The CHC-MCO is responsible for submitting prior authorization approval and denial information in a format designated by the Department.

- b. The CHC-MCO must implement use of the Statewide PDL, any changes to the Statewide PDL, the Statewide PDL prior authorization guidelines, and any changes to the Statewide PDL prior authorization guidelines on the effective date provided by the Department.
- c. The CHC-MCO must apply Statewide PDL prior authorization guidelines to all drugs and products included on the Statewide PDL. The CHC-MCO may not impose additional prior authorization requirements for drugs and products included on the Statewide PDL. Quantity limits can be no more restrictive than the Department's quantity limits. The CHC-MCOs may develop brand Medically Necessary prior authorization policies to determine whether a specific drug is Medically Necessary when both the brand and generic product of a specific drug are non-preferred on the Statewide PDL.

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

the Department and at least annually.

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

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

- e. The CHC-MCO must allow access to all non-formulary or non-preferred drugs that are included in the CMS Quarterly Drug Information File, other than those excluded from coverage by the Department, when determined to be Medically Necessary through a process such as Prior Authorization (including Step Therapy), in accordance with Section V. B.1., Prior Authorization of Services, and Exhibit E, Prior Authorization Guidelines for the CHC-MCO, and this Exhibit.
- f. The CHC-MCO must receive written approval from the Department of the Formulary or PDL, the list of specialty drugs, quantity limits, age edits, and the policies, procedures and guidelines to determine medical necessity of drugs and products not included on the Statewide PDL that require Prior Authorization, including drugs that require Step Therapy and drugs that are designated as non-formulary or non-preferred, prior to implementation of the Formulary or PDL, the designation of specialty, and the requirements. CHC-MCOs may add drugs to the specialty drug list that are in therapeutic classes already included on the specialty drug list prior to receiving approval from the Department. However, these additions must be included in the specialty drug designations submitted to the Department for written approval. Submissions for annual reviews must occur at least 30 days before the effective date of the updated information.
- g. The CHC-MCO must submit all Formulary or PDL deletions for drugs and products outside the scope of the Statewide PDL to the Department for review and written approval prior to implementation.
- h. The CHC-MCO must submit written notification of any Formulary or PDL additions for drugs and products outside the scope of the Statewide PDL to the Department within fifteen (15) days of implementation.
- i. In addition to providing a link to the Statewide PDL on the CHC-MCO's website, the CHC-MCO must make available on the website in electronic format, information about its drug Formulary or PDL, listing which medications are covered, including both brand and generic names.

4 Prior Authorization of Drugs

- a. For Covered Drugs that require Prior Authorization (including Step Therapy) as a condition of coverage or payment:

- i. The CHC-MCO must provide a response to the request for Prior Authorization by telephone or other telecommunication device to approve or deny the prescription within twenty-four (24) hours of the request; and
- ii. If a Participant's prescription for a medication is not filled when a prescription is presented to the pharmacist due to a Prior Authorization requirement, the CHC-MCO must instruct the pharmacist to dispense either:
 - 1) A fifteen (15) day supply if the prescription qualifies as an Ongoing Medication.
 - 2) A seventy-two (72) hour supply of a new medication.
- b. For drugs not able to be divided and dispensed into individual doses, the CHC-MCO must instruct the pharmacist to dispense the smallest amount that will provide at least a seventy-two (72) hour or fifteen (15) day supply, whichever is applicable.
- c. The requirement that the Participant be given at least a seventy-two (72) hour supply for a new medication or a fifteen (15) day supply for an Ongoing Medication does not apply when a pharmacist determines that the taking of the prescribed medication, either alone or along with other medication that the Participant may be taking, would jeopardize the health or safety of the Participant. The CHC-MCO and/or its subcontractor must require that its participating dispensing Provider make good faith efforts to contact the prescriber.
- d. If the CHC-MCO denies the request for Prior Authorization, the CHC-MCO must issue a written denial notice to the Participant and the Provider, using the appropriate Drug Denial Notice template within twenty-four (24) hours of receiving the request for Prior Authorization. The specific reason(s) for denial must be included in the notice of decision. If additional information is required to approve the request, the specific documentation needed must be listed in the notice. If the requested drug is non-preferred/non-formulary and within the scope of the Statewide PDL or the CHC-MCO's Formulary, the CHC-MCO must list preferred alternatives appropriate for the beneficiary's diagnosis and clinical condition in the denial notice.
- e. If the CHC-MCO approves the request for prior authorization, the CHC-MCO must issue a written approval notice to Participant and Provider including the drug name and strength, effective and end dates of the approval within twenty-four (24) hours of receiving the request for prior authorization.
- f. If the Participant files a Grievance or DHS Fair Hearing request from a denial of an Ongoing Medication, the CHC-MCO must authorize the medication until the Grievance or DHS Fair Hearing request is resolved.

- g. When medication is authorized due to the obligation to cover pre-existing services while a Grievance or DHS Fair Hearing is pending, a request to refill that prescription, made after the Grievance or DHS Fair Hearing has been finally concluded in favor of the MCO, is not an Ongoing Medication.
- h. Requests for Prior Authorization will not be denied for lack of Medical Necessity unless a physician reviews the request for a Medical Necessity determination. Such a request for Prior Authorization must be approved when, in the professional judgment of the physician reviewer, the services are Medically Necessary to meet the medical needs of the Participant.
- i. When medication is authorized due to the CHC-MCO's obligation to continue services while a Participant's Grievance or Fair Hearing is pending, and the final binding decision is in favor of the CHC-MCO, a request for subsequent refill of the prescribed medication does not constitute an Ongoing Medication.
- j. The CHC-MCO guidelines to determine Medical Necessity of Covered Drugs outside the scope of the Statewide PDL cannot be more stringent than the FFS guidelines. The CHC-MCO must follow the Statewide PDL Prior Authorization guidelines for drugs and products included on the Statewide PDL.
- k. The CHC-MCO must comply with the requirements of Section V. B. 1. Of the Agreement, Prior Authorization of Services, and Exhibit E, Prior Authorization Guidelines for CHC-MCOs, and receive written approval from the Department prior to implementation and annually thereafter. If a CHC-MCO covers a specific drug through both their medical and pharmacy benefits, the CHC-MCO must apply the same Department approved prior authorization guidelines to prior authorization requests.

5. Provider and Participant Notification

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

- a. Written notification for changes to the requirements must be provided to all affected Providers and Participants at least thirty (30) days prior to the effective date of the change.
- b. The CHC-MCO must provide all other Providers and Participants written notification of changes to the requirements upon request.
- c. The CHC-MCO also must generally notify Providers and Participants of

changes through Participant and Provider newsletters, its website, or other regularly published media of general distribution.

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

6. CHC-MCO Pharmacy & Therapeutics (P&T) Committee

- a. The P&T Committee membership must include physicians (including a minimum of two (2) behavioral health physicians), pharmacists, Medical Assistance Program Participants and other appropriate clinicians. Medical Assistance Program Participant representative membership must include the following:
 - i. One (1) physical health Participant representative. The physical health Participant representative must be a Participant enrolled in the CHC-MCO, or a physician, a pharmacist, or a physical health Participant advocate designated by Participants enrolled in the CHC-MCO to represent them.
 - ii. One (1) behavioral health Participant representative. The behavioral health Participant representative must be a Participant enrolled in the CHC-MCO, or a physician, a pharmacist, a behavioral health Participant advocate, or a family member designated by Participants enrolled in the CHC-MCO to represent them.
 - iii. One (1) LTSS Participant representative. The LTSS Participant representative must be a Participant enrolled in the CHC-MCO, or a physician, a pharmacist, a LTSS Participant advocate, or a family member designated by Participants enrolled in the CHC-MCO to represent them.
- b. The CHC-MCO must submit a P&T Committee membership list for Department review and approval upon request.
- c. When the P&T Committee addresses specific drugs or entire drug classes requiring medical expertise beyond that of the P&T Committee membership, specialists with knowledge appropriate to the drug(s) or class of drugs being addressed must be added as non-voting, ad hoc members.
- d. The minutes from each CHC-MCO P&T Committee meeting must be posted for public view on the CHC-MCO's website within thirty (30) days of the date of the meeting at which the minutes are approved. Minutes will include vote totals.

7. Pharmacy Provider Network and Payment

- a. The CHC-MCO or Subcontractor must contract on an equal basis with any pharmacy qualified to participate in the Medical Assistance program that is willing to comply with the CHC-MCO's payment rates and terms and to adhere to quality standards established by the CHC-MCO as required by 62 P.S. § 449.

- i. The provisions for any willing pharmacy apply if the CHC-MCO or Subcontractor enters into agreements with specific pharmacies to provide defined drugs or services, such as but not limited to, specialty, mail order, and 90-day supplies. CHC-MCOs are required to contract on an equal basis with any pharmacy qualified to participate in the Medical Assistance program that is willing to accept the same payment rate(s) and comply with the same terms and conditions for quality standards and reporting.
 - ii. Subcontracts and agreements with specific pharmacies contracted to provide defined drugs or services must be submitted to the Department for advance written approval. Any changes to subcontracts or agreements must also be submitted to the Department for advance written approval.
 - iii. The CHC-MCO must submit annually the list of specific pharmacies contracted to provide defined drugs or services, and a list of the drugs or services each pharmacy is contracted to provide, to the Department for review and written approval. Submissions for annual reviews must occur at least thirty (30) days before the effective date of the updated information.
 - iv. The CHC-MCO must notify the Department on an ongoing basis of the following: (1) specific pharmacies that are no longer contracted to provide defined drugs or services and the reason why, (2) pharmacies that request contracting to provide defined drugs or services but are not admitted into the specific pharmacy network and the reason why, (3) any pharmacies that are only contracted to provide a limited scope of defined drugs or services and the reason why.
- b. The CHC-MCO and any subcontractor must develop, implement, and maintain a process that ensures the amount paid to all network pharmacies reflects the pharmacy's acquisition cost for the ingredient, professional services, and cost to dispense the prescription to a Medicaid beneficiary. The CHC-MCO must submit to the Department the policies and procedures for development of network pharmacy payment methodology including the process to ensure that brand and generic payment rates reflect the pharmacy's acquisition cost (from a readily available distributor doing business in Pennsylvania) and the professional dispensing fee accurately reflects the pharmacist's professional services and cost to dispense the prescription to a Medicaid beneficiary. The CHC-MCO must submit to the Department for review and approval the transparent pricing formula utilized in claims processing to determine the rates paid to pharmacies, with sufficient detail for the Department to assess compliance with Act 120 of 2020 and with the terms of this Agreement.
- c. The CHC-MCO or subcontractor must submit to the Department for review and approval all changes to the payment methodology, rates, and dispensing fees prior to implementation. This requirement applies to all changes being implemented by or on behalf of the CHC-MCO, whether through a direct or

indirect subcontract.

- d. The CHC-MCO or subcontractor must report all changes to the payment methodology, rates, and dispensing fee in advance to network pharmacy providers.
- e. The CHC-MCO or subcontractor must report all changes to the maximum allowable cost rates in real-time to network pharmacy providers.
- f. (1) If a network pharmacy's claim is approved through the adjudication process, the CHC-MCO and any subcontractor may not retroactively deny or modify the payment unless any of the following:
 - i. The claim was fraudulent.
 - ii. The claim was duplicative of a previously paid claim.
 - iii. The pharmacy did not render the service.
- (2) Nothing in 7.e.(1) shall be construed to prohibit the modification of or recovery of an adjudicated claim that was determined to be an overpayment or underpayment resulting from audit, review, or investigation by a federal or state agency or CHC-MCO.
- g. The CHC-MCO and any subcontractor shall not charge a claim transmission/transaction fee to a network pharmacy.
- h. The CHC-MCO and any subcontractor shall use a PA MA specific processor Control Number (PCN) or PA MA specific Group number for drug claims. The PCN or group number and the Bank Identification Number (BIN) shall be submitted on the claim adjudication record.
- i. The CHC-MCO and any subcontractor shall not utilize an effective rate for reimbursement to a network pharmacy, including, but not limited to, generic effective rates, brand effective rates, dispensing fee effective rates, and direct and indirect remuneration fees. For the purposes of this Exhibit, an "effective rate contract" allows for adjustment of reimbursements over time so the overall reimbursement averages out to a guaranteed amount; the result is some claims are paid below the effective rate and others are paid above the effective rate. For the purposes of this Exhibit, "direct and indirect remuneration fees" are any fees charged by PBMs to pharmacies that are outside of administration fees and are generally collected after the point of sale.

8. Drug Rebate Program

- a. The CHC-MCO must report the necessary Drug Encounter Data in order for the Department to invoice drug manufacturers for rebates for all Covered Drugs. This includes physician-administered drugs, drugs dispensed by 340B covered entities or contract pharmacies, and drugs dispensed to Participants with private or public pharmacy coverage and CHC-MCO secondary coverage.

- b. The CHC-MCO must report all Drug information, including National Drug Codes (NDCs) and accurate NDC units for all drug claim types, NCPDP, 837 Professional, 837 Institutional, etc., as designated by the Department.

If the CHC-MCO fails to submit Drug Encounter Data, then the Department shall impose a sanction of Twenty-Five Thousand Dollars (\$25,000.00) per quarter until the CHC-MCO is compliant.

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

9. Drug Encounters

- a. The CHC-MCO shall submit all Drug Encounters to the Department within thirty (30) days (for NCPDP) and 90 days (for 837P and 837I) of the adjudication date of the claim to the CHC-MCO for payment.
- b. The CHC-MCO shall provide all Pharmacy Drug Encounter Data and supporting information as specified below for the Department to collect rebates through the Medicaid Drug Rebate Program and the Statewide PDL. For all Drug Encounter Data, including pharmacy point-of-sale (NCPDP), physician-administered drugs (837P), hospital drugs (837I), and drugs dispensed by 340B-covered entities and contract pharmacies, the following data elements are required:
 - i. Valid NDC for the drug or product dispensed.
 - 1. The CHC-MCO shall also include the HCPCS code associated with the NDC for all 837P and 837I Encounters where payment was made by the CHC-MCO based on the HCPCS code and HCPCS code units.
 - 2. The CHC-MCO shall also include the diagnosis codes associated with the NDC for all 837P and 837I Encounters where payment was made by the CHC-MCO based on the HCPCS code and HCPCS code units.
 - ii. Valid NDC units for the drug or product dispensed.

1. The CHC-MCO shall also include the HCPCS units associated with the NDC for all 837P and 837I Encounters where payment was made by the CHC-MCO based on the HCPCS code and HCPCS code units.
- iii. Actual paid amount by the CHC-MCO to the Provider for the drug dispensed.
- iv. Actual TPL amount paid by the Participant's primary pharmacy coverage to the Provider for the drug dispensed.
- v. Actual copayment paid by the Participant to the Provider for the drug dispensed.
- vi. Actual dispensing fee paid by the CHC-MCO to the Provider for the drug dispensed.
- vii. The billing Provider's:
 1. NPI and/or Medical Assistance Identification Number.
 2. Full address and phone number associated with the NPI.
- viii. The prescribing Provider's:
 1. NPI and/or Medical Assistance Identification Number.
 2. Full address and phone number associated with the NPI.
- ix. The date of service for the dispensing of the drug by the billing Provider.
- x. The date of payment by the CHC-MCO, or the CHC-MCO's PBM, to the Provider for the drug.
- xi. Any other data elements identified by the Department to invoice for drug rebates.
- c. The CHC-MCO shall edit and validate claim transaction submissions and Drug Encounter Data for completeness and accuracy in accordance with claim standards such as NCPDP. The actual paid amount by the CHC-MCO to the dispensing Provider must be accurately submitted on each pharmacy Encounter to the Department.
- d. The CHC-MCO shall ensure that the NDC on all Drug Encounters is appropriate for the HCPCS code based on the NDC and units billed.
- e. The Department will review the Drug Encounters and remove applicable 340B covered entity Encounters from the drug rebate invoicing process.
- f. The CHC-MCO shall meet Drug Encounter Data accuracy requirements by

submitting CHC-MCO paid pharmacy Encounters with no more than a three percent (3%) error rate, calculated for a month's worth of Encounter submissions. The Department will monitor the CHC-MCO's corrections to denied Encounters by random sampling performed quarterly and over the term of this Agreement. The CHC-MCO shall have corrected and resubmitted seventy-five percent (75%) of the denied Encounters for services covered under this Agreement included in the random sample within thirty (30) calendar days of denial.

- g. If the CHC-MCO fails to submit Drug Encounter data within timeframes specified, the Department shall assess civil monetary penalties upon the CHC-MCO. These penalties shall be Two Thousand Dollars (\$2,000.00) for each calendar day that the Drug Encounter Data is not submitted. The Department may waive these sanctions if it is determined that the CHC-MCO was not at fault for the late submission of the data.

10. Prospective Drug Utilization Review (Pro-DUR)

- a. The CHC-MCO must provide for a review of drug therapy before each prescription is filled or delivered to a Participant at the point-of-sale or point-of-distribution. The review shall include screening for potential drug therapy problems due to therapeutic duplication, drug-disease contraindications, drug-drug interactions, incorrect drug dosage or duration of drug treatment, drug-allergy interactions and clinical abuse/misuse.
- b. The CHC-MCO must provide for counseling of Participants receiving benefits from pharmacists in accordance with State Board of Pharmacy requirements.

11. Retrospective Drug Utilization Review (Retro-DUR)

- a. The CHC-MCO must, through its drug claims processing and information retrieval system, examine claims data and other records to identify patterns of fraud, abuse, gross overuse, or inappropriate or medically unnecessary care among physicians, pharmacists, and Participants.
- b. The CHC-MCO shall, on an ongoing basis, assess data on drug use against explicit predetermined standards (using nationally recognized compendia and peer-reviewed medical literature), including but not limited to monitoring for therapeutic appropriateness, overutilization and underutilization, appropriate use of generic products, therapeutic duplication, drug-disease contraindications, drug-drug interactions, incorrect drug dosage or duration of drug treatment, and clinical abuse/misuse, and, as necessary, introduce remedial strategies, in order to improve the quality of care.
- c. The CHC-MCO shall provide for active and ongoing educational outreach programs to educate practitioners on common drug therapy problems

aimed at improving prescribing or dispensing practices.

12. Annual DUR Report

The CHC-MCO must submit an annual report on the operation of its Pennsylvania Medicaid Drug Utilization Review (DUR) program in a format designated by the Department. The format of the report will include a description of the nature and scope of the prospective and retrospective drug use review programs, a summary of the interventions used, an assessment of the impact of these educational interventions on quality of care, and an estimate of the cost savings generated as a result of the DUR program.

13. Drug Utilization Review Board (DUR Board)

The Department maintains a DUR Board that reflects the structure of the healthcare delivery model that includes both a managed care and a Fee-for-Service delivery system. Each CHC-MCO that does not already include a PH-MCO representative and each BH-MCO is required to include a representative to serve as a member of the DUR Board. The DUR Board is a standing advisory committee that recommends the application of predetermined standards related to Pro-DUR, Retro-DUR, and related administrative and educational interventions designed to protect the health and safety of the Medical Assistance Program Participants. The Board reviews and evaluates pharmacy claims data and prescribing practices for efficacy, safety, and quality against predetermined standards using nationally recognized drug compendia and peer-reviewed medical literature as a source. The Board recommends appropriate utilization controls and protocols, including Prior Authorization, automated Prior Authorization, system edits, guidelines to determine medical necessity, generic substitution, and quantity limits for individual medications or for therapeutic categories.

14. Pharmacy Benefit Manager (PBM)

The CHC-MCO may use a PBM to process prescription Claims only if the PBM Subcontract complies with the provisions in Section XII, Sub-contractual Relationships, Exhibit P: Required Contract Terms for Administrative Subcontractors, and has received advance written approval by the Department. The standards for Network composition and adequacy for Covered Drug services includes the requirements for any willing pharmacy as described above. The CHC-MCO must indicate the intent to use a PBM, identify the proposed PBM Subcontract and the ownership of the proposed PBM subcontractor.

The PBM subcontract must be submitted in unredacted format to the Department for review and written approval prior to implementation, prior to implementation of any changes, and annually thereafter. Changes that only impact non-Community HealthChoices lines of business do not need to be submitted for Department approval. The final Department-approved, fully executed, and unredacted CHC-MCO and PBM subcontract must be submitted to the Department.

If the PBM is owned wholly, in part, or by the same parent company as a CHC-MCO, retail pharmacy Provider, chain drug store or pharmaceutical manufacturer,

the CHC-MCO must submit a written description of the assurances and procedures that will be put in place under the proposed PBM Subcontract, such as an independent audit, to assure confidentiality of proprietary information. These assurances and procedures must be submitted and receive advance written approval by the Department prior to initiating the PBM Subcontract. The Department will allow the continued operation of existing PBM Subcontracts while the Department is reviewing new contracts.

The CHC-MCO must:

- a. Report the PBM's payment methodology, or methodologies for actual payment to all network pharmacy providers of covered drugs, including community pharmacies, long-term care pharmacies, network pharmacies contracted to provide specialty drugs, and dispensing prescribers for existing PBM Subcontractors and new PBM Subcontractors.
- b. Submit unredacted PBM contracts with the CHC-MCO's network pharmacies upon request.
- c. Include on each drug encounter the PBM received amount (amount paid to the PBM by the CHC-MCO [ingredient cost and dispensing fee]) and the provider received amount (the actual amount paid by the PBM [ingredient cost and dispensing fee] to the dispensing pharmacy or prescribing provider.
- d. Report any differences between the amount paid by the CHC-MCO to the PBM and the amount paid by the PBM to the providers of covered drugs as other fees.
- e. Report all PBM fees charged to the CHC-MCO and to the pharmacy provider, in a format designated by the Department.
- f. Submit a written description of the procedures that the CHC-MCO will put in place to monitor the PBM for compliance with the term and conditions of the Agreement related to covered drugs and actual payments to the providers of covered drugs.
- g. Upon request by the Department, conduct an independent audit of the PBM's transparent pricing arrangement in compliance with the provision in Exhibit O CHC Audit Clause.
- h. Ensure that the PBM is fully compliant with the requirements in Section V. T. Provider Dispute Resolution System.
- i. Develop, implement, and maintain a Second Level PBM Provider Pricing Dispute Resolution Process that provides for settlement of a PBM network Provider's pricing dispute with the PBM, on the condition that the PBM's network Provider exhausted all of its remedies against the PBM.
- j. Submit to the Department, prior to implementation, the CHC-MCO's policies and procedures relating to the resolution of PBM Provider pricing disputes.
 - i. The CHC-MCO must submit any changes to the policies and procedures to the Department for approval prior to implementation of the changes.

- ii. 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 that 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 the Department approves the new or revised version.
- k. At a minimum, include in the CHC-MCO's Second Level PBM Provider Pricing Dispute Resolution policies and procedures the following:
 - i. The process for submission and settlement of Second Level PBM Provider Pricing Disputes;
 - ii. A requirement that the PBM Provider must exhaust all of its remedies against the PBM before requesting a CHC-MCO Second Level PBM Provider Pricing Dispute Resolution;
 - iii. Acceptance and usage of the Department's definition/delineation of Provider Disputes;
 - iv. Timeframes for submission and resolution of Second Level PBM Provider Pricing Disputes;
 - v. Processes to ensure equal treatment of all PBM providers in the resolution of pricing disputes.
 - vi. Process to ensure the paid amount reflects the pharmacy's drug acquisition cost, professional services, and cost to dispense the prescription to an MA beneficiary.
 - vii. A requirement for both the PBM Provider and the PBM to provide documentation supporting each entity's position(s) related to the pricing dispute;
 - viii. Designation of CHC-MCO staff responsible for resolution of the PBM Provider Pricing Dispute who have:
 - The knowledge and expertise to address and resolve PBM Provider Pricing Disputes;
 - Access to data and documentation of the informal resolution of the PBM Provider Dispute and the formal PBM Provider Appeal and decisions necessary to assist in making decisions; and
 - ix. Mechanisms and time frames for reporting CHC-MCO PBM Provider

Pricing Dispute decisions to the PBM Provider, the PBM and the Department. If the dispute is denied by the CHC-MCO, the Provider Pricing Dispute decisions must include the specific rationale for the denial;

- I. Require the PBM and the PBM provider to abide by the final decision of the CHC-MCO. If the Provider Pricing Dispute is overturned by the CHC-MCO, adjustment must be made to the appealed claim and to future claims for the appealed drug. The PBM/CHC-MCO must update their payment methodology for the appealed drug; and
- m. Require the PBM to inform all PBM providers of the process and conditions to request a Second Level PBM Provider Pricing Dispute.

15. Requirements for CHC-MCO and BH-MCO Interaction and Coordination of Drug Services

- a. BH-MCO prescribing Providers must comply with the CHC-MCO requirements for Utilization Management of behavioral health drugs.
- b. The BH-MCO will be required to issue an initial list of BH-MCO Providers to the CHC-MCO, and quarterly updates that include additions and terminations. Should the CHC-MCO receive a request to dispense medication prescribed by a BH Provider not listed on the BH-MCO's Provider file, the CHC-MCO must work through the appropriate BH-MCO to identify the Provider. The CHC-MCO is prohibited from denying prescribed medications solely on the basis that the BH-MCO Provider is not clearly identified on the BH-MCO Providerfile.
- c. Payment for inpatient pharmaceuticals during a BH admission is the responsibility of the BH-MCO and is included in the hospitalcharge.
- d. The CHC-MCO may deny payment of a Claim for a Covered Drug prescribed by a BH-MCO Provider only if one of the following occurs:
 - i. The drug is not being prescribed for the treatment of substance use disorder or mental illness and any side effects of psychopharmacological agents. Those drugs are to be prescribed by the CHC-MCO's PCP or specialists in the Participant's CHC-MCO Network.
 - ii. The prescription has been identified as a case of Fraud, Abuse, or gross overuse, or the dispensing pharmacist determined that taking the medication either alone or along with other medications that the Participant may be taking would jeopardize the health and safety of the Participant.

- e. The CHC-MCO must receive written approval from the Department of the policies and procedures for the CHC-MCO and BH-MCO to:
 - i. When deemed advisable, require consultation between practitioners before prescribing medication, and sharing complete, up-to-date medication records.
 - ii. Comply with any CHC-BH MCO drug data exchange procedures specified by the Department.
 - iii. Timely resolve disputes which arise from the payment for or use of drugs, including a mechanism for timely, impartial mediation when resolution between the CHC-MCO and BH-MCO does not occur.
 - iv. Share independently developed Quality Management/Utilization Management information related to drug services, as applicable.
 - v. Collaborate in adhering to a drug utilization review program approved by the Department. Collaborate in identifying and reducing the frequency of patterns of Fraud, Abuse, gross overuse, inappropriate or medically unnecessary care among physicians, pharmacists and Participants associated with specific drugs.

EXHIBIT E

PRIOR AUTHORIZATION GUIDELINES FOR THE CHC-MCO

A. GENERAL REQUIREMENT

The CHC-MCOs must submit to the Department all written policies and procedures for the Prior Authorization of services. Prior authorization is not required for Family Planning services (V.A.6), Emergency Services (see V.A.8), or services for which Medicare is the primary payor except where Medicare has denied the service. The CHC-MCO may require Prior Authorization for any services that require Prior Authorization in the Medical Assistance Fee-for-Service (FFS) Program. The CHC-MCO must notify the Department of the FFS authorized services they will continue to prior authorize and the basis for determining if the service is Medically Necessary. The CHC-MCO must receive advance written approval from the Department to require the Prior Authorization of any services not currently required to be Prior Authorized under the FFS Program. For each service to be Prior Authorized, the CHC-MCO must submit for the Department's review and approval the written policies and procedures in accordance with the guidelines described below. The policies and procedures must:

- Be submitted in writing, for all new and revised criteria, prior to implementation;
- Be approved by the Department in writing prior to implementation;
- Adhere to specifications of the CHC RFA, this Agreement, the CHC 1915(c) Waiver, federal regulations, and Department regulations, including 55 Pa. Code Chapter 1101;
- Ensure that Covered Services are Medically Necessary and provided in an appropriate, effective, timely, and cost-efficient manner;
- Adhere to the applicable requirements of Centers for Medicare and Medicaid Services (CMS) Guidelines for Internal Quality Assurance Programs of Health Maintenance Organizations (HMOs), Health Insuring Organizations, and Prepaid Health Plans (PHPs), contracting with Medicaid/Quality Assurance Reform Initiative (QARI);
- Include an expedited review process to address those situations when an item or service must be provided on an urgent basis;
- Specify that Person-Centered Service Plans serve as Prior Authorization for the services outlined therein.

Future changes in State and Federal statutes, regulations, or court cases may require re-evaluation of any previously approved Prior Authorization proposal. Any deviation from the policies and procedures approved by the Department, including time frames for decisions, is considered to be a change and requires a new request for approval. Failure

of the CHC-MCO to comply may result in sanctions and/or penalties by the Department.

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

The Department's Prior Authorization Review Panel (PARP) has the sole responsibility to review and approve all Prior Authorization proposals from the CHC-MCOs.

B. GUIDELINES FOR REVIEW

1. Basic Requirements:

- a. The CHC-MCO must identify individual service(s), medical item(s), and/or therapeutic categories of drugs to be Prior Authorized.
- b. If the Prior Authorization is limited to specific populations, the CHC-MCO must identify all populations who will be affected by the proposal for Prior Authorization.

2. Medically Necessary Requirements:

- a. The CHC-MCO must describe the process to validate medical necessity for:
 - covered care and services;
 - procedures and level of care;
 - medical or therapeutic items.
- b. The CHC-MCO must identify the source of the criteria used to review the request for Prior Authorization of services. The criteria must be consistent with the CHC Agreement definition for a service or benefit that is Medically Necessary. All criteria must be submitted to the Department for evaluation and approval under Utilization Review Criteria Assessment Process (URCAP).
- c. For CHC-MCOs, if the criteria being used are:
 - Purchased and licensed, the CHC-MCO must identify the vendor;
 - Developed/recommended/endorsed by a national or state Provider association or society, the CHC-MCO must identify the association or society;
 - Based on national best practice guidelines, the CHC-MCO must identify the source of those guidelines;
 - Based on the medical training, qualifications, and experience of the CHC-MCO's Medical Director, Dental Director, or other qualified and trained practitioners, the CHC-MCO must identify the individuals who will determine

if the service or benefit is Medically Necessary.

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

Requests for service will not be denied for lack of Medical Necessity unless a physician or other healthcare professional with appropriate clinical expertise in treating the Participant's condition or disease determines:

- That the prescriber did not make a good faith effort to submit a complete request, or
 - That the service or item is not Medically Necessary, after making a reasonable effort to consult with the prescriber. The reasonable effort to consult must be documented in writing.
- f. The CHC-MCO must outline how the Service Planning process with PCPT approach will ensure that Medically Necessary services specified in the Person-Centered Service Plan are authorized by virtue of inclusion in the Person-Centered Service Plan and processed into all appropriate systems.
 - g. In accordance with Section V.I., the CHC-MCO must outline which PCSP changes during the period covered by the PCSP may be made by the Participant and Service Coordinator without PCPT involvement and which must be made by the CHC-MCO in accordance with the CHC-MCO Prior Authorization plan and must outline the timeframes specified in V.B.2.
 - h. For LTSS in home and community-based settings, Covered Services will be authorized in accordance with the requirements of the CHC 1915(c) Waiver.

3. Administrative Requirements

- a. The CHC-MCO's written policies and procedures must identify the time frames for review and decisions and the CHC-MCO must demonstrate that the time frames are consistent with the requirements specified in V.B.2 and Exhibit D for drug services.
- b. The CHC-MCO's written policies and procedures must demonstrate how the CHC-MCO will ensure adequate care management and overall continuity of care among all levels and specialty areas.

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

4. Notification, Grievance, and DHS Fair Hearing Requirements

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

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

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

EXHIBIT 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/

recrediting 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 recrediting 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. Recrediting 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 recrediting, 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.

EXHIBIT G

COMPLAINT, GRIEVANCE, AND DHS FAIR HEARING PROCESSES

A. General Requirements

1. The CHC-MCO must obtain the Department's prior written approval of its Complaint, Grievance, and Fair Hearing policies and procedures.
2. The CHC-MCO must have written policies and procedures for registering, responding to, and resolving Complaints and Grievances as they relate to the MA population and must make these policies and procedures available to Participants upon request.
3. The CHC-MCO must maintain an accurate written record of each Complaint and Grievance and the actions taken by the CHC-MCO to resolve each Complaint and Grievance. The record must include at least the following:
 - a. The name of the Participant on whose behalf the Complaint or Grievance was filed;
 - b. The date the Complaint or Grievance was received;
 - c. A description of the reason for the Complaint or Grievance;
 - d. The date of each review or review meeting;
 - e. The date of resolution of the Complaint or Grievance and how the Complaint or Grievance was resolved; and
 - f. A Copy of any documents or records reviewed.

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

4. The CHC-MCO must submit a log of all Complaint and Grievance decisions in a format specified by the Department and must include review of the Complaint and Grievance processes in its QM and UM programs as outlined in Exhibit F Quality Management and Utilization Management Program Requirements.
5. The CHC-MCO must have a data system to process, track, and trend all Complaints and Grievances.
6. The CHC-MCO must designate and train sufficient staff as reported in the Operating Procedures Report (OPS) 11 Provider Education, to be responsible for receiving, processing, and responding to Participant Complaints and Grievances in accordance with the requirements specified in this Exhibit.

7. CHC-MCO staff performing Complaint and Grievance reviews must have the necessary orientation, clinical training, and experience to make an informed and impartial determination regarding issues assigned to them.
8. The CHC-MCO must provide information about the Complaint and Grievance process to all Providers and subcontractors when the CHC-MCO enters into a contract or agreement with the Provider or subcontractor.
9. The CHC-MCO may not use the timeframes or procedures of the Complaint or Grievance process to avoid the medical decision process or to discourage or prevent a Participant from receiving Medically Necessary care in a timely manner.
10. The CHC-MCO must require that anyone who participates in making the decision on a Complaint or Grievance was not involved in and is not a subordinate of an individual who was involved in any previous level of review or decision-making on the issue that is the subject of the Complaint or Grievance.
11. The CHC-MCO may not charge Participants a fee for filing a Complaint or a Grievance.
12. CHC-MCOs must permit both a Participant or Participant's representative, which may include the Participant's Provider, with proof of the Participant's written authorization for the representative to be involved and/or act on the Participant's behalf, to file a Complaint or Grievance. If a Complaint or Grievance is received by a CHC-MCO from a representative on behalf of the Participant that does not include the Participant's authorization the CHC-MCO must contact the Participant to obtain authorization. Participants must be notified both verbally and in writing if a Complaint or Grievance is unable to be processed due to lack of Participant authorization.
13. The CHC-MCO must allow the Participant and the Participant's representative to have access to all relevant documentation pertaining to the subject of the Complaint or Grievance free of charge and sufficiently in advance of the time frame for resolution of the Complaint or Grievance outlined in this Exhibit.
14. The CHC-MCO must maintain the following information in the Participant's case file:
 - a. Medical records;
 - b. Any documents or records relied upon or generated by the CHC-MCO in connection with the Complaint or Grievance, including any Medical Necessity criteria used to make a decision or information on coverage limits relied upon to make a decision; and
 - c. Any new or additional evidence considered, relied upon, or generated by the CHC-MCO in connection with the Complaint or Grievance.
15. The CHC-MCO must ask the Participant if the Participant needs interpreter services. The CHC-MCO must provide language interpreter services at no cost when requested by a Participant. The CHC-MCO must include in the Complaint or

Grievance record documentation that the Participant was asked if the Participant needed an interpreter and if an interpreter was provided.

16. The CHC-MCO must accept Complaints and Grievances from individuals with disabilities which are in alternative formats including: TTY/Videophone/TDD for telephone inquiries and Complaints and Grievances from Participants who are deaf or hearing impaired; Braille; tape; computer disk; and other commonly accepted alternative forms of communication. The CHC-MCO must make its employees who receive telephone Complaints and Grievances aware of the speech limitations of Participants with disabilities so they treat these individuals with patience, understanding, and respect.
17. The CHC-MCO must provide Participants with disabilities assistance in presenting their case at Complaint or Grievance reviews at no cost to the Participant. This includes but is not limited to:
 - a. Providing qualified sign language interpreters for Participants who are deaf or hearing impaired;
 - b. Providing information submitted on behalf of the CHC-MCO at the Complaint or Grievance review in an alternative format accessible to the Participant filing the Complaint or Grievance. The alternative format version must be supplied to the Participant at or before the review, so the Participant can discuss and/or refute the content during the review; and
 - c. Providing personal assistance to a Participant filing the Complaint or Grievance who has other physical limitations in copying and presenting documents and other evidence.
18. The CHC-MCO must offer Participants the assistance of a CHC-MCO staff member throughout the Complaint and Grievance processes at no cost to the Participant.
19. The CHC-MCO must provide Participants with a toll-free number to file a Complaint or Grievance, request information about the Complaint or Grievance process, and ask any questions the Participant may have about the status of a Complaint or a Grievance.
20. The CHC-MCO must, at a minimum, hold in-person reviews of Complaints and Grievances at one location within each of its zones of operation. If a Participant requests an in-person review, the CHC-MCO must notify the Participant of the location of the review and who will be present at the review, using the template specified by the Department.
21. The CHC-MCO must ensure that any location where it will hold in-person reviews is physically accessible for persons with disabilities.

22. The CHC-MCO must notify the Participant when the CHC-MCO fails to decide a first level Complaint or a Grievance within the time frames specified in this Exhibit, using the template specified by the Department. The CHC-MCO must mail this notice to the Participant one (1) day following the date of the decision (day 31).

23. The CHC-MCO must notify the Participant when it denies payment after a service or item has been delivered because the service or item was provided without authorization by a provider not enrolled in the MA Program, using the template specified by the Department. The CHC-MCO must mail this notice to the Participant on the day the decision is made to deny payment.

24. The CHC-MCO must notify the Participant when it denies payment after a service or item has been delivered because the service or item provided is not a Covered Service for the Participant, using the template specified by the Department. The CHC-MCO must mail this notice to the Participant on the day the decision is made to deny payment.

25. The CHC-MCO must notify the Participant when it denies payment after a service or item has been delivered because the CHC-MCO determined that the service or item was not Medically Necessary, using the template specified by the Department. The CHC-MCO must mail this notice to the Participant on the day the decision is made to deny payment.

26. The CHC-MCO must notify the Participant when it denies the Participant's request to dispute a financial liability, including cost sharing, copayments, premiums, deductibles, coinsurance, and other enrollee financial liabilities using the template specified by the Department. The CHC-MCO must mail this notice to the Participant on the day the decision is made to deny payment.

27. If a Participant continued to receive services at the previously authorized level because the Participant filed a Complaint, Grievance, or Fair Hearing to dispute a decision to discontinue, reduce, or change a service that the Participant has been receiving within fifteen (15) days from the mail date on the written notice of decision, the CHC-MCO must pay for the services pending resolution of the Complaint, Grievance, or Fair Hearing.

28. The CHC-MCO must use all templates specified by the Department, which are available in DocuShare. The CHC-MCO may not modify the templates. The CHC-MCO must follow the instructions in the templates for including detailed, specific information related to the Complaint or Grievance.

B. Complaint Requirements

Complaint: A dispute or objection regarding a particular Provider or the coverage operations, or management of a CHC-MCO, which has not been resolved by the CHC-MCO and has been filed with the CHC-MCO or with PID's Bureau of Managed Care (BMC), including but not limited to:

- a denial because the requested service or item is not a Covered Service; which does not include BLE;
- the failure of the CHC-MCO to provide a service or item in a timely manner, as defined by the Department;
- the failure of the CHC-MCO to decide a Complaint or Grievance within the specified time frames;
- a denial of payment by the CHC-MCO after a service or item has been delivered because the service or item was provided without authorization by a provider not enrolled in the MA Program;
- a denial of payment by the CHC-MCO after a service or item has been delivered because the service or item provided is not a Covered Service for the Participant; or
- a denial of a Participant's request to dispute a financial liability, including cost sharing, copayments, premiums, deductibles, coinsurance, and other Participant financial liabilities.

The term does not include a Grievance.

1. First Level Complaint Process

- a. A CHC-MCO must permit a Participant or Participant's representative, which may include the Participant's Provider, with proof of the Participant's written authorization for the representative to be involved and/or act on the Participant's behalf, to file a first level Complaint either in writing or orally. The CHC-MCO must commit oral requests to writing if not confirmed in writing by the Participant and must provide the written Complaint to the Participant or Participant's representative for signature. The signature may be obtained at any point in the process, and failure to obtain a signed Complaint may not delay the Complaint process. Participants must be notified both verbally and in writing if a Complaint is unable to be processed due to lack of Participant authorization.

- b. If the first level Complaint disputes one of the following, the Participant must file a Complaint within sixty (60) days from the date of the incident complained of or the date the Participant receives written notice of a decision:
- a denial because the service or item is not a Covered Service;
 - the failure of the CHC-MCO to provide a service or item in a timely manner, as defined by the Department;
 - the failure of the CHC-MCO to decide a Complaint or Grievance within the specified time frames;
 - a denial of payment after the service or item has been delivered because the service or item was provided without authorization by a provider not enrolled in the MA Program;
 - a denial of payment after the service or item has been delivered because the service or item provided is not a Covered Service for the Participant; or
 - a denial of a Participant's request to dispute a financial liability, including cost sharing, copayments, premiums, deductibles, coinsurance, and other Participant financial liabilities,

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

- c. A Participant who files a first level Complaint to dispute a decision to discontinue, reduce, or change a service or item that the Participant has been receiving on the basis that the service or item is not a Covered Service must continue to receive the disputed service or item at the previously authorized level pending resolution of the first level Complaint, if the first level Complaint is made verbally, hand delivered, faxed, submitted electronically (via secure e-mail or secure web portal, if available), or post-marked within fifteen (15) days from the mail date on the written notice of decision.
- d. Upon receipt of the Complaint, the CHC-MCO must send the Participant and Participant's representative, if the Participant has designated one in writing, a first level Complaint acknowledgment letter using the template specified by the Department. The first level Complaint acknowledgement letter must be sent no later than three (3) business days after the receipt of the Complaint.
- e. The first level Complaint review for Complaints **not involving a clinical issue** must be conducted by a first level Complaint review committee, which must include one or more employees of the CHC-MCO who were not involved in and are not the subordinates of an individual involved in any previous level of review or decision-making on the issue that is the subject of the Complaint.

- f. The first level Complaint review for Complaints **involving a clinical issue** must be conducted by a first level Complaint review committee, which must include one or more employees of the CHC-MCO who were not involved in and are not the subordinates of an individual involved in any previous level of review or decision-making on the issue that is the subject of the Complaint. The first level Complaint review committee must include a licensed physician or licensed dentist in the same or similar specialty that typically manages or consults on the service or item in question. Other appropriate providers may participate in the review, but the licensed physician or licensed dentist in the same or similar specialty that typically manages or consults on the service or item in question must decide the first level Complaint.
- g. A committee member who does not personally attend the first level Complaint review meeting may not be part of the decision-making process unless that member actively participates in the review by telephone or videoconference and has the opportunity to review all information presented during the review.
- h. The CHC-MCO must afford the Participant a reasonable opportunity to present evidence and testimony and make legal and factual arguments, in person as well as in writing.
- i. The CHC-MCO must give the Participant at least ten (10) days advance written notice of the first level Complaint review date, using the template specified by the Department. The CHC-MCO must be flexible when scheduling the review to facilitate the Participant's attendance. If the Participant cannot appear in person at the review, the CHC-MCO must provide an opportunity for the Participant to communicate with the first level Complaint review committee by telephone or videoconference.
- j. The Participant may elect not to attend the first level Complaint review meeting, but the meeting must be conducted with the same protocols as if the Participant was present. All Complaint review meetings must be recorded and transcribed and the recording and transcription must be maintained as part of the Complaint record.
- k. If a Participant requests an in-person first level Complaint review, at a minimum, a member of the first level Complaint review committee must be physically present at the location where the first level Complaint review is held and the other members of the first level Complaint review committee must participate in the review through the use of videoconferencing.
- l. The decision of the first level Complaint review committee must take into account all comments, documents, records, and other information submitted by the Participant or the Participant's representative without regard to whether such information was submitted or considered in the initial determination of the issue.

- m. Prior to the start of the first level Complaint review meeting, the Participant must be told that the testimony will be recorded. If the Participant agrees to the testimony taken by the Complaint review committee (including the Participant's comments) being recorded, the testimony must be recorded and transcribed verbatim and maintained as part of the Complaint record. If the Participant objects to the testimony being recorded, the Participant's objection must be documented in the Complaint record and the first level Complaint review meeting must proceed without the testimony being recorded.
- n. The first level Complaint review committee must complete its review of the Complaint as expeditiously as the Participant's health condition requires.
- o. The first level Complaint review committee must prepare a summary of the issues presented and decisions made, which must be maintained as part of the Complaint record.
- p. The CHC-MCO must send a written notice of the first level Complaint decision, using the template specified by the Department, to the Participant, Participant's representative, if the Participant has designated one, service Provider and prescribing Provider, if applicable, within thirty (30) days from the date of receipt of the Complaint unless the time frame for deciding the Complaint has been extended by up to fourteen (14) days at the request of the Participant.
- q. If the Complaint disputes one of the following, the Participant may file a request for a Fair Hearing, a request for an external review, or both a request for a Fair Hearing and a request for an external review:
 - a denial because that service or item is not a Covered Service;
 - the failure of the CHC-MCO to provide a service or item in a timely manner, as defined by the Department;
 - the failure of the CHC-MCO to decide the Complaint or Grievance within the specified time frames;
 - a denial of payment by the CHC-MCO after the service or item has been delivered because the service or item was provided without authorization by a provider not enrolled in the MA Program;
 - a denial of payment by the CHC-MCO after the service or item has been delivered because the service or item provided is not a Covered Service for the Participant; or
 - a denial of a Participant's request to dispute a financial liability, including cost sharing, copayments, premiums, deductibles, coinsurance, and other Participant financial liabilities.

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

The Participant or Participant's representative, which may include the Participant's Provider, with proof of the Participant's written authorization for the representative to be involved and/or act on the Participant's behalf, may file a request for an external review in writing with PID within fifteen (15) days from the date the Participant receives written notice of the CHC-MCO's first level Complaint decision.

For all other Complaints, the Participant or Participant's representative, which may include the Participant's Provider, with proof of the Participant's written authorization for the representative to be involved and/or act on the Participant's behalf, may file a second level Complaint either in writing or orally within forty-five (45) days from the date the Participant receives written notice of the CHC-MCO's first level Complaint decision.

2. Second Level Complaint Process

- a. A CHC-MCO must permit a Participant or Participant's representative, which may include the Participant's Provider, with proof of the Participant's written authorization for the representative to be involved and/or act on the Participant's behalf, to file a second level Complaint either in writing or orally for any Complaint for which a Fair Hearing and external review is not available. Participants must be notified both verbally and in writing if a Complaint is unable to be processed due to lack of Participant authorization.
- b. Upon receipt of the second level Complaint, the CHC-MCO must send the Participant and Participant's representative, if the Participant has designated one in writing, a second level Complaint acknowledgment letter using the template specified by the Department. The second level Complaint acknowledgement letter must be sent no later than three (3) business days after the receipt of the second level Complaint.
- c. The second level Complaint review for Complaints **not involving a clinical issue** must be performed by a second level Complaint review committee made up of three (3) or more individuals who were not involved in and are not the subordinates of an individual involved in any previous level of review or decision-making on the issue that is the subject of the Complaint.
- d. The second level Complaint review for Complaints **involving a clinical issue** must be conducted by a second level Complaint review committee made up of three (3) or more individuals who were not involved in and are not the subordinates of an individual involved in any previous level of review or decision-making on the issue that is the subject of the Complaint. The second level Complaint review committee must include a licensed physician or

licensed dentist in the same or similar specialty that typically manages or consults on the service or item in question. Other appropriate providers may participate in the review, but the licensed physician or licensed dentist in the same or similar specialty that typically manages or consults on the service or item in question must decide the second level Complaint.

- e. At least one-third of the second level Complaint review committee members may not be employees of the CHC-MCO or a related subsidiary or Affiliate.
- f. A committee member who does not personally attend the second level Complaint review may not be part of the decision-making process unless that member actively participates in the review by telephone or videoconference and has the opportunity to review all information introduced during the review.
- g. The CHC-MCO must afford the Participant a reasonable opportunity to present evidence and testimony and make legal and factual arguments, in person as well as in writing.
- h. The CHC-MCO must give the Participant at least fifteen (15) days advance written notice of the second level review date, using the template specified by the Department. If the Participant cannot appear in person at the review, the CHC-MCO must provide an opportunity for the Participant to communicate with the second level Complaint review committee by telephone or videoconference. The CHC-MCO must be flexible when scheduling the review to facilitate the Member's attendance.
- i. The Participant may elect not to attend the second level Complaint review meeting, but the meeting must be conducted with the same protocols as if the Participant was present. All second level Complaint review meetings must be recorded and transcribed verbatim and the recording and transcription must be maintained as part of the second level Complaint record.
- j. If a Participant requests an in-person second level Complaint review, at a minimum, a member of the second level Complaint review committee must be physically present at the location where the second level Complaint review is held and the other members of the second level Complaint review committee must participate in the review through the use of videoconferencing.
- k. The decision of the second level Complaint review committee must take into account all comments, documents, records, and other information submitted by the Participant or the Participant's representative without regard to whether such information was submitted or considered previously. The decision of the second level Complaint review committee must be based solely on the information presented at the review.

- l. Prior to the start of the second level Complaint review meeting, the Participant must be told that the testimony will be recorded. If the Participant agrees to the testimony taken by the second level Complaint review committee (including the Participant's comments) being recorded, the testimony must be tape-recorded and transcribed verbatim and maintained as part of the second level Complaint record. If the Participant objects to the testimony being recorded, the Participant's objection must be documented in the second level Complaint record and the second level Complaint review meeting must proceed without the testimony being recorded
- m. The second level Complaint review committee must complete its review of the second level Complaint as expeditiously as the Participant's health condition requires.
- n. The CHC-MCO must send a written notice of the second level Complaint decision, using the template specified by the Department, to the Participant, Participant's representative, if the Participant has designated one in writing, service Provider, and prescribing Provider, if applicable, within forty-five (45) days from the date of receipt of the second level Complaint.
- o. The Participant or the Participant's representative, which may include the Participant's Provider, with proof of the Participant's written authorization of the representative to be involved and/or act of the Participant's behalf, may file in writing a request for an external review of the second level Complaint decision with PID within fifteen (15) days from the date the Participant receives the written notice of the CHC-MCO's second level Complaint decision.

3. External Complaint Process

- a. If a Participant files a request directly with PID for an external review of a Complaint decision that disputes a decision to discontinue, reduce, or change a service or item that the Participant has been receiving on the basis that the service or item is not a Covered Service, the Participant must continue to receive the disputed service or item at the previously authorized level pending resolution of the external review, if the request for external review is hand-delivered, faxed, or post-marked within fifteen (15) days from the mail date on the written notice of the CHC-MCO's first or second level Complaint decision.
- b. Upon the request of PID, the CHC-MCO must transmit all records from the CHC-MCO's Complaint review to PID within thirty (30) days from the request in the manner prescribed by PID. The Participant, the Provider, or the CHC-MCO may submit additional materials related to the Complaint.

4. Expedited Complaint Process

- a. The CHC-MCO must conduct expedited review of a Complaint if the CHC-MCO determines that the Participant's life, physical or mental health, or ability to attain, maintain, or regain maximum function would be placed in jeopardy by following the regular Complaint process or if a Participant or Participant's representative, with proof of the Participant's written authorization for the representative to be involved and/or act on the Participant's behalf, provides the CHC-MCO with a certification from the Participant's Provider that the Participant's life, physical or mental health, or ability to attain, maintain, or regain maximum function would be placed in jeopardy by following the regular Complaint process. The certification must include the Provider's signature.
- b. A request for an expedited review of a Complaint may be filed in writing via mail, by fax, submitted electronically (via secure email or secure web portal, if available), or orally.
- c. Upon receipt of an oral or written request for expedited review, the CHC-MCO must inform the Participant of the right to present evidence and testimony and make legal and factual arguments in person as well as in writing and of the limited time available to do so.
- d. If the Provider certification is not included with the request for an expedited review and the CHC-MCO cannot determine based on the information provided that the Participant's life, physical or mental health, or ability to attain, maintain, or regain maximum function would be placed in jeopardy by following the regular Complaint process, the CHC-MCO must inform the Participant that the Provider must submit a certification as to the reasons why the expedited review is needed. The CHC-MCO must make a reasonable effort to obtain the certification from the Provider. If the Provider certification is not received within seventy-two (72) hours of the Participant's request for expedited review, the CHC-MCO must decide the Complaint within the standard time frames as set forth in this Exhibit, unless the time frame for deciding the Complaint has been extended by up to fourteen (14) days at the request of the Participant. If the CHC-MCO decides that expedited consideration within the initial or extended time frame is not warranted, the CHC-MCO must make a reasonable effort to give the Participant prompt oral notice that the Complaint is to be decided within the standard time frame and send a written notice within two (2) business days of the decision to deny expedited review, using the template specified by the Department.
- e. A Participant who files a request for expedited review of a Complaint to dispute a decision to discontinue, reduce, or change a service or item that the Participant has been receiving on the basis that the service or item is not a Covered Service must continue to receive the disputed service or item at the previously authorized level pending resolution of the Complaint, if the request for expedited review is made orally, hand delivered, faxed, submitted electronically (via secure email or secure web portal, if available), or post-

marked within fifteen (15) days from the mail date on the written notice of decision.

- f. Expedited review of a Complaint must be conducted by a Complaint review committee that includes a licensed physician or licensed dentist in the same or similar specialty that typically manages or consults on the service or item in question. If the Complaint is related to dental services, the expedited Complaint review committee must include a dentist. Other appropriate providers may participate in the review, but the licensed physician or licensed dentist in the same or similar specialty that typically manages or consults on the service or item in question must decide the Complaint. The members of the expedited Complaint review committee may not have been involved in and not be the subordinates of an individual involved in any previous level of review or decision-making on the issue that is the subject of the Complaint.
- g. Prior to the start of the expedited Complaint review meeting, the Participant must be told that the testimony will be recorded. If the Participant agrees to the testimony taken by the Complaint review committee (including the Participant's comments) being recorded, the testimony must be recorded and transcribed verbatim and maintained as part of the Complaint record. If the Participant objects to the testimony being recorded, the Participant's objection must be documented in the Complaint record and the expedited review meeting must proceed without the testimony being recorded.
- h. The CHC-MCO must issue the decision resulting from the expedited review in person or by phone to the Participant, the Participant's representative, if the Participant has designated one in writing, service Provider and prescribing Provider, if applicable, within either forty-eight (48) hours of receiving the Provider certification or seventy-two (72) hours of receiving the Participant's request for an expedited review, whichever is shorter, unless the time frame for deciding the expedited complaint has been extended by up to fourteen (14) days at the request of the Participant. In addition, the CHC-MCO must mail written notice of the decision to the Participant, the Participant's representative, if the Participant has designated one in writing, the Participant's service Provider, and prescribing Provider, if applicable, within two (2) business days of the decision, using the template specified by the Department.
- i. The Participant or the Participant's representative may file a request for a Fair Hearing within one hundred and twenty (120) days from the mail date on the written notice of the CHC-MCO's expedited Complaint decision.
- j. A request for an expedited external Complaint review may be filed orally, or in writing via mail, or secure web portal.

- k. The Participant, or the Participant's representative, which may include the Participant's Provider, with proof of the Participant's written authorization for the representative to be involved and/or act on the Participant's behalf, may file a request for an expedited external Complaint review with the CHC-MCO within two (2) business days from the date the Participant receives the CHC-MCO's expedited Complaint decision. A Participant who files a request for an expedited Complaint review that disputes a decision to discontinue, reduce, or change a service or item that the Participant has been receiving must continue to receive the disputed service or item at the previously authorized level pending resolution of the request for expedited Complaint review. Participants must be notified both verbally and in writing if a Complaint is unable to be processed due to lack of Participant authorization.
- l. The CHC-MCO must follow PID guidelines relating to submission of requests for expedited external Complaint reviews.
- m. The CHC-MCO may not take punitive action against a Provider who requests expedited resolution of a Complaint or supports a Participant's request for expedited review of a Complaint.

C. Grievance Requirements

Grievance: A request to an MA Managed Care Plan by a Participant or a health care provider (with the written consent of the Participant), or a Participant's authorized representative to have an MA Managed Care Plan reconsider a decision solely concerning the medical necessity, appropriateness, health care setting, level of care or effectiveness of a health care service. If the MA Managed Care Plan is unable to resolve the matter, a grievance may be filed regarding the decision that:

- (1) disapproves full or partial payment for a requested health care service;
- (2) approves the provision of a requested health care service for a lesser scope or duration than requested; or
- (3) disapproves payment for the provision of a requested health care service but approves payment for the provision of an alternative health care service
- (4) reduces, suspends, or terminates a previously authorized service.

The term does not include a complaint.

1. Grievance Process

- a. A CHC-MCO must permit a Participant or Participant's representative, which may include the Participant's Provider, with proof of the Participant's written authorization for the representative to be involved and/or act on the Participant's behalf, to file a Grievance either in writing or orally. The CHC-MCO must commit oral requests to writing if not confirmed in writing by the

Participant and must provide the written Grievance to the Participant or the Participant's representative for signature. The signature may be obtained at any point in the process, and the failure to obtain a signed Grievance may not delay the Grievance process. Participants must be notified both verbally and in writing if a Grievance is unable to be processed due to lack of Participant authorization.

- b. A Participant must file a Grievance within sixty (60) days from the date the Participant receives written notice of decision.
- c. A Participant who files a Grievance to dispute a decision to discontinue, reduce, or change a service or item that the Participant has been receiving must continue to receive the disputed service or item at the previously authorized level pending resolution of the Grievance, if the request for review of the Grievance is made orally, hand delivered, faxed, submitted electronically (via secure email or secure web portal, if available), or post-marked within fifteen (15) days from the mail date on the written notice of decision.
- d. Upon receipt of the Grievance, the CHC-MCO must send the Participant and Participant's representative, if the Participant has designated one in writing, a Grievance acknowledgment letter using the template specified by the Department. The Grievance acknowledgement letter must be sent no later than three (3) business days after receipt of the Grievance.
- e. A Participant who consents to the filing of a Grievance by a Provider may not file a separate Grievance. The Participant may rescind consent throughout the process upon written notice to the CHC-MCO and the Provider.
- f. In order for the Provider to represent the Participant in the conduct of a Grievance, the Provider must obtain the written consent of the Participant and submit the written consent with the Grievance. A Provider may obtain the Participant's written permission at the time of treatment. The CHC-MCO must assure that a Provider does NOT require a Participant to sign a document authorizing the Provider to file a Grievance as a condition of treatment. The written consent must include:
 - i. The name and address of the Participant, the Participant's date of birth and identification number;
 - ii. If the Participant is legally incompetent, the name, address, and relationship to the Participant of the person who signed the consent;

- iii. The name, address, and CHC-MCO identification number of the Provider to whom the Participant is providing consent;
 - iv. The name and address of the CHC-MCO to which the Grievance will be submitted;
 - v. An explanation of the specific service or item which was provided or denied to the Participant to which the consent will apply;
 - vi. The following statement: “The Participant or the Participant’s representative may not submit a Grievance concerning the service or item listed in this consent form unless the Participant or the Participant’s representative rescinds consent in writing. The Participant or the Participant’s representative has the right to rescind consent at any time during the Grievance process.”;
 - vii. The following statement: “The consent of the Participant or the Participant’s representative shall be automatically rescinded if the Provider fails to file a Grievance or fails to continue to prosecute the Grievance through the review process.”;
 - viii. The following statement: “The Participant or the Participant’s representative, if the Participant is legally incompetent, has read, or has been read, this consent form, and has had it explained to his/her satisfaction. The Participant or the Participant’s representative understands the information in the Participant’s consent form.”; and
 - ix. The dated signature of the Participant, or the Participant’s representative, and the dated signature of a witness.
- g. The Grievance review must be conducted by a Grievance review committee made up of three (3) or more individuals who were not involved in and are not the subordinates of an individual involved in any previous level of review or decision-making on the issue that is the subject of the Grievance.
 - h. At least one-third of the Grievance review committee may not be employees of the CHC-MCO or a related subsidiary or Affiliate.
 - i. The Grievance review committee must include a licensed physician or licensed dentist in the same or similar specialty that typically manages or consults on the service or item in question. If the Grievance is related to dental services, the Grievance review committee must include a dentist. Other appropriate providers may participate in the review, but the licensed physician

or licensed dentist in the same or similar specialty that typically manages or consults on the service or item in question must decide the Grievance.

- j. A committee member who does not personally attend the Grievance review may not be part of the decision-making process unless that member actively participates in the review by telephone or videoconference and has the opportunity to review all information introduced during the review.
- k. The CHC-MCO must afford the Participant a reasonable opportunity to present evidence and testimony and make legal and factual arguments, in person as well as in writing.
- l. The CHC-MCO must give the Participant at least ten (10) days advance written notice of the review date, using the template specified by the Department. The CHC-MCO must be flexible when scheduling the review to facilitate the Participant's attendance. If the Participant cannot appear in person at the review, the CHC-MCO must provide an opportunity for the Participant to communicate with the Grievance review committee by telephone or videoconference.
- m. The Participant may elect not to attend the Grievance review meeting, but the meeting must be conducted with the same protocols as if the Participant was present. All Grievance review meetings must be recorded and transcribed verbatim and the recording and transcription must be maintained as part of the Grievance record.
- n. If a Participant requests an in-person Grievance review, at a minimum, a member of the Grievance review committee must be physically present at the location where the Grievance review is held and the other members of the Grievance review committee must participate in the review through the use of videoconferencing.
- o. The decision of the Grievance review committee must take into account all comments, documents, records, and other information submitted by the Participant or the Participant's representative without regard to whether such information was submitted or considered in the initial determination of the issue. The decision of the Grievance review committee must be based solely on the information presented at the review.
- p. Prior to the start of the Grievance review meeting, the Participant must be told that the testimony will be recorded. If the Participant agrees to the testimony taken by the Grievance review committee (including the Participant's comments) being recorded, the testimony must be recorded and transcribed verbatim and a written transcription prepared and maintained as part of the Grievance record. If the Participant objects to the testimony being recorded,

the Member's objection must be documented in the Grievance record and the Grievance review meeting must proceed without the testimony being recorded.

- q. The Grievance review committee must complete its review of the Grievance as expeditiously as the Participant's health condition requires.
- r. The CHC-MCO must send a written notice of the Grievance decision, using the template specified by the Department, to the Participant, Participant's representative, if the Participant has designated one in writing, service Provider and prescribing Provider, if applicable, within thirty (30) days from the date the CHC-MCO received the Grievance, unless the time frame for deciding the Grievance has been extended by up to fourteen (14) days at the request of the Participant.
- s. The Participant may file a request for a Fair Hearing, a request for an external review, or both a request for a Fair Hearing and a request for an external review.
- t. The Participant or Participant's representative may file a request for a Fair Hearing within one hundred and twenty (120) days from the mail date on the written notice of the CHC-MCO's Grievance decision.
- u. The Participant or Participant's representative, which may include the Participant's Provider, with proof of the Participant's written authorization for a representative to be involved and/or act on the Participant's behalf, may file a request with the CHC-MCO for an external review of a Grievance decision by a IRO appointed by PID. The request must be filed in writing or orally within fifteen (15) days from the date the Participant receives the written notice of the CHC-MCO's Grievance decision.

2. External Grievance Process:

- a. The CHC-MCO must process all requests for external Grievance review. The CHC-MCO must follow the protocols established by PID in meeting all time frames and requirements necessary in coordinating the request and notification of the decision to the Participant, Participant's representative, if the Participant has designated one in writing, service Provider, and prescribing Provider.
- b. A Participant who files a request for an external Grievance review that disputes a decision to discontinue, reduce, or change a service or item that the Participant has been receiving must continue to receive the disputed service or item at the previously authorized level pending resolution of the external

Grievance review, if the request for external Grievance review is made orally, hand delivered, faxed, or post-marked within fifteen (15) days from the mail date on the written notice of the CHC-MCO's Grievance decision.

- c. Within five (5) business days of receipt of the request for an external Grievance review, the CHC-MCO must notify the Participant, the Participant's representative, if the Participant has designated one in writing, the Provider if the Provider filed the request for the external Grievance, and PID that the request for external Grievance review has been filed.
- d. The external Grievance review must be conducted by a IRO not affiliated with the CHC-MCO.
- e. Within two (2) business days from receipt of the request for an external Grievance review, PID will randomly assign a IRO to conduct the review and notify the CHC-MCO and assigned IRO of the assignment.
- f. Within the same two (2) business day timeframe, PID shall notify the Participant or the Participant's authorized representative of the name, address, e-mail address, fax number and telephone number of the IRO assigned under this subsection. The notice shall inform the Participant and the Participant's authorized representative of the right to submit additional written information to the IRO within twenty (20) days of the date the IRO assignment notice was mailed and shall include instructions for submitting additional information to the IRO by mail, fax, or electronically.
- g. If PID fails to select an IRO within two (2) business days from receipt of a request for an external Grievance review, the CHC-MCO may designate an IRO to conduct a review from the list of IROs approved by PID. The CHC-MCO may not select an IRO that has a current contract or is negotiating a contract with the CHC-MCO or its Affiliates or is otherwise affiliated with the CHC-MCO or its Affiliates.
- h. The CHC-MCO must forward all documentation regarding the Grievance decision, including all supporting information, a summary of applicable issues, and the basis and clinical rationale for the Grievance decision, to the IRO conducting the external Grievance review. The CHC-MCO must transmit this information within fifteen (15) days from receipt of the Participant's request for an external Grievance review.
- i. Within fifteen (15) days from receipt of the request for an external Grievance review by the CHC-MCO, the Participant or the Participant's representative, or the Participant's Provider, may supply additional information to the IRO conducting the external Grievance review for consideration. Copies must also

be provided at the same time to the CHC-MCO so that the CHC-MCO has an opportunity to consider the additional information.

- j. Within sixty (60) days from the filing of the request for the external Grievance review, the IRO conducting the external Grievance review must issue a written decision to the CHC-MCO, the Participant, the Participant's representative, PID and the Provider (if the Provider filed the Grievance with the Participant's consent), that includes the basis and clinical rationale for the decision. The standard of review must be whether the service or item is Medically Necessary and appropriate under the terms of this Agreement.
- k. The external Grievance decision may be appealed by the Participant, the Participant's representative, or the Provider to a court of competent jurisdiction within sixty (60) days from the date the Participant receives notice of the external Grievance decision.

3. Expedited Grievance Process

- a. The CHC-MCO must conduct expedited review of a Grievance if the CHC-MCO determines that the Participant's life, physical or mental health, or ability to attain, maintain, or regain maximum function would be placed in jeopardy by following the regular Grievance process or if a Participant or Participant representative, with proof of the Participant's written authorization for a representative to be involved and/or act on the Participant's behalf, provides the CHC-MCO with a certification from the Participant's Provider that the Participant's life, physical or mental health, or ability to attain, maintain, or regain maximum function would be placed in jeopardy by following the regular Grievance process. The certification must include the Provider's signature.
- b. A request for expedited review of a Grievance may be filed either in writing via mail, by fax, electronically (via secure email or secure web portal, if available), or orally.
- c. The expedited review process is bound by the same rules and procedures as the Grievance review process with the exception of timeframes, which are modified as specified in this section.
- d. Upon receipt of an oral or written request for expedited review, the CHC-MCO must inform the Participant of the right to present evidence and testimony and make legal and factual arguments in person as well as in writing and of the limited time available to do so.
- e. If the Provider certification is not included with the request for an expedited review and the CHC-MCO cannot determine based on the information

provided that the Participant's life, physical or mental health, or ability to attain, maintain, or regain maximum function would be placed in jeopardy by following the regular Grievance process, the CHC-MCO must inform the Participant that the Provider must submit a certification as to the reasons why the expedited review is needed. The CHC-MCO must make a reasonable effort to obtain the certification from the Provider. If the Provider certification is not received within seventy-two (72) hours of the Participant's request for expedited review, the CHC-MCO must decide the Grievance within the standard time frames as set forth in this Exhibit unless the time frame for deciding the Grievance has been extended by up to fourteen (14) days at the request of the Participant. If the CHC-MCO decides that expedited consideration with the initial or extended time frame is not warranted, the CHC-MCO must make a reasonable effort to give the Participant prompt oral notice that the Grievance is to be decided within the standard time frame and send a written notice within two (2) business days of the decision to deny expedited review, using the template specified by the Department.

- f. A Participant who files a request for expedited review of a Grievance to dispute a decision to discontinue, reduce or change a service or item that the Participant has been receiving must continue to receive the disputed service or item at the previously authorized level pending resolution of the Grievance, if the request for expedited review of a Grievance is made verbally, hand delivered, submitted electronically (via secure email or secure web portal, if available), or post-marked within fifteen (15) days from the mail date on the written notice of decision.
- g. Expedited review of a Grievance must be conducted by a Grievance review committee made up of three (3) or more individuals who were not involved in and are not the subordinates of an individual involved in any previous level of review or decision-making on the issue that is the subject of the Grievance.
- h. At least one-third of the expedited Grievance review committee may not be employees of the CHC-MCO or a related subsidiary or Affiliate.
- i. The expedited Grievance review committee must include a licensed physician or licensed dentist in the same or similar specialty that typically manages or consults on the service or item in question. If the Grievance is related to dental services, the expedited Grievance review committee must include a dentist. Other appropriate providers may participate in the review, but the licensed physician or licensed dentist in the same or similar specialty that typically manages or consults on the service or item in question must decide the Grievance.
- j. Prior to the start of the expedited Grievance review meeting, the Participant must be told that the testimony will be recorded. If the Participant agrees to the testimony taken by the Grievance review committee (including the Participant's comments) being recorded, the testimony must be recorded and

transcribed verbatim and a written transcription prepared and maintained as part of the Grievance record. If the Participant objects to the testimony being recorded, the Participant's objection must be documented in the expedited Grievance record and the expedited Grievance review meeting must proceed without the testimony being recorded.

- k. The CHC-MCO must issue the decision resulting from the expedited review in person or by phone to the Participant, to the Participant's representative if the Participant has designated one in writing, to the service Provider, and to the prescribing Provider within either forty eight (48) hours of receiving the Provider certification or seventy-two (72) hours of receiving the Participant's request for an expedited review, whichever is shorter, unless the time frame for deciding the expedited Grievance has been extended by up to fourteen (14) days at the request of the Participant. In addition, the CHC-MCO must mail written notice of the decision to the Participant, to the Participant's representative, if the Participant has designated one in writing, to the service Provider, and to the prescribing Provider, if applicable, within two (2) business days of the decision, using the template specified by the Department.
- l. The Participant or the Participant's representative may file a request for a Fair Hearing within one hundred and twenty (120) days from the mail date on the written notice of the CHC-MCO's expedited Grievance decision.
- m. A request for an expedited Fair Hearing may be filed with the Department's Bureau of Hearings and Appeals verbally, or in writing via mail, fax, or secure email.
- n. The Participant, or Participant's representative, which may include the Participant's Provider, with proof of the Participant's written authorization for the representative to be involved and/or act on the Participant's behalf, may file a request for an expedited external Grievance review with the CHC-MCO within two (2) business days from the date the Participant receives the CHC-MCO's expedited Grievance decision. A Participant who files a request for an expedited external Grievance review to dispute a decision to discontinue, reduce, or change a service or item that the Participant has been receiving must continue to receive the disputed service or item at the previously authorized level pending resolution of the request for expedited Grievance review.
- o. The CHC-MCO must follow PID guidelines relating to submission of requests for expedited external reviews.
- p. The CHC-MCO may not take punitive action against a Provider who requests expedited resolution of a Grievance or supports a Participant's request for expedited review of a Grievance.

D. Department's Fair Hearing Requirements

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

1. Fair Hearing Process

- a. A Participant or Participant's representative must file a Complaint or Grievance with the CHC-MCO and receive a decision on the Complaint or Grievance before filing a request for a Fair Hearing. If the CHC-MCO fails to provide written notice of a Complaint or Grievance decision within the time frames specified in this Exhibit, the Participant is deemed to have exhausted the Complaint or Grievance process and may request a Fair Hearing.
- b. The Participant or the Participant's representative may request a Fair Hearing within one hundred and twenty (120) days from the mail date on the written notice of the CHC-MCO's first level Complaint decision or Grievance decision for any of the following:
 - i. the denial, in whole or part, of payment for a requested service or item based on lack of Medical Necessity;
 - ii. the denial of a requested service or item because the service or item is not a Covered Service;
 - iii. the reduction, suspension, or termination of a previously authorized service or item;
 - iv. the denial of a requested service or item but approval of an alternative service or item;
 - v. the failure of the CHC-MCO to provide a service or item in a timely manner, as defined by the Department;
 - vi. the failure of a CHC-MCO to decide a Complaint or Grievance within the specified time frames;
 - vii. the denial of payment after a service or item has been delivered because the service or item was provided without authorization by a provider not enrolled in the MA Program;

- viii. the denial of payment after a service or item has been delivered because the service or item is not a Covered Service for the Participant;
 - ix. the denial of a Participant's request to dispute a financial liability, including cost sharing, copayments, premiums, deductibles, coinsurance, and other Participant financial liabilities.
- c. The request for a Fair Hearing must include a copy of the written notice of decision that is the subject of the request unless the CHC-MCO failed to provide written notice of the Complaint or Grievance decision within the time frames specified in this Exhibit. Requests must be sent to:

Department of Human Services
OLTL/Forum Place 6th Floor
Complaint, Grievance and Fair Hearings
P.O. Box 8025
Harrisburg, Pennsylvania 17105-8025

- d. A Participant who files a request for a Fair Hearing that disputes a decision to discontinue, reduce, or change a service or item that the Participant has been receiving must continue to receive the disputed service or item at the previously authorized level pending resolution of the Fair Hearing, if the request for a Fair Hearing is hand delivered, emailed, faxed, or post-marked within fifteen (15) days from the mail date on the written notice of decision.
- e. Upon receipt of the request for a Fair Hearing, BHA will schedule a hearing. The Participant and the CHC-MCO will receive notification of the hearing date by letter at least ten (10) days before the hearing date, or a shorter time if requested by the Participant. The letter will outline the type of hearing, the location of the hearing (if applicable), and the date and time of the hearing.
- f. The CHC-MCO is a party to the hearing and must be present. The CHC-MCO, which may be represented by an attorney, must be prepared to explain and defend the issue on appeal. BHA's decision is based solely on the evidence presented at the hearing. The absence of the CHC-MCO from the hearing will not be reason to postpone the hearing.
- g. The CHC-MCO must provide Participants, at no cost, with records, reports, and documents, relevant to the subject of the Fair Hearing. The CHC-MCO must provide all information and documents relevant to the subject of the Fair Hearing to BHA through the Department's Electronic Case Management System.

- h. BHA will issue an adjudication within ninety (90) days of the date the Participant filed the first level Complaint or the Grievance with the CHC-MCO, not including the number of days before the Participant requested the Fair Hearing. If BHA fails to issue an adjudication within ninety (90) days of receipt of the initial request for the Fair Hearing, the CHC-MCO must comply with the requirements at 55 Pa. Code § 275.4 regarding the provision of interim assistance upon the request for such by the Participant. When the Participant is responsible for delaying the hearing process, the time limit by which BHA must issue the adjudication prior to interim assistance being afforded will be extended by the length of the delay attributed to the Participant.
- i. BHA's adjudication is binding on the CHC-MCO unless reversed by the Secretary of Human Services. Either party may request reconsideration from the Secretary within fifteen (15) days from the date of the adjudication. Only the Participant may appeal to Commonwealth Court within thirty (30) days from the date of the BHA adjudication or from the date of the Secretary's final order, if reconsideration was granted. The decisions of the Secretary and the Court are binding on the CHC-MCO.
- j. The CHC-MCO must provide continuation of benefits if the Participant requests reconsideration from the Secretary, pursuant to 55 Pa. Code 275.4(h)(4)(iii).

2. Expedited Fair Hearing Process

- a. A Participant or the Participant's representative may file a request for an expedited Fair Hearing with the Department either in writing or orally.
- b. A Participant must exhaust the Complaint or Grievance process prior to filing a request for an expedited Fair Hearing.
- c. BHA will conduct an expedited Fair Hearing if a Participant or a Participant's representative provides the Department with a signed written certification from the Participant's Provider that the Participant's life, physical or mental health, or ability to attain, maintain, or regain maximum function would be placed in jeopardy by following the regular Fair Hearing process. If a Participant's Provider does not send a letter, the Fair Hearing will not be expedited. The Fair Hearing will be scheduled and decided using the usual time frame.
- d. A Participant who files a request for an expedited Fair Hearing to dispute a decision to discontinue, reduce, or change a service or item that the Participant has been receiving must continue to receive the disputed service or item at the previously authorized level pending resolution of the Fair Hearing, if the request for an expedited Fair Hearing is made verbally, hand

delivered, emailed, faxed, or post-marked within fifteen (15) days from the mail date on the written notice of decision.

- e. Upon the receipt of the request for an expedited Fair Hearing, BHA will review the documentation and schedule an expedited hearing when it meets criteria and a regular hearing when it does not.
- f. The CHC-MCO is a party to the hearing and must be present. The CHC-MCO, which may be represented by an attorney, must be prepared to explain and defend the issue on appeal. The absence of the CHC-MCO from the hearing will not be reason to postpone the hearing.
- g. The CHC-MCO must provide the Participant, at no cost, with records, reports, and documents relevant to the subject of the Fair Hearing.
- h. If the criteria for an expedited Fair Hearing is met, BHA has three (3) business days from the receipt of the Participant's oral or written request for an expedited review to process final administrative action.
- i. BHA's adjudication is binding on the CHC-MCO unless reversed by the Secretary of Human Services. Either party may request reconsideration from the Secretary within fifteen (15) days from the date of the adjudication. Only the Participant may appeal to Commonwealth Court within thirty (30) days from the date of adjudication or from the date of the Secretary's final order, if reconsideration was granted. The decisions of the Secretary and the Court are binding on the CHC-MCO.

E. Provision of and Payment for Service or Item Following Decision

- 1. If the CHC-MCO, IRO, BHA, or the Secretary reverses a decision to deny, limit, or delay a service or item that was not furnished during the Complaint, Grievance, External Grievance Review, or Fair Hearing process, the CHC-MCO must authorize or provide the disputed service or item as expeditiously as the Participant's health condition requires but no later than seventy-two (72) hours from the date it receives notice that the decision was reversed. If the CHC-MCO requests reconsideration, the CHC-MCO must authorize or provide the disputed service or item pending reconsideration unless the CHC-MCO requests a stay of the BHA decision and the stay is granted.
- 2. If the CHC-MCO, IRO, BHA, or the Secretary reverses a decision to deny authorization of a service or item, and the Participant received the disputed service or item during the Complaint, Grievance, External Grievance Review, or

Fair Hearing process, the CHC-MCO must pay for the service or item that the Participant received.

3. If a Participant requests both an external appeal/review and a Fair Hearing, and if the decisions rendered as a result of the external review and Fair Hearing are in conflict with one another, the CHC-MCO must abide by the decision most favorable to the Participant. In the event of a dispute or uncertainty regarding which decision is most favorable to the Participant, the CHC-MCO must submit the matter to DHS' the Department's Grievance and Appeals Coordinator for review and resolution.

EXHIBIT H

COORDINATION WITH

BEHAVIORAL HEALTH MANAGED CARE ORGANIZATIONS

Written agreements between the CHC-MCO and the BH-MCO must reflect the requirements for how the CHC-MCO and BH-MCO will coordinate services for all Participants, including those in NFs and those receiving LTSS at home. A sample coordination agreement (which does not include all required procedures) is available on the Intranet supporting CHC. The written agreements must include, but not be limited to:

- Procedures which govern referral, collaboration, and coordination of diagnostic assessment and treatment, prescribing practices, the provision of ED services, and other treatment issues necessary for optimal health and prevention of disease. The CHC-MCO and the BH-MCO must collaborate in relation to the provision of ED services. Emergency services provided in general hospital EDs are the responsibility of the CHC-MCO, regardless of the diagnosis or services provided. The only exception is for ED evaluations for voluntary or involuntary commitment pursuant to the 1976 Mental Health Procedures Act, 50 P.S. §§ 7107 - 7116, which are the responsibility of the BH-MCO. Responsibility for inpatient admission will be based upon the Participant's primary diagnosis. Procedures must define and explain how payment will be shared when the Participant's primary diagnosis changes during a continuous hospital stay;
- Procedures, including Prior Authorization, which govern reimbursement by the BH-MCO to the CHC-MCO for BH services provided by the CHC-MCO or vice versa. Procedures must include provisions for differential diagnosis of persons with coexisting physical and BH disorders, as well as provisions for cost-sharing when both physical and BH services are provided to a Participant;
- Procedures for the exchange of enrollment and health-related information among the BH-MCO, the CHC-MCO, the PCP, and Providers of BH and Covered Services in accordance with Federal and State confidentiality statutes and regulations (e.g., periodic treatment updates with identified primary and relevant specialty Providers);
- Policy and procedures for obtaining releases to share clinical information and providing health records to each other as requested, consistent with Federal and State confidentiality requirements;
- Procedures for training and consultation to each other to facilitate continuity of care and cost-effective use of resources;
- A mechanism for timely resolution of any clinical and fiscal payment disputes, including procedures for entering into binding arbitration to obtain final resolution;
- Procedures for serving on interagency teams, as necessary;

- Procedures for the development of adequate Provider Networks to serve special needs populations and coordination of specialized service plans between the BH-MCO service managers, BH service provider(s) and the PCP for Participants with special health needs (e.g., older adults with coexisting physical and behavioral health disorders);
- Procedures for the coordination and payment of emergency and non-emergency Medically Necessary ambulance transportation of Participants. All emergency and non-emergency Medically Necessary ambulance transportation for both physical and BH services Covered Services is the responsibility of the CHC-MCO, including for a BH diagnosis.
- Procedures for the coordination of laboratory services;
- Mechanisms and procedures to ensure coordination between the BH-MCO service managers, Participant services staff and BH-MCO network providers with the CHC-MCO's Service Coordination unit. The effectiveness of these mechanisms shall be included as an area for review by the BH-MCO's Quality Assurance Program and the CHC-MCO's QM Program;
- Procedures for the CHC-MCO to provide physical examinations required for the delivery of BH services, within designated time frames for each service;
- Procedures for the interaction and coordination of pharmacy services.

To ensure that there is support for the coordination of care between the PCP and the BH provider, appropriate county contacts can be found at the following Internet addresses:

County MH/ID Administrators:

<https://www.dhs.pa.gov/providers/Providers/Pages/County-Mental-Health-System.aspx>

Single County Authorities (SCAs):

<https://www.ddap.pa.gov/Get%20Help%20Now/Pages/County-Drug-and-Alcohol-Offices.aspx>

EXHIBIT I

**GUIDELINES FOR CHC-MCO
ADVERTISING, SPONSORSHIPS, AND OUTREACH**

I. Overview

The CHC-MCO must submit a plan for advertising, sponsorship, and outreach procedures to the Department for advance written approval in accordance with the guidelines outlined in this exhibit. This plan must address how the CHC-MCO will market its D-SNP to Participants.

II. Community HealthChoices Outreach Procedures

The CHC-MCO must adhere to the following guidelines and all the requirements specified in Section V.O.2, CHC-MCO Outreach Materials, and V.O.3, CHC-MCO Outreach Activities, of the Agreement when submitting outreach materials, policies and procedures to the Department.

A. Submission of CHC-MCO Outreach Materials

Purpose: To obtain Department approval of new or revised outreach materials, plans or procedures.

Objectives:

1. To assure that CHC-MCO outreach materials are accurate.
2. To prevent the CHC-MCO from distributing outreach materials that mislead, confuse or defraud either the Participant or the Department.

Process:

1. The CHC-MCO submits outreach materials to the Department for prior approval using the CHC Educational Materials Approval Form (form attached).
2. The Department's contract monitoring Core Team will review and forward to the CHC-MCO a preliminary response within thirty (30) calendar days from date of receipt of the request form.

Exception: Should the materials require comments or approval from offices outside the Department contract monitoring Core Team, the turnaround time would be as soon as possible.

3. The CHC-MCO will submit a final copy of the outreach materials to the Department contract monitoring Core Team for a final written approval

prior to circulating the materials.

4. The Department review agency will forward a final written approval to the CHC-MCO within ten (10) business days.
5. Outreach material usage:
 - a. Direct outreach materials will be used only by the IEB personnel after final written approval is received by the CHC-MCO from the Department.
 - b. Indirect outreach materials (i.e., advertisements) may be utilized immediately after final written approval is received by the CHC-MCO from the Department.

B. Criteria for Review of CHC-MCO Outreach Materials

Purpose: To ensure that printed materials, advertising, promotional activities, and new Participant orientations coordinated through the IEB are designed to enable Participants to make an informed choice.

Objectives:

1. To ensure that the information complies with all Federal and State requirements.
2. To determine if the information is grammatically correct and appropriate for Pennsylvania's Medical Assistance population.
3. To ensure that outreach materials are accurate and do not mislead, confuse, or defraud the Participant or the Department with the assertion or statement that the Participant must enroll in the CHC-MCO in order to obtain Medical Assistance benefits, or in order to not lose Medical Assistance benefits.
4. To ensure that the outreach materials do not contain assertions or statements that a Participant must enroll in the aligned D-SNP of the CHC-MCO.
5. To ensure that there are no assertions or statements that the CHC-MCO is endorsed by CMS, the Federal or State government, or similar entity.

Process:

1. Receive a written overall outreach plan annually if the CHC-MCO anticipates participation in outreach activities. Requests for specific indirect advertising must be submitted thirty (30) calendar days in

- advance for written Department approval.
2. Determine if approval is necessary from other offices.
 3. Review the information with the following criteria:
 - a. Is the CHC-MCO identified?
 - b. Does the information comply with all Federal and State regulations?
 - c. Is the information presented in grammatically correct, precise, appropriate and unambiguous language, easily understood by the target audience (i.e., age and language) and does it avoid the use of industry jargon?
 - d. Is the information fair, relevant, accurate and not misleading or disparaging to competitors?
 - e. Can the information be easily understood by a person with a sixth grade education?
 - f. Does the information include symbols or pictures that are discriminating because of race, color, creed, age, religion, sex, sexual orientation, gender identity, national origin, ancestry, marital status, income status, health status, physical or mental disability, or otherwise?
 - g. Does the information create a negative image of the traditional FFS system?
 4. The Department will forward a final written response to the CHC-MCO within ten (10) business days.

C. CHC-MCO Participating In or Hosting an Event

The CHC-MCO may submit requests to sponsor or participate in health fairs or community events; the request should demonstrate that the CHC-MCO will participate in such fairs or events through activities, including approved outreach activities that are primarily health-care related. The CHC-MCO must receive advance written approval from the Department prior to the event date. All requests must be submitted to the Department at least thirty (30) calendar days in advance of the event, on the forms which are included as part of this attachment.

Purpose: To clarify for CHC-MCOs that Pennsylvania laws and regulations prohibit certain kinds of offers or payments to Participants as inducements or incentives for Participants to use the CHC-MCO's services.

Objectives:

1. To provide amenities that create an environment that is comfortable and convenient for Participants but is not offered as an artificial outreach inducement or incentive.
2. To eliminate fraudulent, abusive and deceptive practices that may occur as incentives or inducements to obtain specific Covered Services from the CHC-MCO.

Process:

1. The CHC-MCO must submit a request, using the applicable Community HealthChoices CHC-MCO Outreach Approval Form or the Community HealthChoices Educational Materials Approval Form, to the appropriate Department review agency thirty (30) calendar days in advance of the event (see attached). Should the event require approval from other offices, the approval process may extend beyond thirty (30) calendar days.
2. The Department review agency considers the request as confidential.

D. Community HealthChoices CHC-MCO Outreach Approval Form

E. Community HealthChoices Educational Materials Approval Form

COMMUNITY HEALTHCHOICES EDUCATIONAL MATERIALS APPROVAL FORM

CHC-MCO Name: _____ Tracking #: _____

Contact Person: _____ Date: _____

Request Received By DHS: _____

Subject: _____

Who: _____

What: _____

When: _____

Where: _____

Any Fees: _____

Confirmation Letter Attached: Yes ☐ No ☐

Discussion:

DHS USE ONLY:

Approved: ☐ Denied: ☐

Reviewer: _____ Final Approval Date: _____

COMMUNITY HEALTHCHOICES CHC-MCO OUTREACH APPROVAL FORM

CHC-MCO Name: _____ Tracking #: _____

Contact Person: _____ Date: _____

Request Received By DHS: _____

Subject: _____

Who: _____

What: _____

When: _____

Where: _____

Any Fees: _____

Confirmation Letter Attached: Yes ☐ No ☐

Discussion:

DHS USE ONLY:

Approved: ☐ Denied: ☐

Reviewer: _____ Final Approval Date: _____

EXHIBIT J

PARTICIPANT CHC-MCO SELECTION AND ASSIGNMENT

IEB Responsibilities for Advance Plan Selections and Plan Assignments

During the pre-transition period, the IEB will contact Potential Participants to offer them information about CHC and the CHC-MCOs and assist the individual to choose a CHC-MCO before being assigned to one. If an individual does not select a CHC-MCO, the individual will be assigned to a CHC-MCO according to the hierarchy criteria described below. If none of the hierarchy criteria applies to an individual, the individual will be assigned to a CHC-MCO using the automatic assignment process described below. Participants who are enrolled in a CHC-MCO through either mechanism may select a different CHC-MCO at any time. The IEB will assist Participants in choosing a different CHC-MCO.

After the CHC transition date, all eligible Participants will be enrolled in a CHC-MCO using the automatic assignment process described below.

Potential Participants who are NFI Dual Eligibles. In making CHC-MCO assignments, the IEB will use the following hierarchy:

- First, if the individual is enrolled in a D-SNP, the individual will be enrolled in the CHC-MCO aligned with that D-SNP;
- Second, if the individual is transferring from Health Choices and is a member of a Physical Health HealthChoices MCO that is also a CHC-MCO, the individual will be enrolled in that CHC-MCO; and
- Last, if the individual's PCP is a Network Provider with only one CHC-MCO, the individual will be enrolled in that CHC-MCO.

Potential Participants who are NFCE. In making CHC-MCO assignments, the IEB will use the following hierarchy:

- First, if on the Enrollment Date the individual is residing in a NF that is a Network Provider in only one CHC-MCO, the individual will be enrolled in that CHC-MCO;
- Second, if the individual is enrolled in a D-SNP, the individual will be enrolled in the CHC-MCO that is aligned with that D-SNP;
- Third, if the individual is transferring from HealthChoices and is a member of a Physical Health HealthChoices MCO that is also a CHC-MCO, the individual will be enrolled in that CHC-MCO;
- Last, if the individual's PCP is a Network Provider with only one CHC-MCO, the individual will be enrolled in that CHC-MCO.

Automatic Assignments

If a Participant does not select a CHC-MCO and none of the hierarchy criteria described above applies to the individual, the Participant will be enrolled in a CHC-MCO using the following auto-assignment process:

- If the Participant's case record includes another active Participant in the case who is enrolled in a CHC-MCO, the Participant will be enrolled in that same CHC-MCO. Participants in a family unit will be enrolled in the same CHC-MCO. These Participants will not be included in the percentages designated for auto-assignment.
- All remaining Participants will be included in the pool of Participants who will be auto-assigned to CHC-MCOs using an algorithm that directs a monthly distribution of Participants in the auto-assignment pool in all Zones based on the number of CHC-MCOs in the Zone. .

A CHC-MCO may not receive auto-assignments if it does not have the capacity to take on additional Participants or if it is subject to sanctions.

A CHC Participant who is auto-assigned to a CHC-MCO may select a different CHC-MCO at any time. The IEB will assist Participants in choosing a different CHC-MCO.

Participant Re-Assignment Following Resumption of Eligibility

A Participant who becomes ineligible and becomes eligible again within six (6) months will automatically be re-enrolled in the Participant's previously selected CHC-MCO, as long as the Participant's eligibility status and geographical residence are still valid for enrollment in that same CHC-MCO.

If a Participant becomes ineligible and becomes eligible again after six (6) months, the Participant may be enrolled in the same CHC-MCO as the payment name, the case payment name, or any other Participant in the case that is enrolled in the CHC-MCO. If there is no active CHC-MCO record in the case, the Participant will be enrolled in a CHC-MCO through the auto-assignment process. Prior to the Start Date of the auto-assigned CHC-MCO, the Participant may select a different CHC-MCO and override the auto-assigned CHC-MCO by contacting the IEB. When the Participant contacts the IEB to make this change, the IEB will enroll the Participant in the CHC-MCO of choice through the weekly enrollment process.

Continued Enrollment When Moving Between Zones

A Participant who moves from one CHC zone to another will remain in the CHC-MCO in which he or she was enrolled prior to the move, if the CHC-MCO is also operational in the zone to which the Participant moved.

The Department may reassess the distribution process, modify it in accordance with sound programmatic management principles, and institute any modifications at any time following appropriate written notification to the CHC-MCO.

EXHIBIT K

CHC-MCO PARTICIPANT COVERAGE DOCUMENT

This Participant Coverage Document (PCD) includes descriptions of policies supported by the Department's data systems and processes. In cases where policies in this document conflict with another provision of the CHC-MCO Agreement, the Agreement will take precedence.

CHC-MCO coverage as detailed in this document does not imply coverage under a Behavioral Health Managed Care Organization (BH-MCO) or a Physical Health Managed Care Organization (PH-MCO). Refer to the BH-MCO Recipient Coverage Document for behavioral health coverage guidelines and the PH-MCO Member Coverage Document for PH-MCO coverage guidelines.

The Department will provide sufficient information to each CHC-MCO to reconcile CHC-MCO Participant data and amounts paid to and recovered from the CHC-MCO. The Department will pay capitation to only one CHC plan per-Participant, per-month.

Coverage Rules

A CHC-MCO is responsible for a Participant if coverage is determined by applying the general rules found in paragraph A or B below, subject to exceptions and clarifications in paragraphs C, D, E, and F.

Refer to the Community HealthChoices Extranet site for additional information on Participant coverage, clarifications, examples, and Enrollment/Disenrollment procedures.

A. Responsibility to Provide MA Benefits - Unless otherwise specified, each CHC-MCO is responsible for providing MA benefits to its Participants in accordance with eligibility information included on the Daily or Monthly 834 Eligibility File, which is provided by the Department to each CHC-MCO.

B. Participant Files/Coverage Dates/Eligibility - Daily and Monthly 834 Eligibility Files are provided to each CHC-MCO containing information and changes that apply to its Participants. The CHC-MCO is responsible for providing services for each non-LTSS CHC-MCO Participant identified on the Daily or Monthly 834 Eligibility File from the first day of the calendar month or the CHC-MCO Start Date, whichever is later, through the last day of the calendar month or the CHC-MCO coverage end date, if different. The Department will pay prorated Capitation to the CHC-MCO from the first day of coverage in a month through the last day of the calendar month. CHC-MCO coverage dates beyond the last day of the month are preliminary information that is subject to change.

For LTSS participants, the CHC-MCO is responsible for providing services starting the day after MA eligibility determination. The Department will provide information about these individuals to the CHC-MCOs on a Daily or Monthly 834 Eligibility File.

Client Information System (eCIS) will retain a Participant's CHC-MCO selection for six (6) months after a Participant becomes ineligible for MA. These Participants will become the responsibility of the same CHC-MCO if they regain MA eligibility during that six-month period and their category of assistance and geographic location are valid for that CHC-MCO. Upon regaining MA eligibility, the CHC-MCO Start Date will be the MA eligibility Start Date on eCIS or the date MA eligibility was reopened in eCIS, whichever is later.

C. Exceptions and Clarifications - The Department will recover Capitation payments made for Participants who the Department has determined the CHC-MCO was not responsible for providing services.

The CHC-MCO will not be responsible for nor paid when the Department notifies the CHC-MCO of Participants for whom they are not responsible.

1. Errors in CHC-MCO coverage identified from any source must be reported to the Department within forty-five (45) days of receipt of the Daily 834 Eligibility File for changes to be considered.

If a Participant is enrolled in a CHC-MCO in error, that CHC-MCO is responsible for covering the Participant until the Department is notified and the correction is applied to the eCIS eligibility record.

If at the time of notification to the Department, the Participant was disenrolled in error from a CHC-MCO and then enrolled in a different CHC-MCO, the Participant will be reenrolled in the previous CHC-MCO effective the first of the next month. However, if at the time of notification, the Participant is covered by FFS, the Participant will be reenrolled into the same CHC-MCO effective the day following notification to the Department.

2. If eCIS shows an exemption code or a facility/placement code that precludes CHC-MCO coverage, the Beneficiary will not be enrolled in a CHC-MCO.
3. If eCIS shows Fee-For-Service (FFS) coverage that coincides with CHC-MCO coverage, the Participant may elect to use either coverage and there will be no monetary adjustment between the Department and the CHC-MCO. (This is subordinate to #7 below.)
4. If a CHC-MCO has actual knowledge that a Participant is deceased, and if such Participant shows on either the Daily or Monthly 834 Eligibility File as active, the CHC-MCO is required to notify the County Assistance Office (CAO) and the Department. The Department will recover Capitation payments made for up to twenty-one (21) months after the service month in which the date of death occurred.

5. The Department will recover Capitation payments for Participants who were later determined to be ineligible for CHC-MCO coverage or who were placed in a setting that results in the termination of CHC-MCO coverage by the Department. The Department will recoup payments back to the month following the month in which the termination of coverage occurred, for up to twelve (12) months afterwards. For example, today's date is 9/18/2022 and central office staff end-dated managed care coverage 9/30/2021 – payments are recouped for 10/2021 through 9/2022. See Section E for examples of placements that result in termination of coverage.
6. A Participant's change of residence out of a CHC-MCO's service area does not necessarily exempt the CHC-MCO from the responsibility to provide MA benefits. It is the CHC-MCO's responsibility to inform the CAO of the address change upon receipt of information that a Participant is residing outside the CHC-MCO service area.
7. Pursuant to the rules outlined in this PCD, the absence of MA eligibility indicated on eCIS for a particular date does not necessarily exempt the CHC-MCO from its responsibility to provide MA benefits for that date. Refer to Section D, Change in CHC-MCO Coverage during Inpatient Hospital Stays, for applicable rules.
8. The Department reserves the right to intercede in requests for expedited enrollments when Medically Necessary. The Department's determination for the expedited enrollment will be final. The Capitation rate will be retroactively adjusted for the CHC-MCO based on the expedited Start Date.
9. The CHC-MCO must provide Out-of-Area Covered Services for a Participant as long as they remain a resident of the Commonwealth and the zone. The CHC-MCO remains responsible for a Participant who is:
 - attending a college or university in a state other than Pennsylvania,
 - attending a college or university in a zone other than their zone of residence, or
 - traveling outside of the zone.
10. If eCIS shows Living Independence for the Elderly (LIFE) coverage that coincides with CHC-MCO coverage due to a Participant transfer from CHC to LIFE, the LIFE program will receive a Capitation payment, and the CHC-MCO will not be entitled to a Capitation payment for the consecutive month(s) after the transfer in which the LIFE and CHC-MCO coverages coincide. The Department will recover Capitation payments received by the CHC-MCO for month(s) the LIFE coverage and CHC-MCO coverage coincide due to a Participant transfer from CHC to LIFE.

11. If a Participant transfers from LIFE to CHC and coverage coincides, the CHC-MCO will receive a Capitation payment, and the LIFE program will not be entitled to a Capitation payment for the consecutive month(s) after the transfer in which the CHC-MCO and LIFE coverages coincide. The Department will recover Capitation payments received by the LIFE program for month(s) the CHC-MCO coverage and LIFE coverage coincide due to a Participant transfer from LIFE to CHC.

D. Change in CHC-MCO Coverage during Inpatient Hospital Stays - Payment responsibility when an MA Participant has CHC coverage during part of a hospital stay is detailed in the rules below. Note that one or more of these rules may apply during a particular hospital stay.

RULE: D-1.	
Condition	A Participant who is covered by FFS when admitted to a hospital becomes eligible for CHC-MCO coverage while still in the hospital.
CHC-MCO Coverage Responsibility	As of the CHC-MCO Start Date, the CHC-MCO is responsible for physician, DME, and all other Covered Services not included in the hospital bill.
MA FFS Coverage Responsibility	The FFS program is responsible for the hospital bill through the date of discharge. Note: If the Participant is discharged from the initial hospital and admitted to another hospital (acute or rehabilitation) after the CHC-MCO Start Date, FFS is only responsible for the stay in the initial hospital through the date of discharge. The CHC-MCO is responsible for the stay in the subsequent hospital upon admission.

RULE: D-2	
Condition	A Participant who is covered by a CHC-MCO when admitted to a hospital loses CHC-MCO coverage and assumes FFS coverage while still in the hospital.
CHC-MCO Coverage Responsibility	The CHC-MCO is responsible for the hospital stay with the following exceptions: EXCEPTION #1: If the Beneficiary is still in the hospital on the FFS coverage begin date, and the Participant's FFS coverage begin date is the first (1st) day of the month, the CHC-MCO is financially responsible for the stay through the last day of that month. Example: If a Participant covered by the CHC-MCO is admitted to a hospital on June 21 and the FFS coverage begin Date is July 1, the FFS program assumes payment responsibility for the stay on August 1. The CHC-MCO remains financially responsible for the stay through July 31. EXCEPTION #2: If the Beneficiary is still in the hospital on the FFS coverage begin date, and the

	Beneficiary's FFS coverage begin date is any day other than the first day of the month, the CHC-MCO is financially responsible for the stay through the last day of the following month. Example: If a Participant covered by a CHC-MCO is admitted to a hospital on June 21 and the FFS program coverage begin date is July 15, the FFS program assumes payment responsibility for the stay on September 1. The CHC-MCO program remains financially responsible for the stay through August 31.
MA FFS Coverage Responsibility	Starting with the FFS coverage begin date, FFS is responsible for physician, DME, and other bills not included in the hospital bill. EXCEPTION #1: The FFS program is financially responsible for the stay beginning on the first day of the next month. EXCEPTION #2: The FFS program is financially responsible for the stay beginning on the first day of the month following the next month.

RULE: D-3	
Condition	A currently hospitalized Participant covered by a CHC-MCO transfers to another CHC-MCO while still hospitalized.
CHC-MCO Coverage Responsibility	The surrendering CHC-MCO is responsible for the hospital stay with the exceptions below. As of the gaining CHC-MCO's Start Date, it is responsible for the physician, DME, and all other Covered Services not included in the hospital bill. EXCEPTION #1: If the Participant is still in the hospital on the receiving CHC-MCO Start Date, and the Participant's gaining CHC-MCO Start Date is the first day of the month, the surrendering CHC-MCO is financially responsible for the stay through the last day of that month. The gaining CHC-MCO is financially responsible for the stay beginning on the first day of the next month. Example: If a Participant is admitted to a hospital on June 21 and the receiving CHC-MCO Start Date is July 1, the gaining CHC-MCO assumes payment responsibility for the stay on August 1. The surrendering CHC-MCO remains financially responsible for the stay through July 31. EXCEPTION #2: If the Participant is still in the hospital on the gaining CHC-MCO Start Date, and the gaining CHC-MCO Start Date is any day other than the first day of the month, the surrendering CHC-MCO is financially responsible for the stay through the last day of the following month. The gaining CHC-MCO is financially responsible for the stay beginning on the first day of the month following the next month. Example: If a Participant is admitted to a hospital on June 21 and the receiving CHC-MCO Start Date is July 15, the gaining CHC-MCO assumes payment responsibility for the stay on September 1.

	The surrendering CHC-MCO remains financially responsible for the stay through August 31.
MA FFS Coverage Responsibility	There is no FFS coverage in this example.

RULE: D-4	
Condition	A Participant covered by a CHC-MCO when admitted to a hospital loses and regains MA eligibility while in the hospital (Participant is not discharged), resulting in a break in CHC-MCO coverage. The Department's Division of Medicaid Management Information Systems (MMIS) Operations becomes aware of the break in CHC-MCO coverage by the end of the month following the month in which coverage is lost.
CHC-MCO Coverage Responsibility	MMIS Operations will reopen the Participant's CHC-MCO coverage retroactive to the day it was end-dated on eCIS and adjust the Capitation payment accordingly. The CHC-MCO continues to be financially responsible for the stay, including the physician, DME, and all other Covered Services. Example: A Participant who is admitted to the hospital on March 10 loses MA eligibility effective March 22 and regains it on April 9 retroactive to March 22. The CHC-MCO coverage on eCIS shows the Participant was end-dated March 31 and reopened in the CHC-MCO with a new CHC-MCO Start Date of April 9. On April 25, MMIS Operations becomes aware of the situation. Because MMIS Operations is aware of the loss of MA eligibility within the month following the month in which it was lost, MMIS Operations reopens the CHC-MCO coverage retroactive to April 1, the day after the CHC-MCO end-date is posted on eCIS (March 31). The CHC-MCO continues to be financially responsible for the stay, including the physician, DME, and all other Covered Services.
MA FFS Coverage Responsibility	There would be no FFS coverage in this example.

RULE: D-5	
Condition	A Participant covered by a CHC-MCO when admitted to a hospital loses and regains MA eligibility while in the hospital (Participant is not discharged), resulting in a break in CHC-MCO coverage. MMIS Operations does not become aware of the break in CHC-MCO coverage by the end of the month following the month in which it is lost.
CHC-MCO Coverage Responsibility	Example: A Participant who is admitted to the hospital on March 10 loses MA eligibility effective March 22 and regains it on April 9 retroactive to March 22. The CHC-MCO coverage on eCIS shows the Participant as end-dated March 31 and reopened in the CHC-MCO with a new begin date of April 9. Because MMIS Operations was not aware of the break in CHC-MCO coverage by the end of the month following the month in which it was lost, the CHC-MCO coverage is not reopened retroactive to the day it was end-dated on eCIS (March 31). The CHC-MCO is only responsible

	for covering the Participant through the end of March, then again starting April 9 with a prorated capitation payment for the remainder of April.
MA FFS Coverage Responsibility	FFS is responsible effective April 1 through April 8.

RULE: D-6.	
Condition	A Participant covered by a CHC-MCO when admitted to a hospital loses MA eligibility while in the hospital. The Participant regains MA eligibility retroactively after the month following the month in which the MA eligibility was ended, regardless of when MMIS Operations became aware of the action.
CHC-MCO Coverage Responsibility	Example: A Participant who is admitted to the hospital on March 10 loses MA eligibility effective March 22. The Participant regains MA eligibility on May 15 retroactive to March 22. The CHC-MCO coverage on eCIS shows the Participant was end-dated March 31 and reopened in the CHC-MCO with a new Start Date of May 15. Because the MA eligibility was not reopened within the month following the month in which it was lost, the CHC-MCO coverage is not reopened retroactive to the day it was end-dated on eCIS (March 31). The CHC-MCO is only responsible for covering the Participant through the end of March.
MA FFS Coverage Responsibility	FFS is responsible effective April 1st.

RULE: D-7.	
Condition	A Participant covered by a CHC-MCO when admitted to a hospital loses MA eligibility while in the hospital. The Participant is discharged from the hospital after the month in which the MA eligibility was lost but before the MA eligibility is regained by the Participant and reopened retroactively, regardless of when MMIS Operations became aware of the situation.
CHC-MCO Coverage Responsibility	Example: A Participant who is admitted to the hospital on March 10 loses MA eligibility effective March 22. The Participant is discharged from the hospital April 3. The Participant regains MA eligibility on April 22 retroactive to March 22. The CHC-MCO coverage on eCIS shows the Participant was end-dated March 31 and reopened in the CHC-MCO with a new Start Date of April 22. Because the Participant was discharged from the hospital before the MA eligibility was reopened, which resulted in a three (3)-day period of FFS coverage on eCIS, MMIS Operations does not reopen the CHC-MCO coverage retroactive to April 1. The CHC-MCO is only responsible for the stay through the end of March.

MA FFS	FFS is responsible effective April 1.
Coverage Responsibility	

RULE: D-8	
Condition	A hospitalized Participant never regains MA eligibility.
CHC-MCO Coverage Responsibility	If the Participant is never determined retroactively eligible for MA, the CHC-MCO is only responsible to cover the Participant through the end of the month in which MA eligibility ended.
MA FFS Coverage Responsibility	FFS is not responsible for coverage since the Participant has not regained MA eligibility.

RULE: D-9	
Condition	A Participant who is covered by a PH-MCO when admitted to a hospital loses PH-MCO and assumes CHC-MCO while still in the hospital.
CHC-MCO Coverage Responsibility	The surrendering PH-MCO is responsible for the hospital stay with the exceptions below. As of the gaining CHC-MCO's Start Date, the gaining CHC-MCO is responsible for the physician, DME, and all other Covered Services not included in the hospital bill. EXCEPTION #1: If the Participant is still in the hospital on the gaining CHC-MCO Start Date, and the Participant's gaining CHC-MCO Start Date is the first (1st) day of the month, the surrendering PH-MCO is financially responsible for the stay through the last day of the month. The gaining CHC-MCO is financially responsible for the stay beginning on the first day of the next month. Example: If a Participant is admitted to a hospital on June 21 and the gaining CHC-MCO Start Date is July 1, the gaining CHC-MCO assumes payment responsibility for the stay on August 1. The surrendering PH-MCO remains financially responsible for the stay through July 31. EXCEPTION #2: If the Participant is still in the hospital on the gaining CHC-MCO Start Date, and the Participant's gaining CHC-MCO Start Date is any day other than the first day of the month, the surrendering PH-MCO is financially responsible for the stay through the last day of the following month. The gaining CHC-MCO is financially responsible for the stay beginning on the first day of the month following the next month. Example: If a Participant is admitted to a hospital on June 21 and the gaining CHC-MCO Start Date is July 15, the gaining CHC-MCO assumes payment responsibility for the stay on September 1. The

	surrendering PH-MCO remains financially responsible for the stay through August 31.
MA FFS Coverage Responsibility	There is no FFS coverage in this example.

RULE: D-10	
Condition	A Participant who is covered by a CHC-MCO when admitted to a hospital loses CHC-MCO and assumes PH-MCO while still in the hospital.
CHC-MCO Coverage Responsibility	The surrendering CHC-MCO is responsible for the hospital stay with the exceptions below. Starting with the gaining PH-MCO's Start Date, the gaining PH-MCO is responsible for the physician, DME, and all other Covered Services not included in the hospital bill. EXCEPTION #1: If the Participant is still in the hospital on the gaining PH-MCO Start Date, and the Participant's gaining PH-MCO Start Date is the first (1st) day of the month, the surrendering CHC-MCO is financially responsible for the stay through the last day of the month. The gaining PH-MCO is financially responsible for the stay beginning on the first day of the next month. Example: If a Participant is admitted to a hospital on June 21 and the gaining PH-MCO Start Date is July 1, the gaining PHC-MCO assumes payment responsibility for the stay on August 1. The surrendering CHC-MCO remains financially responsible for the stay through July 31. EXCEPTION #2: If the Participant is still in the hospital on the gaining PH-MCO Start Date, and the Participant's gaining PH-MCO Start Date is any day other than the first day of the month, the surrendering CHC-MCO is financially responsible for the stay through the last day of the following month. The gaining PH-MCO is financially responsible for the stay beginning on the first day of the month following the next month. Example: If a Participant is admitted to a hospital on June 21 and the gaining PH-MCO Start Date is July 15, the gaining PH-MCO assumes payment responsibility for the stay on September 1. The surrendering CHC-MCO remains financially responsible for the stay through August 31.
MA FFS Coverage Responsibility	There is no FFS coverage in this example.

E. Other Causes for Coverage Termination and Involuntary Disenrollment - If a condition described in the following sections occurs, the CHC-MCO must notify the Department. In accordance with the Department's disenrollment guidelines, MMIS Operations will take action to disenroll the Participant. The Department will recoup payments back to the month following the month in which the termination of coverage occurred, for up to twelve (12) months afterwards. For example, today's date is 9/18/2022 and central office staff end date Managed care Coverage 9/30/2021 – payments are recouped for 10/2021 through 9/2022).

If a Participant is placed in a setting listed in these sections and is under FFS prior to the CHC-MCO's Start Date, CHC-MCO coverage will be voided, and adjustments will be processed for any capitation payments made.

The CHC-MCO must notify the Department within sixty (60) days following the satisfaction of the Department's disenrollment guidelines for MMIS Operations to end-date the Participant's enrollment. Failure on the part of the CHC-MCO to notify MMIS Operations within the sixty (60) days will result in the end-date being delayed, thereby extending the CHC-MCO's responsibility for covering the Participant. The CHC-MCO should not hold and then later submit the notifications.

RULE: E-1	
Condition	A Participant is admitted to an out-of-state Nursing Facility (regardless of who places the Participant in the facility).
CHC-MCO Coverage Responsibility	The CHC-MCO is not responsible for Participants who are placed in a Nursing Facility outside of Pennsylvania. A Participant who is placed in an out-of-state Nursing Facility is disenrolled from the CHC-MCO the day before the admission date.

RULE: E-2	
Condition	A Participant is admitted to a Veteran's Home (MA Provider type/specialty 03/042).
CHC-MCO Coverage Responsibility	The CHC-MCO is not responsible for Participants who are admitted to a Veteran's Home. A Participant who is admitted to a Veteran's Home is disenrolled from the CHC-MCO the day before the admission date.

RULE: E-3	
Condition	A Participant is admitted to a State Facility (MA Provider Type/Specialty Codes 01/23 - Public Psychiatric Hospital and 03/37 - State LTC Unit located at State Mental Hospitals).
CHC-MCO Coverage	The CHC-MCO is not responsible for Participants in a State Facility. A Participant admitted to a State Facility is disenrolled from the CHC-MCO the day before the admission date.

Responsibility	
MA FFS Coverage Responsibility	FFS coverage is effective on the admission date.

RULE: E-4	
Condition	A Participant is incarcerated in a Penal Facility, Correctional Institution (including work release), or Youth Development Center.
CHC-MCO Coverage Responsibility	The CHC-MCO is not responsible for coverage since the Participant is no longer eligible for MA upon placement in a correctional facility. The Participant is disenrolled from the CHC-MCO effective the day before incarceration in the facility or institution.
MA FFS Coverage Responsibility	FFS is not responsible for coverage since the Participant is no longer eligible for MA upon placement in a correctional facility, except for inpatient hospital services. Note: This rule is based upon section 392.2 of the MA Eligibility Handbook which states: “For purposes of MA eligibility, other than eligibility for inpatient hospital services, the needs of an inmate in a correctional institution are the responsibility of the governmental authority exercising administrative control over the facility.”

RULE: E-5	
Condition	A Participant is enrolled in the Living Independence for the Elderly Program (LIFE) (MA Provider Type/Specialty Code 07/70 – LIFE). LIFE is Pennsylvania’s Managed Care option for individuals who are Nursing Home Clinically Eligible (NFCE) and age 55 and older. It provides fully integrated acute care, long-term care, behavioral health, and pharmacy services to individuals who wish to remain in the community.
CHC-MCO Coverage Responsibility	A Participant enrolled in LIFE is disenrolled from the CHC-MCO effective the day before the Start Date in the LIFE program.
MA FFS Coverage Responsibility	LIFE coverage begins the day after the disenrollment date.

F. Other Facility Placement Coverage - The following rules provide information relating to CHC-MCO coverage of Participants placed in psychiatric facilities.

RULE: F-1	
Condition	A Participant is admitted to an Extended Acute Psychiatric Care Hospital (MA Provider Type/Specialty Code 01/18 – Extended Acute Psych Inpatient Unit).
CHC-MCO Coverage Responsibility	A Participant admitted to an extended acute psychiatric hospital remains covered by the selected CHC-MCO for all Covered Services. If the Participant is placed in the facility by the BH-MCO, then the BH-MCO is responsible for the residential and treatment costs.
MA FFS Coverage Responsibility	FFS is responsible for the residential and treatment costs.

RULE: F-2	
Condition	A Participant is admitted to an Inpatient Private Psychiatric Facility (MA Provider Type/Specialty Code 01/11 – Private Psychiatric Hospital and 01/22 – Private Psychiatric Unit).
CHC-MCO Coverage Responsibility	A Participant admitted to a Private Psychiatric Hospital remains covered by the selected CHC-MCO for all Covered Services. The BH-MCO is responsible for the residential and treatment costs.
MA FFS Coverage Responsibility	FFS is responsible for the residential and treatment costs.

Exhibit L

PARTICIPANT RIGHTS AND RESPONSIBILITIES

PARTICIPANTS' RIGHTS

Each CHC-MCO must have written policies regarding the Participant rights specified in this Exhibit.

Each CHC-MCO must comply with any applicable Federal and State laws that pertain to Participant rights, and its staff and Network Providers must take those rights into account when furnishing services to enrollees.

A participant has the right to:

- Receive information in a manner and format that may be easily understood and is readily accessible to Participants and potential Participants.
- Receive accurate, easily understood information and assistance in making informed health care and LTSS decisions about his or her health plans, professionals, and facilities.
- A choice of healthcare and LTSS providers that is sufficient to ensure access to appropriate high-quality healthcare.
- Access emergency health care services when and where the need arises.
- Fully participate in all decisions related to his or her healthcare and LTSS. Participants who are unable to fully participate in treatment decisions have the right to be represented by parents, guardians, family members, or other conservators.
- Considerate, courteous and respectful care from all members of the healthcare and LTSS system at all times and under all circumstances.
- Communicate with Providers in confidence and to have the confidentiality of his or her individually identifiable healthcare and LTSS information protected. Participants also have the right to review and copy his or her own medical and LTSS records and request amendments or corrections to their records.
- A fair and efficient process for resolving differences with their health plans, healthcare and LTSS Providers, and the institutions that serve them, including a rigorous system of internal review and an independent system of external review.
- Be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience or retaliation, as specified in other Federal regulations on the use of restraints and seclusion.

The information requirements for services that are not covered under the contract because of moral or religious objections are set forth in 42 C.F.R. §438.10(g)(2)(ii)(A) and (B).

Each Participant is free to exercise his or her rights, and the exercise of those rights may not adversely affect the way the CHC-MCO and its providers treat the enrollee.

Each CHC-MCO must comply with any other applicable Federal and State laws (such as: Title VI of the Civil Rights Act of 1964 as implemented by regulations at 45 CFR part 80; the Age Discrimination Act of 1975 as implemented by regulations at 45 CFR part 91; the Rehabilitation Act of 1973; and Titles II and III of the Americans with Disabilities Act.

PARTICIPANTS' RESPONSIBILITIES

CHC Participants have the following responsibilities:

- Take responsibility for maximizing healthy habits, such as exercising, not smoking, and eating a healthy diet.
- Become involved in specific health care decisions.
- Work collaboratively with healthcare and LTSS Providers in developing and carrying out agreed-upon treatment plans.
- Disclose relevant information and clearly communicate wants and needs.
- Use the health plan's internal complaint and appeal processes to address concerns that may arise.
- Avoid knowingly spreading disease.
- Recognize the reality of risks and limits of the science of medical care and the human fallibility of the health care professional.
- Be aware of a healthcare and LTSS Provider's obligation to be reasonably efficient and equitable in providing care to other patients and the community.
- Become knowledgeable about his or her health plan, LTSS coverage, and LTSS options (when available) including all covered benefits, limitations, and exclusions, rules regarding use of network providers, coverage and referral rules, appropriate processes to secure additional information, and the process to appeal coverage decisions.
- Show respect for other patients, health workers, and LTSS workers.
- Make a good-faith effort to meet financial obligations.
- Abide by administrative and operational procedures of health plans, healthcare and LTSS Providers, and Government health benefit programs.
- Report wrongdoing and fraud to appropriate resources or legal authorities.

EXHIBIT M

PARTICIPANT HANDBOOK

The CHC-MCO must adhere to the following guidelines and all the requirements in section V.O.4, LEP requirements, V.O.5, Alternative Format Requirements, and V.O.16, Participant handbook. The CHC-MCO must utilize the Participant handbook template provided by the Department. The CHC-MCO must provide a Participant Handbook in the appropriate prevalent language, or alternative format, to all Participants within five (5) business days of being notified of a Participant's Enrollment.

At a minimum, the Participant handbook must include:

1. Information about the CHC-MCO, its Covered Services, excluded services, Network Providers, and the Participant's rights and responsibilities as outlined in Exhibit L, Participant Rights and Responsibilities.
2. Role of the PCP in directing and managing care and as a Participant advocate.
3. Information on the role of the IEB and how to access services, including but not limited to what services it provides to Participants and contact information.
4. Description of services, which should include assistance with changing CHC-MCOs, PCPs, and the right to request an updated Provider Directory.
5. Procedure to access after-hour, non-emergency care.
6. Description of the CHC-MCO ID card and the ACCESS card and their uses.
7. Statement that no balanced billing is allowed, Participants are not to be balanced billed by Providers, and are to be held harmless for any bills the CHC-MCO declines to pay, and a statement of what steps to take in the event the Participant is billed or balance billed.
8. Information about the right to contact the Long-Term Care ombudsman, and about how to contact Protective Services (to assist those at risk for abuse, neglect, financial exploitation, and abandonment).
9. Information about co-payments, Prior Authorization, service limits, and the Covered Services exception process.
10. An explanation of the Participant's financial responsibilities for payment of services provided by an Out-of-Network Provider, when an item or service that requires Prior Authorization is provided without Prior Authorization being obtained, or when an item or service is provided that is not covered by the CHC-MCO.

- An explanation that prescriptions for medications that are written by Out-of-Network Providers (whether or not they are presented at an out-of-network pharmacy) will be the Participant's

Responsibility, with the following exceptions:

- The Non-Participating Provider or non-network Provider arrangements were approved in advance by the CHC-MCO and any Prior Authorization requirements (if applicable) were met;
 - The Non-Participating Provider or non-network prescriber and the pharmacy are the Participant's Medicare Providers; or
 - The Participant is covered by a third party carrier, and the Non-Participating Provider or non-network prescriber and the pharmacy is the Participant's third party Provider.
- 11. Information that the Participant is not liable for payment of authorized Covered Services provided when a Medical Assistance participating Provider does not receive payment from the CHC-MCO.
- 12. Rights of the Participant regarding confidentiality of his or her medical records.
- 13. Rights of the Participant to request and receive a copy of his or her medical records and to request that they be corrected or amended as specified in 45 C.F.R. §§164.524 and 164.526.
- 14. Rights of Participants to receive information regarding the patient payment responsibilities related to NF services.
- 15. Information on the availability of and how to access or receive assistance in accessing, at no cost to the Participant, oral interpretation services for all services provided by the CHC-MCO in all non-English languages and translated Vital Documents, in prevalent languages identified by the Department.
- 16. Availability of and information on how to access or receive assistance in accessing, at no cost to the Participant, communication methods including TTY/Videophone and relay services and materials in alternative formats such as Braille, audio tape, large print, compact disc (CD), DVD, computer diskette, and/or electronic communication, including how the CHC-MCO will arrange for providing these alternative format Participant materials.
- 17. Table of contents.
- 18. Information about choosing and changing PCPs.
- 19. Information about choosing a primary dentist, if applicable.
- 20. Information on how to request a specialist as a PCP or a standing referral to a specialist.
- 21. Information on availability of specialists.

22. Information about Dual Eligibles' right to access Medicare providers for Medicare services regardless of whether the Medicare providers are in the CHC-MCO network and without having to obtain prior approval from the CHC-MCO for Medicare-covered services.
23. Information about what to do when family size, address, or phone number changes.
24. Information regarding appointment standards.
25. Information regarding Participants' rights and CHC-MCOs' responsibilities per Section 1867 of the SSA.
26. A description of all available Covered Services, including LTSS, and how to access those services, which services require Prior Authorization, and an explanation of any service limitations or exclusions from coverage, specific instructions on how transportation is provided, and a notice stating that the CHC-MCO will be liable only for those services that are the responsibility of the CHC-MCO.
27. A description of the services not covered if the CHC-MCO elects not to provide, reimburse for, or provide coverage of, a counseling or referral service because of an objection on moral or religious grounds and information on how to access the services.
28. Information on how to request guidelines, including utilization review and clinical practice guidelines.
29. An explanation of the procedures for obtaining benefits, including self-referred services, services requiring Prior Authorization, services requiring a Covered Service Limit Exception request, if applicable, and services requiring a referral.
30. Information on how to contact Participant Services, the Nurse Hotline, the Service Coordinator unit and a description of their functions.
31. Information regarding the Complaint, Grievance and DHS Fair Hearing processes, as set forth in the CHC Participant Handbook Template for Complaints, Grievances and Fair Hearings, and the right to interim relief within the relevant time frames of the process, 55 Pa. Code § 275.4(d).
32. What to do in case of an Emergency Medical Condition and instructions for receiving advice on care in case of an emergency, including instructions to use the emergency medical services (EMS) available and/or activate EMS by dialing 9-1-1 in a life-threatening situation.

33. Information on how to obtain non-medical transportation, emergency transportation, and non-emergency medical transportation.
34. The names and telephone numbers for county MATP Providers. The following information about the Medical Assistance Transportation Program (MATP) and Non-Emergency Medical Transportation (NEMT).
 - The names and telephone numbers for county MATP Providers.
 - Information about the scope of MATP services, and the responsibilities of the CHC-MCO to provide NEMT.
 - Information regarding the NEMT referral process and how a Participant may be notified if they're being referred to or from MATP.
35. Information on how and where to access Behavioral Health, Family Planning and vision services.
36. Information on how to obtain prescription drugs, including information on how to request a copy of the CHC-MCO's formulary or PDC, and how to obtain assistance with the benefit of enrolling in a Medicare Part D plan with a zero copay.
37. Information on what to do regarding out-of-county and out-of-state moves.
38. A description of wellness behaviors and activities the Participant can engage in to improve his or her own health, such as diet, exercise, and age-appropriate vaccinations and screenings.
39. Information regarding pregnancies which conveys the importance of prenatal care and continuity of care to promote optimum care for mother and infant, including the concept of remaining with the same CHC-MCO for the entire pregnancy.
40. Notification that the selection of certain PCP sites may result in medical residents, nurse practitioners, and physicians assistants providing care to Participants.
41. Information regarding the availability of second opinions and when and how to access them.
42. Information regarding the right to receive services from an Out-of-Network Provider when the CHC-MCO cannot offer a choice of two (2) qualified specialists, and an explanation of how to request authorization for Out-of-Network services.
43. Information on the availability and process for accessing MA Out-of-Plan Services which are not the responsibility of the CHC-MCO, but are available to Participants.

44. Information regarding the WIC Program (WIC) and how to access the program.
45. Information regarding HIV/AIDS Programs and how to access them.
46. Information on Tobacco Cessation Programs and how to access them.
47. Information about Estate Recovery.
48. Information about Assessment, Reassessment, and PSCP processes.
49. Information about Service Coordination.
50. Information on advance directives (durable healthcare power of attorney and living wills) for adult Participants, including:
 - a. The description of State law, if applicable.
 - b. The process for notifying the Participant of any changes in applicable State law as soon as possible, but no later than ninety (90) days after the effective date of the change.
 - c. Any limitation the CHC-MCO has regarding implementation of advanced directives as a matter of conscience.
 - d. The process for Participants to file a Complaint concerning noncompliance with the advanced directive requirements with the CHC-MCO and DOH.
 - e. How to request written information on advance directive policies.
51. A statement that all Participants will be treated with respect and due consideration for their dignity and privacy.
52. A statement that Participants may receive, from a Provider, information on available treatment options and alternatives, presented in a manner appropriate to the Participant's condition and ability to understand.
53. A statement that Participants have the right to participate in decisions regarding their healthcare, including the right to refuse treatment.
54. A statement that Participants are guaranteed the right to be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience, or retaliation.
55. A statement that each Participant is free to exercise his or her rights and that the exercise of those rights does not adversely affect the way the CHC-MCO and its Providers or the Department treat the Participant.
56. An explanation of the CHC-MCO's and Recipient Restriction Program, including how to request a DHS Fair Hearing regarding a restriction action and how to request a change of pharmacy or Provider.
57. A description of the Department's MA Provider Compliance Hotline telephone number.

58. A description of the Expanded Services or Value-Added Services the CHC-MCO has been approved by the Department to provide and the guaranteed period in which those services must be available to participants.
59. Information on how Participants can participate in CHC-MCO advisory committees.
60. Procedures for disenrolling from the CHC-MCO and policies for transition of care.
61. Procedures for recommending changes in policies and services.

EXHIBIT N

PROVIDER DIRECTORY

The Provider Directory must include, at a minimum, the following information about PCPs, hospitals, specialists, or ancillary providers, Pharmacies, and LTSS providers:

- The names, addresses, website address, group practice names, email address if the Provider makes the address available to patients, and telephone numbers of Provider.
- The hospital affiliations of the Provider.
- Information on whether or not the Provider is accepting new patients.
- Identification of whether the Provider is a Doctor of Medicine or Osteopathy.
- Identification of whether the Providers are board-certified and, if so, in what area(s).
- Identification of whether a dental Provider is DDS or DMD, and whether the dentist is a periodontist.
- Identification of whether the dentist possesses anesthesia certificates.
- Identification of whether the dentist is able to serve adults with developmental disabilities.
- Identification of the specialty area of each specialist.
- Identification of the Provider's cultural and linguistic capabilities, including languages (including American Sign Language) offered by the provider or a certified medical interpreter at the Provider's office, and whether the Provider has completed cultural competence training
- Identification of sites which are wheelchair accessible for people with physical disabilities, including offices, exam room(s) and equipment
- Identification of the days of operation and the hours when the Provider's office is available to Participants.
- Identification of the availability of telehealth services.

The CHC-MCO, at the request of the PCP or dentist, may include the PCP's or dentist's experience or expertise in serving individuals with particular conditions.

EXHIBIT O

CHC AUDIT CLAUSE

Annual Agreement Audits

The CHC-MCO shall cause, and bear the costs of, an annual agreement audit to be performed by an independent, licensed Certified Public Accountant. The agreement audit shall be completed using guidelines provided by the Department. Such audit shall be made in accordance with generally accepted government auditing standards. The contract audit shall be digitally submitted to OLTL, Bureau of Finance via the E-FRM system no later than June 30 after the contract year is ended.

If circumstances arise in which the Department or the CHC-MCO invokes the termination clause or determines this Agreement will cease, the agreement audit for the period ending with the termination date or the last date the CHC-MCO is responsible to provide Covered Services to Participants shall be submitted to the Department within one hundred eighty (180) days after the termination date or the last date the CHC-MCO is responsible to provide Covered Services.

The CHC-MCO shall ensure that audit working papers and audit reports are retained by the CHC-MCO's auditor for a minimum of ten (10) years from the date of final payment under the Agreement, unless the CHC-MCO's auditor is notified in writing by the Commonwealth to extend the retention period. Audit working papers shall be made available, upon request, to authorized representatives of the Commonwealth or federal agencies. Copies of working papers deemed necessary shall be provided by the CHC-MCO's auditor.

Annual Entity-Wide Financial Audits

The CHC-MCO shall provide to the Department a copy of its annual entity-wide financial audit, performed by an independent, licensed Certified Public Accountant. Such audit shall be made in accordance with generally accepted auditing standards. Such audit shall be submitted to the OLTL, Bureau of Finance via E-FRM within thirty (30) days from the date it is made available to the CHC-MCO.

Other Financial and Performance Audits

The Commonwealth reserves the right for Federal and State agencies or their authorized representatives to perform additional financial or performance audits of the CHC-MCO, its subcontractors or Providers. Any such additional audit work will rely on work already performed by the CHC-MCO's auditor to the extent possible. The costs incurred by the Federal or State agencies for such additional work will be borne by those agencies.

Audits of the CHC-MCO, its subcontractors, or Providers may be performed by the

Commonwealth or its designated representatives and include, but are not limited to:

1. Financial and compliance audits of operations and activities for the purpose of determining the compliance with financial and programmatic record keeping and reporting requirements of this Agreement.
2. Audits of automated data processing operations to verify that systems are in place to ensure that financial and programmatic data being submitted to the Department is properly safeguarded, accurate, timely, complete, reliable, and in accordance with contract terms and conditions.
3. Program audits and reviews to measure the economy, efficiency, and effectiveness of program operations under this Agreement.
4. The Commonwealth must periodically, but no less frequently than once every three (3) years, conduct or contract for the conducting of, an independent audit of the accuracy, truthfulness, and completeness of the encounter and financial data submitted by, or on behalf of, the CHC-MCO.

Audits performed by the Commonwealth shall be in addition to any federally-required audits or any monitoring or review efforts. Commonwealth audits of the CHC-MCO or its subcontractor's operations will generally be performed on an annual basis. However, the Commonwealth reserves the right to audit more frequently, to vary the audit period, and to determine the type and duration of these audits. Audits of subcontractors or Providers will be performed at the Commonwealth's discretion.

The following provisions apply to the CHC-MCO, its subcontractors, and Providers:

1. Except in cases where advance notice is not possible or advance notice may render the audit less useful, the Commonwealth will give the entity at least three (3) weeks advance written notice of the start date, expected staffing, and estimated duration of the audit. In the event of a claims processing audit, the Commonwealth will strive to provide advance written notice of a minimum of thirty (30) calendar days. While the audit team is on-site, the entity shall provide the team with adequate and secure workspace; access to a telephone, photocopier, and facsimile machine; access to the Internet; electrical outlets; and privacy for conferences. The CHC-MCO shall also provide, at its own expense, necessary systems and staff support to timely extract and/or download information stored in electronic format, gather requested documents or information, complete forms, or questionnaires, and respond to auditor inquiries. The entity shall cooperate fully with the audit team in furnishing, either in advance or during the course of the audit, any policies, procedures, job descriptions, contracts or other documents or information requested by the audit team.

2. Upon issuance of the final report to the entity, the entity shall prepare and submit, within thirty (30) calendar days after issuance of the report, a Corrective action plan for each observation or finding contained therein. The corrective action plan shall include a brief description of the finding, the specific steps to be taken to correct the situation or specific reasons why corrective action is not necessary, a timetable for performance of the corrective action steps, and a description of the monitoring to be performed to ensure that the steps are taken.

Record Availability, Retention and Access

The CHC-MCO shall, at its own expense, make all records available for audit, review or evaluation by the Commonwealth, its designated representatives or federal agencies. Access shall be provided either on-site during normal business hours or through the mail. During the contract and record retention period, these records shall be available at the CHC-MCO's chosen location, subject to approval of the Commonwealth. All records to be sent by mail shall be sent to the requesting entity within fifteen (15) calendar days of such request and at no expense to the requesting entity. Such requests made by the Commonwealth shall not be unreasonable.

The CHC-MCO shall maintain books, records, documents, and other evidence pertaining to all revenues, expenditures and other financial activity pursuant to this Agreement as well as to all required programmatic activity and data pursuant to this Agreement. Records other than medical records may be kept in an original paper state or preserved on micro media or electronic format. Medical records shall be maintained in a format acceptable by the Department. These books, records, documents and other evidence shall be available for review, audit or evaluation by authorized Commonwealth personnel or their representatives during the contract period and ten (10) years thereafter, except if an audit is in progress or audit findings are yet unresolved, in which case records shall be kept until all tasks are completed.

Audits of Subcontractors

The CHC-MCO shall include, in all risk sharing CHC-MCO subcontract agreements, clauses, which reflect the above provisions relative to "Annual Contract Audits," "Annual Entity-Wide Financial Audits," "Other Financial and Performance Audits" and "Record Availability, Retention, and Access."

The CHC-MCO shall include, in all contract agreements with other subcontractors or Providers, clauses which reflect the above provisions relative to "Other Financial and Performance Audits" and "Record Availability, Retention, and Access."

EXHIBIT P

**REQUIRED CONTRACT TERMS FOR
ADMINISTRATIVE SUBCONTRACTORS**

All subcontracts must be in writing and must include, at a minimum, the following provisions:

- The specific activities and report responsibilities delegated to the subcontractor.
- A provision for revoking delegation or imposing other sanctions if the subcontractor's performance is inadequate.
- All applicable requirements of this Agreement.
- The applicable requirements of 42 C.F.R. § 434.6.

Nondiscrimination provisions. The requirements of the Americans with Disabilities Act (42 U.S.C. §§ 12101 et seq.).

- In all subcontracts with any individual firm, corporation, or any other entity which provides medical services or LTSS and receives payment from the CHC-MCO either directly or indirectly through capitation, a requirement that data for all services provided will be reported timely to the CHC-MCO and that penalties and sanctions will be imposed for failure to comply. The data is to be included in the utilization and Encounter Data provided to the Department in the format required.
- In all subcontracts with any individual, firm, corporation, or any other entity which provides medical services or LTSS to CHC Participants, a requirement that the subcontractor will report all new third party resources to the CHC-MCO identified through the provision of medical services, which previously did not appear on the Department's Participant information files provided to the CHC-MCO.
- A hold harmless clause that stipulates that the CHC-MCO subcontractor agrees to hold harmless the Commonwealth, all Commonwealth officers and employees and all CHC-MCO Participants in the event of nonpayment by the CHC-MCO to the subcontractor. The subcontractor shall further indemnify and hold harmless the Commonwealth and its agents, representatives, officers, and employees against all injuries, death, losses, damages, claims, suits, liabilities, judgments, costs, and expenses which may in any manner accrue against the Commonwealth or its agents, representatives, officers or employees, through the intentional conduct, negligence or omission of the subcontractor, its agents, representatives, officers, or employees or the CHC-MCO.
- Compliance with all applicable Federal and State laws and policy and guidance issued by the Department.

- In all subcontracts with any individual firm, corporation or any other entity which provides medical services or LTSS to Community HealthChoices Participants, that prohibits gag clauses which limit the subcontractor from disclosure of Medically Necessary or appropriate healthcare information or alternate therapies to Participants, other healthcare professionals, or the Department.
- In all employee contracts prohibiting gag clauses which limit said employees from the disclosure of information pertaining to the Community HealthChoices Program.
- In all subcontracts with any individual, firm, corporation or any other entity which provides medical services or LTSS to Community HealthChoices Participants, that limits incentives to those permissible under the applicable federal regulation.

The CHC-MCO shall require as a written provision in all subcontracts that the Department has ready access to any and all documents and records of transactions pertaining to the provision of services to Participants.

The CHC-MCO and its subcontractor(s) must agree to maintain books and records relating to CHC services and expenditures, including reports to the Department and source information used in preparation of these reports. These records include but are not limited to financial statements, records relating to quality of care, medical records and prescription files.

The CHC-MCO and its subcontractor(s) also must agree to comply with all standards for practice and medical records keeping specified by the Commonwealth.

The CHC-MCO and its subcontractor(s) shall, at their own expense, make all records available for audit, review or evaluation by the Commonwealth, its designated representatives or federal agencies. Access shall be provided either on-site during normal business hours or through the mail. During the contract and record retention period, these records shall be available at the CHC-MCO's chosen location, subject to approval of the Commonwealth. The CHC-MCO must fully cooperate with any and all reviews and/or audits by Federal or State agencies or their agents, such as the Independent Assessment Contractor, by assuring that appropriate employees and involved parties are available for interviews relating to reviews or audits. All records to be sent by mail shall be sent to the requesting entity in the form of accurate, legible paper copies, unless otherwise indicated, within fifteen (15) calendar days of such request and at no expense to the requesting entity. Such requests made by the Commonwealth shall not be unreasonable.

The CHC-MCO and its subcontractor(s) shall maintain books, records, documents and other evidence pertaining to all revenues, expenditures and other financial activity pursuant to this contract as well as to all required programmatic activity and data pursuant to this contract. Records other than medical records may be kept in an original paper state or preserved on micro media or electronic format. Medical records shall be maintained in a format acceptable by the Department. These books, records, documents and other evidence shall be available for review, audit or evaluation by authorized Commonwealth personnel or their representatives during the contract period and ten (10) years thereafter, except if an audit is in progress or audit findings are yet unresolved, in which case, records shall be kept until all tasks are completed.

The CHC-MCO shall require as a written provision in all subcontracts that the subcontractor recognize that payments made to the subcontractor are derived from Federal and State funds. Additionally, the CHC-MCO shall require, as a written provision in all contracts for services rendered to the Participant, that the subcontractor shall be held civilly and/or criminally liable to both the CHC-MCO and the Department in the event of nonperformance, misrepresentation, fraud, waste, or abuse. The CHC-MCO shall notify its PCPs and all subcontractors of the prohibition and sanctions for the submission of false claims and statements.

The CHC-MCO shall require as a written provision in all subcontracts that the subcontractor cooperate with Quality Management/Utilization Management Program requirements.

The CHC-MCO shall require Providers to comply with all Service Coordination program requirements, including, where applicable, cooperation with the PCPT approach for PCSP and Service Coordination.

The CHC-MCO shall monitor the subcontractor's performance on an ongoing basis and subject it to formal review according to a periodic schedule established by the Department, consistent with industry standards or State statutes and regulations. If the CHC-MCO identifies deficiencies or areas needing improvement, the CHC-MCO and the subcontractor must take corrective action.

EXHIBIT Q

REPORTING SUSPECTED FRAUD, WASTE, AND ABUSE

The following requirements are adapted from 55 Pa. Code § 1101, General Provisions for the Medical Assistance Program, specifically 55 Pa. Code § 1101.75(a) and (b), Provider Prohibited Acts, which are directly adapted from 62 P.S. § 1407 (also referred to as Act 105 of 1980, Fraud and Abuse Control Act), and Federal Regulation 42 CFR § 438.608(a)(7). The basis for Participant referrals is 55 Pa. Code § 1101.91 (relating to Recipient misutilization and abuse) and § 1101.92 (relating to Recipient Prohibited Acts). For information on these regulations, go to the Pennsylvania Code and Bulletin website <http://www.pacode.com>.

Reporting Requirements:

CHC-MCOs are required to report to the Department any act by any MA enrolled Providers or their employees as well as by any MA Recipients or their caregivers that may affect the integrity of the CHC Program under the Medical Assistance Program. Specifically, if the CHC-MCO suspects that Fraud, Abuse or Waste (as discussed in Section V.X.4, Fraud and Abuse, of the Agreement) may have occurred, the CHC-MCO must report the issue to the Department's Bureau of Program Integrity (BPI). The CHC-MCO must have a process to notify the Department of any adverse actions and/or Provider disclosures taken during the credentialing/re-credentialing process. Depending on the nature or extent of the problem, it may also be advisable to place the individual Provider on prepayment review to avoid unnecessary expenditures during the review process.

The CHC-MCO is required to refer any abuse, waste, or any potential fraud referrals using the Department's CHC-MCO Referral Form. If the CHC-MCO selects the potential fraud option on the Department's CHC-MCO Referral Form, the referral form will be sent directly to the Pennsylvania Office of Attorney General's, Medicaid Fraud Control Section in accordance with 42 CFR § 438.608(a)(7). Additionally, after review, if the Department determines there is a credible allegation of fraud, the Department will refer the potential fraud to the Pennsylvania Office of Attorney General's, Medicaid Fraud Control Section. After the referral form is submitted to the Department, the CHC-MCO is required to upload all supporting documentation to the Department using DocuShare. The CHC-MCO is also required to upload the same supporting documentation to the Office of Attorney General, Medicaid Fraud Control Section through ShareFile.

CHC-MCOs are also required to refer quality issues to the Department for further investigation. Quality issues are those which, on an individual basis, affect the Participant's health (e.g., poor quality services, inappropriate treatment, aberrant and/or abusive prescribing patterns, and withholding of Medically Necessary services from the Participant).

All Confirmed Abuse, Waste, or quality referrals must be made with supporting documentation promptly, within thirty (30) calendar days of the identification of the problem/issue. For all Potential Fraud referrals, the CHC-MCO must conduct a preliminary investigation to the level of the indicia of potential fraud, i.e., there is

indicia of reliability of the allegation of fraud.

The CHC-MCO may informally consult with other state agencies or law enforcement to reach this determination. The CHC-MCO must send to BPI all relevant documentation within thirty (30) calendar days after the preliminary allegations have been confirmed through the additional review and/or documentation and the CHC-MCO believes that there is now a potential credible allegation of fraud. Such information includes, but is not limited to, the materials listed on the "Checklist of Supporting Documentation for Referrals" located at the end of this exhibit. The Fraud and Abuse Coordinator, or the responsible party completing the referral, should check the appropriate boxes on the "Checklist of Supporting Documentation for Referrals" form to indicate the supporting documentation that is sent with each referral. A copy of the completed checklist and all supporting documentation should accompany each referral. Any egregious situation or act (e.g., those that are causing or imminently threaten to cause harm to a Participant or significant financial loss to the Department or its agent) must be referred immediately to the Department's Bureau of Program Integrity for further investigation.

Failure to comply with the requirements of Exhibit Q will result in sanctions and/or corrective action as stated in this Agreement. The Department must suspend all Medicaid payments to a provider after a determination that there is a credible allegation of fraud for which an investigation is pending under the Medicaid program against an individual or entity unless the Department has good cause not to suspend payments or to suspend payment only in part [42 CFR § 455.23(a)]. Upon notification from the Department of the imposition of a payment suspension, the CHC-MCO, at a minimum, must also suspend payments to the provider.

The following processes are required for Provider/Caregiver and Employee referrals, unless prior approval is received from BPI. Reports must be submitted online using the CHC-MCO Referral Form. The instructions and form templates are located on the HealthChoices extranet website under Community HealthChoices Program/Fraud and Abuse::

https://www.humanservices.state.pa.us/hc-extranet/forms/form_mcoreferral_chc.asp

Once completed, the CHC-MCO must electronically submit the form to BPI. Additionally, the following information must be submitted to BPI electronically using a DocuShare folder designated by BPI: Checklist of Supporting Documentation for Referrals, accessible on the CHC-MCO Referral Form; and

- A copy of the confirmation page which will appear after "Submit" button is clicked, submitting the CHC-MCO Referral Form; and
- All supporting documentation. Referrals will not be processed but will be returned for further development if they are received without all supporting documentation. The same information must be uploaded to the Office of Attorney General, Medicaid Fraud Control Section ShareFile system.

If DocuShare is inaccessible for any reason, then mail the supporting information above to the below address:

Attn: Division Director

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

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

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

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

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

Checklist of Supporting Documentation for Referrals

- All referrals should have the confirmation page from the online referral attached.
- Please check the appropriate boxes that indicate the supporting documentation included with your referral.

Example of materials for Provider, Caregiver, or staff person referrals [***The below list is provided as examples of materials that could be relevant to an investigation of the referral. The list is not all-inclusive.***] –

- ☐ confirmation page from online referral
- ☐ FEIN#
- ☐ encounter forms (lacking signatures or forged signatures)
- ☐ timesheets
- ☐ attendance records of Participant, such as
written statement from parent, Provider, school officials or client that
services were not rendered or a forged signature
- ☐ progress notes
- ☐ internal audit report
- ☐ interview findings
- ☐ sign-in log sheet
- ☐ complete medical records
- ☐ résumé and supporting résumé documentation (college transcripts, copy of
degree)
- ☐ credentialing file (DEA license, CME, medical license, board certification)
- ☐ copies of complaints filed by Participants
- ☐ admission of guilt statement
- ☐ other: _____

Example of materials for pharmacy referrals –

- ☐ paid claims
- ☐ prescriptions
- ☐ signature logs
- ☐ encounter forms
- ☐ purchase invoices
- ☐ EOBs
- ☐ delivery slips
- ☐ licensing information
- ☐ other: _____

Example of materials for behavioral health referrals –

- ☐ complete medical and mental health record
- ☐ results of treatment rendered/ordered, including the results of all lab tests and diagnostic studies
- ☐ summaries of all hospitalizations
- ☐ all psychiatric examinations
- ☐ all psychological evaluations treatment plans
- ☐ all prior authorizations request packets and the resultant prior authorization number(s)
- ☐ encounter forms (lacking signatures or forged signatures) plan of care summaries
- ☐ documentation of treatment team or Interagency Service Planning Team meetings
- ☐ progress notes
- ☐ other: _____

Example of materials for DME referrals –

- ☐ orders, prescriptions, and/or certificates of medical necessity (CMN for the equipment)
 - ☐ delivery slips and/or proof of delivery of equipment copies of checks
 - ☐ or proof of copay payment by recipient diagnostic testing in the records
 - ☐ copy of company's current licensure
 - ☐ copy of the Policy and Procedure manual applicable to DME items
 - ☐ other: _____
-

EXHIBIT R

Behavioral Health Mixed Services Protocol

Services	Payment/Clinical Responsibility
Ambulatory Care	
Assessment and treatment of a BH condition when provided by a BH provider	BH-MCO
Assessment and treatment of a BH condition when provided by a PCP	CHC-MCO
Assessment and treatment of dementia/Alzheimer's	CHC-MCO
Assessment and treatment of Asperger's/Autism Spectrum Disorder	BH-MCO or CHC-MCO depending on provider type and location of care
Methadone Maintenance Treatment	BH-MCO
Medication Assisted Treatment (MAT) for opioid addiction	CHC-MCO
Psychiatrist prescribed Medication Assisted Treatment (MAT) for opioid addiction	BH-MCO
24-Hour Care	
Admission to an acute care hospital, psychiatric facility or other specialty facility that is a licensed mental health inpatient facility for the treatment of a BH condition	BH-MCO
Admission to an inpatient drug and alcohol detoxification hospital that is licensed by DDAP	BH-MCO
Detoxification in a medical bed that is certified by DDAP for acute withdrawal, seizures, delirium tremens or medical instability	BH-MCO
Stabilization in a medical bed or in an intensive care unit for treatment of eating disorders or following attempted suicide or self-induced trauma/poisoning	CHC-MCO
Residential services for treatment of MH or SUD	BH-MCO
Emergency Department	
Facility and ancillary charges and professional fees for primary BH diagnoses	CHC-MCO
Facility and ancillary charges and professional fees for primary PH diagnosis, including medical stabilization for attempted suicide or self-induced trauma/poisoning	CHC-MCO

Services	Payment/Clinical Responsibility
Emergency room evaluations for voluntary and involuntary commitments pursuant to the Mental Health Procedures act of 1976	BH-MCO
All emergency and non-emergency medically necessary ambulance transportation for both PH and BH covered services, including BH diagnosis	CHC-MCO
Consults	
BH consultation specific to a BH diagnosis on medical surgical unit, nursing home or assisted living facility	BH-MCO
BH consultation not specific to a Serious Mental Illness (SMI) on medical surgical unit, nursing home or assisted living facility	CHC-MCO
Medical/surgical consult on a BH unit	CHC-MCO
Medical/surgical assessment on an inpatient admission with primary BH diagnoses	CHC-MCO
Psychological Testing	
Psychological/neuropsychological testing requested by a BH provider and/or used to clarify BH diagnosis.	BH-MCO
Psychological/neuropsychological testing when ordered by medical provider to rule out or clarify organic pathology	CHC-MCO
Miscellaneous	
Any BH service delivered through a federally qualified health center or rural health clinic	BH-MCO
Electroconvulsive therapy, including anesthesiology services	BH-MCO

EXHIBIT S

PROVIDER MANUAL

The CHC-MCO shall work with the Department to develop, distribute, and maintain a Provider manual. In addition, the CHC-MCO and/or CHC-MCO Subcontractors will be expected to distribute copies of all manuals and subsequent policy clarifications and procedural changes to Network Providers following advance written approval of the documents by the Department. Provider manuals must be updated to reflect any program or policy change(s) made by the Department via Medical Assistance bulletin within six (6) months of the effective date of the change(s), or within six (6) months of the issuance of the Medical Assistance bulletin, whichever is later, when such change(s) affect(s) information that the CHC-MCO is required to include in its Provider manual, as set forth in this exhibit. The Provider manual must include, at a minimum, the following information:

- A. A description of the needs screening, Assessment and Reassessment, service planning system and protocols and a description of the Provider's role in Service Planning and Service Coordination.
- B. A description of Service Coordination and how the Provider will fit into the Person-Centered Planning Team approach.
- C. A description of the population being served through CHC.
- D. A description of the accessibility requirements with which Providers are required to comply.
- E. A description of the role of a PCP as described in Section II, Definitions, and Section V.BB.4, Primary Care Practitioner (PCP) responsibilities.
- F. Information on how Participants may access specialists, including standing referrals and specialists as PCPs.
- G. A summary of the guidelines and requirements of Title VI of the Civil Rights Act of 1964, as amended, and its guidelines, and how Providers can obtain qualified interpreters familiar with medical terminology.
- H. Contact information to access the CHC-MCO, DHS, advocates, other related organizations, etc.
- I. A copy of the CHC-MCO's Prior Authorization and program exception process.
- J. A copy of the CHC-MCO's Formulary in the same machine readable file and format as made available to enrollees as specified under 42 C.F.R. § 438.10(i)(3).
- K. Contact follow-up responsibilities for missed appointments.

- L. Description of role of the Service Coordinator and how to contact them.
- M. Description of drug and alcohol treatment available and how to make referrals.
- N. Complaint, Grievance and DHS Fair Hearing information.
- O. Information on Provider Disputes.
- P. CHC-MCO policies, procedures, available services, and sample forms applicable to the Provider type.
- Q. A full description of Covered Services, listing all Covered Services outlined in Exhibit A, Covered Services List.
- R. Billing instructions.
- S. Information regarding applicable portions of 55 Pa. Code, Chapter 1101, General Provisions.
- T. Information on self-referred services and services which are not the responsibility of the CHC-MCO but are available to Participants on a Fee-for-Service basis.
- U. Provider performance expectations, including disclosure of Quality Management and Utilization Management criteria and processes.
- V. Information on procedures for sterilizations, hysterectomies and abortions (if applicable).
- W. A description of certain Providers' obligations, under law, to follow applicable procedures in dealing with Participants on "Advanced Directives" (durable healthcare power of attorney and living wills). This includes notification and record keeping requirements.
- X. Information on ADA and Section 504 of the Rehabilitation Act of 1973, other applicable laws, and available resources related to the same.
- Y. A definition of "Medically Necessary" consistent with the language in this Agreement.
- Z. Information on Participant confidentiality requirements.
- AA. The Department's Medical Assistance Provider Compliance Hotline (formerly the Fraud and Abuse Hotline) telephone number and explanatory statement.
- BB. Explanation of CHC-MCO's and the Department's Recipient Restriction Program.

- CC. Information regarding written translation and oral interpretation services for Participants with LEP and alternate methods of communication for those requesting communication in alternate formats.
- DD. List and scope of services for referral and Prior Authorization.
- EE. Information about Recipient Restriction and how it works.
- FF. All of the items in Section V AA.2- Provider Orientation and Ongoing Education.
- GG. Information regarding mandatory reporting requirements under both the Adult Protective Services Act (APS) and the Older Adult Protective Services Act (OAPSA) and cooperation with investigations.

The CHC-MCO is required to provide documented training to its Providers and their staffs and to Subcontractors regarding the contents and requirements of the Provider manuals.

EXHIBIT T

PROVIDER NETWORK COMPOSITION/SERVICE ACCESS

1. Network Composition

The CHC-MCO must consider the following in establishing and maintaining its Provider Network:

- The anticipated Medical Assistance Enrollment.
- The expected utilization of services, taking into consideration the characteristics and needs of specific Medical Assistance populations represented in the CHC-MCO.
- The number and types, in terms of training, experience, and specialization, of Providers required to furnish the contracted Medical Assistance services.
- All Providers operating within the Provider Network who provide services to Recipients must be enrolled in the Commonwealth's Medical Assistance program and possess an active MMIS Provider ID.
- The number of Network Providers who are not accepting new Medical Assistance Participants.
- The geographic location of Providers and Participants, considering distance, travel time, the means of transportation ordinarily used by Participants, and whether the location provides physical access for Participants with disabilities.

The CHC-MCO must ensure that its Provider Network is adequate to provide its Participants in this CHC zone with access to quality Participant care through participating professionals, in a timely manner, and without the need to travel excessive distances. Upon request from the Department, the CHC-MCO must supply geographic access maps using Participant-level data detailing the number, location, and specialties of its Provider Network in order to verify accessibility of Providers within its Network in relation to the location of its Participants. The Department may require additional numbers of specialists, ancillary, and LTSS Providers should it be determined that geographic access is not adequate. The CHC-MCO must also have a process in place which ensures that the CHC-MCO knows the capacity of its Network PCP panels at all times and have the ability to report on this capacity.

The CHC-MCO must make all reasonable efforts to honor a Participant's choice of Providers who are credentialed in the Network. If the CHC-MCO is unable to ensure a Participant's access to Provider or specialty Provider services within the Provider Network, within the travel times set forth in this exhibit, the CHC-MCO must make all reasonable efforts to ensure the Participant's access to these services within the travel times herein through Out-of-Network providers.

In locations where the CHC-MCO can provide evidence that it has conducted all reasonable efforts to contract with Providers and specialists and can provide verification that no Providers or specialists exist to ensure a Participant's access to these services within the travel times set forth in this exhibit, the CHC-MCO must work with Participants to offer reasonable Provider alternatives. Additionally, the CHC-MCO must ensure and demonstrate that the following Provider Network and access requirements are established and maintained for the entire CHC zone in which the CHC-MCO operates if Providers exist.

The Department will require annual submission of a GeoAccess Report and Gap Analysis to be done by the CHC-MCO. The CHC-MCO must demonstrate access to the provider types outlined below through application of the specified access criteria. The Network Gap Analysis must be detailed and include all reasonable efforts to fill network gaps.

a. PCPs

Make available to every Participant a choice of at least two (2) appropriate PCPs who are accepting new patients whose offices are located within a travel time no greater than thirty (30) minutes (Urban) and sixty (60) minutes (Rural).

Participants may, at their discretion, select PCPs located further from their homes.

b. Specialists

For the following Provider types, the CHC-MCO must ensure a choice of at least two (2) Providers who are accepting new patients within the travel time limits (thirty (30) minutes Urban, sixty (60) minutes Rural).

General Surgery	Orthopedic Surgery
Optometry	Allergy and Immunology
Physical Medicine and Rehabilitation	Otolaryngology
Neurological Surgery	Neurology
Urology	Cardiology
Dermatology	Gastroenterology
Oral Surgery	Podiatry
Durable Medical Equipment and Supplies	
Common Laboratory and Diagnostic Service	
Obstetrical and Gynecological Service	
Pharmacy	Chiropractor
Physical Therapy	Occupational Therapy
Home Health Including RN and LPN Nursing Services and Home Health Aide	Radiology
General Dentistry	Nursing Facility
Ophthalmology	
Opioid Use Disorder Centers of Excellence	

For the following provider types, the CHC-MCOs must ensure at least one (1) provider who is accepting new patients within the travel time limits (30 minutes Urban, 60 minutes Rural) and a second choice, within the CHC Zone.

Endocrinologist	Hematology/Oncology
Rheumatology	Nephrology
Speech and Language Therapy	

All Other Provider Types must meet the Participants needs through in-network or out-of-network arrangements. CHC-MCOs should make all reasonable efforts to offer at least two (2) or more Specialty Providers when possible.

c. Hospitals

Ensure at least one (1) hospital within the travel time limits (thirty (30) minutes Urban, sixty (60) minutes Rural) and a second (2nd) choice within the CHC zone.

d. LTSS Providers

For the following Provider types, the CHC-MCO must ensure a choice of at least two (2) Providers who are accepting new patients within the travel time limits (thirty (30) minutes Urban, sixty (60) minutes Rural).

Adult Day – Basic	Adult Day-Enhanced
Behavior Therapy	Benefits Counseling
Career Assessment	Community Integration
Counseling Services	Nursing Facility
Employment Skills Development	Home Health Aide Services
Job Coaching	Job Finding
Nutritional Consultation	Physical Therapy Services
Residential Habilitation	
Structured Day Habilitation Services	
Cognitive Rehabilitation Therapy Services	
Teleservices- Cognitive Rehabilitation Therapy	
Teleservices- Counseling	
Teleservices- Nutritional Consultation	
Occupational Therapy Services	

Specialized Medical Equipment and Supplies

For the following Provider type, the CHC-MCO must ensure at least one (1) Provider who is accepting new patients within the travel time limits (thirty (30) minutes Urban, sixty (60) minutes Rural) and one (1) additional Provider within the CHC zone.

Speech and Language Therapy Services

For the following Provider types, the CHC-MCO must ensure a choice of at least two (2) Providers servicing the county.

Assistive Technology

Home Adaptations

Home Delivered Meals

Non-Medical Transportation

Pest Eradication

Telecare

Vehicle Modifications

Chore Services

Community Transition Services

Personal Emergency Response Services (PERS)

For in lieu of services (ILOS) the CHC-MCO is required to contract with at least one (1) ILOS provider who offers each ILOS service in each zone in which the plan is approved to offer the ILOS service.

Network adequacy for the following Provider types is based on the full-time equivalent (FTE) calculations developed by the Department.

Licensed Practical Nurse

Personal Assistance Services

Registered Nurse

Respite

e. Out-of-Network Access

Ensure the provision of Covered Services to all Participants such that if the CHC-MCO does not have at least two (2) specialists or sub-specialists qualified to meet the particular needs of the individuals who are accepting new patients and within the travel time requirements, then the CHC-MCO must allow Participants to pick an Out-of-Network Provider if not satisfied with the Network Provider.

The CHC-MCO must develop a system to determine Prior Authorization for Out-of-Network Services through the Person-Centered Planning Team and UM, depending on the service for which the Out-of-Network Provider is being authorized, including provisions for informing the Participant of how to request this authorization for Out-of-Plan Services.

If the CHC-MCO is unable to ensure a Participant's access to Provider or specialty Provider services within the Provider Network, within the travel times set forth in this exhibit, the CHC-MCO must make all reasonable efforts to ensure the Participant's access to these services within the travel

times herein through Out-of-Network Providers. In locations where the CHC-MCO can provide evidence that it has conducted all reasonable efforts to contract with Providers and specialists and can provide verification that no Providers or specialists exist to ensure a Participant's access to these services within the travel times set forth in this exhibit, the CHC-MCO must work with Participants to offer reasonable Provider alternatives.

f. Medicare Network Compliance

If the Medicare Network standards would require more Providers for any Provider type or Service Area, the CHC-MCO must meet the Medicare standards in its CHC-MCO.

h. Rehabilitation Facilities

Ensure a choice of at least two (2) rehabilitation facilities within the Provider Network, at least one (1) of which must be located within this CHC zone.

i. CNMs / CRNPs, Other Providers

Ensure access to Certified Nurse Midwives (CNMs), Certified Registered Nurse Practitioners (CRNPs) and other Providers. The CHC-MCO must demonstrate its attempts to contract in good faith with a sufficient number of CNMs, CRNPs and other Providers and maintain payment policies that reimburse CNMs, CRNPs and other Providers for all services provided within the scope of their practice and allow them to practice to the fullest extent of their education, training and licensing.

j. Qualified Providers

The CHC-MCO must limit its PCP Network to appropriately Qualified Providers. The CHC-MCO's PCP Network must meet the following:

- Seventy-five to one hundred percent (75-100%) of the Network consists of PCPs who have completed an approved Primary Care residency in family medicine, osteopathic general medicine, or internal medicine.
- No more than twenty-five percent (25%) of the Network consists of PCPs without appropriate residencies but who have, within the past seven (7) years, five (5) years of post-training clinical practice experience in family medicine, osteopathic general medicine, internal medicine. Post-training experience is defined as having practiced at least as a 0.5 full-time equivalent in the practice areas described.

k. Participant Freedom of Choice

The CHC-MCO must demonstrate its ability to offer its Participants freedom of choice in selecting a PCP. At a minimum, the CHC-MCO must have or

provide one (1) full-time equivalent (FTE) PCP who serves no more than one thousand (1,000) Participants. For the purposes of this section, a full-time equivalent PCP must be a physician involved in clinical care. The minimum weekly work hours for one (1.0) FTE is the number of hours that the practice considers to be a normal work week, which may be thirty-seven-and-one-half (37.5), forty (40), or fifty (50) hours. A physician cannot be counted as more than one (1.0) FTE regardless of the number of hours worked. If the PCP/PCP Site employs Certified Registered Nurse Practitioners (CRNPs)/Physician Assistants (PAs), then the Provider/Provider Site will be permitted to add an additional one thousand (1,000) Participants to the panel. The number of Participants assigned to a PCP may be decreased by the CHC-MCO if necessary to maintain the appointment availability standards.

I. PCP Composition and Location

The CHC-MCO and the Department will work together to avoid the PCP having a caseload or medical practice composed predominantly of Participants. In addition, the CHC-MCO must organize its PCP Sites so as to ensure continuity of care to Participants and must identify a specific PCP within the PCP site for each Participant. The CHC-MCO may apply to the Department for a waiver of these requirements on a PCP Site-specific basis. The Department may waive these requirements for good cause demonstrated by the CHC-MCO.

m. FQHCs/RHCs/Certified Perinatal Doulas

The CHC-MCO must contract with a sufficient number of Federally Qualified Health Centers (FQHCs) and Rural Health Clinics (RHCs) to ensure access to FQHC and RHC services. If the CHC-MCO's Primary care Network includes FQHCs and RHCs, these sites may be designated as PCP Sites. If a CHC-MCO cannot contract with a sufficient number of FQHCs and RHCs, the CHC-MCO must demonstrate in writing it has attempted to reasonably contract in good faith.

The CHC-MCO must demonstrate its attempts to contract in good faith with a sufficient number of Doulas who have been certified by the Pennsylvania Certification Board as Certified Perinatal Doulas and enrolled as MA Providers to provide its Participants in this CHC Zone with access to quality Participant care through participating professionals, in a timely manner, and without the need to travel excessive distances.

n. Medically Necessary Emergency Service

The CHC-MCO must comply with the provisions of Act 112 of 1996 (H.B. 1415, P.N. 3853, signed July 11, 1996), the Balanced Budget Reconciliation Act of 1997, as amended, and Act 68 of 1998, the Quality Healthcare

Accountability and Protection Provisions, 40 P.S. §§ 991.2101 et seq. pertaining to coverage and payment of Medically Necessary Emergency Services. The definition of such services is set forth at Section III, Definitions.

o. ADA Accessibility Guidelines

The CHC-MCO must inspect the office of any Provider who provides services on site at the Provider's location and who seeks to participate in the Provider Network to determine whether the office is architecturally accessible to persons with mobility impairments. Architectural accessibility means compliance with ADA accessibility guidelines with reference to parking (if any), path of travel to an entrance, and the entrance to both the building and the office of the Provider, if different from the building entrance.

The CHC-MCO must submit quarterly reports to the Department, in a format to be specified by the Department, on the results of the inspections. OLTL will also utilize other reporting mechanisms, such as Physical Health HealthChoices reports and licensing visits.

If the office or facility is not accessible under the terms of this paragraph, the office or facility may participate in the Provider Network provided that the office or facility: 1) requests and is determined by the CHC-MCO to qualify for an exemption from this paragraph, consistent with the requirements of the ADA; or 2) agrees in writing to remove the barrier to make the office or facility accessible to persons with mobility impairments within one hundred-eighty (180) days after the CHC-MCO identified the barrier.

The CHC-MCO must document its efforts to determine architectural accessibility. The CHC-MCO must submit this documentation to the Department upon request.

p. Laboratory Testing Sites

The CHC-MCO must ensure that all laboratory testing sites providing services have either a Clinical Laboratory Improvement Amendment (CLIA) certificate of waiver or a certificate of registration along with a CLIA Community HealthChoices Agreement identification number in accordance with CLIA 1988. Those laboratories with certificates of waiver will provide only the eight (8) types of tests permitted under the terms of their waiver. Laboratories with certificates of registration may perform a full range of laboratory tests. The PCP must provide all required demographics to the laboratory when submitting a specimen for analysis.

q. CHC-MCO Discrimination

The CHC-MCO may not discriminate with respect to participation,

reimbursement, or indemnification as to any Provider who is acting within the scope of the Provider's license or certification under applicable State law, solely on the basis of such license or certification or on the basis that the provider serves high risks populations or specializes in conditions that require costly treatment. This paragraph must not be construed to prohibit a CHC-MCO from including Providers only to the extent necessary to meet the needs of the organization's Participants or from establishing any measure designed to maintain quality and control costs consistent with the responsibilities of the CHC-MCO.

r. Declined Providers

If the CHC-MCO declines to include individual Providers or groups of Providers in its Network, it must give the affected Providers written notice of the reason for its decision.

s. Second Opinions

The CHC-MCO must provide for a second opinion from a qualified Provider within the Network, at no cost to the Participant. If a qualified Provider is not available within the Network, the CHC-MCO must assist the Participant in obtaining a second opinion from a qualified Provider outside the Network, at no cost to the Participant, unless co-payments apply.

2. Appointment Standards

The CHC-MCO will require the PCP, dentist, or specialist to conduct or contact the Services Coordinator to conduct affirmative outreach whenever a Participant misses an appointment and to document this in the medical record. Such an effort shall be deemed to be reasonable if it includes three (3) attempts to contact the Participant. Such attempts may include, but are not limited to: written attempts, telephone calls and home visits. At least one (1) such attempt must be a follow-up telephone call. Service Coordinators will evaluate any barriers to Participant attendance at appointments and develop any necessary plan to facilitate and improve Participant compliance with appointments scheduled.

a. General

PCP scheduling procedures must ensure that:

- i. Emergency Medical condition cases must be immediately seen or referred to an emergency facility.
- ii. Urgent Medical Condition cases must be scheduled within twenty- four (24) hours.
- iii. Non-Urgent Sick Visits must be scheduled with a PCP within

seventy-two (72) hours of request, as clinically indicated.

- iv. Routine appointments must be scheduled within ten (10) business days. Health assessment/general physical examinations and first examinations must be scheduled within three (3) weeks of Enrollment.
- v. The CHC-MCO must provide the Department with its protocol for ensuring that a Participant's average office waiting time for an appointment for Routine Care is no more than thirty (30) minutes or at any time no more than up to one (1) hour when the physician encounters an unanticipated Urgent Medical Condition visit or is treating a Participant with a difficult medical need. The Participant must be informed of scheduling timeframes through educational outreach efforts.
- vi. The CHC-MCO must monitor the adequacy of its appointment processes and reduce the unnecessary use of ED visits.

b. Specialty Appointments

For specialty providers that utilize appointment scheduling, the CHC-MCO must be able to provide for:

- i. Emergency Medical Condition appointments immediately upon referral.
- ii. Urgent Medical Condition care appointments within twenty-four (24) hours of referral.
- iii. Scheduling of appointments for routine care shall be scheduled to occur within thirty (30) days for all specialty Provider types.

c. Pregnant Women

Should the IEB or Participant notify the CHC-MCO that a new Participant is pregnant or there is a pregnancy indication on the files transmitted to the CHC-MCO by the Department, the CHC-MCO must contact the Participant within five (5) days of the Start Date to assist the woman in obtaining an appointment with an OB/GYN or Certified Nurse Midwife. For maternity care, the CHC-MCO must arrange initial prenatal care appointments for enrolled pregnant Participants as follows:

- i. First trimester — within ten (10) business days of the Participant being identified as being pregnant.
- ii. Second trimester — within five (5) business days of the Participant being identified as being pregnant.

iii. Third trimester — within four (4) business days of the Participant being identified as being pregnant.

iv. High-risk pregnancies — within twenty-four (24) hours of identification of high risk to the CHC-MCO or maternity care Provider, or immediately if an emergency exists.

3. Policies and Procedures for Appointment Standards

The CHC-MCO will comply with the program standards regarding service accessibility standards that are set forth in this exhibit and in Section V.BB.2. of the Agreement, Provider Agreements.

The CHC-MCO must have written policies and procedures for disseminating its appointment standards to all Participants through its Participant Handbook and through other means. In addition, the CHC-MCO must have written policies and procedures to educate its Provider Network about appointment standard requirements. The CHC-MCO must monitor compliance with appointment standards and must have a corrective action plan when appointment standards are not met.

4. LTSS Access Standards

a. Initiation of Services

When new Personal Assistance, Home Adaptations, Assistive Technology, Personal Emergency Response (PERS), Vehicle Modifications, Pest Eradication, Residential Habilitation, Structured Day Habilitation, In-Person and Virtual Cognitive Therapy, Adult Day Basic, and Adult Day Enhanced 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.

b. Non-Medical Transportation Services

The CHC-MCO must provide 86% of requested non-medical transportation trips as authorized on the PCSP.

c. Home Delivered Meals

90% of Participant responses must indicate the Participant was "Always" or "Usually Satisfied" with their Home Delivered Meals.

5. Compliance with Access Standards

a. Mandatory Compliance

The CHC-MCO must comply with the access standards in accordance with this exhibit and Section V.BB.2 of the Agreement, Provider Agreements. If the CHC-MCO fails to meet any of the access standards by the dates specified by the Department, the Department may terminate this Agreement. To the extent the Department designates new provider types in the future, the CHC-MCOs must adhere to distance standards for those new provider types when it promotes the objectives of the Medicaid program for the provider type to be subject to time and distance access standards, as determined by CMS, if the provider type is covered under the Agreement.

b. Reasonable Efforts and Assurances

The CHC-MCO must make reasonable efforts to honor a Participant's choice of Providers among Network Providers as long as:

- i. The CHC-MCO's Agreement with the Network Provider covers the services required by the Participant.
- ii. The CHC-MCO has not determined that the Participant's choice is clinically inappropriate.

The CHC-MCO must provide the Department adequate assurances that the CHC-MCO, with respect to this CHC zone, has the capacity to serve the expected Enrollment in this CHC zone. The CHC-MCO must provide assurances that it will offer the full scope of Covered Services as set forth in this Agreement and access to preventive and Primary Care services. The CHC-MCO must also maintain a sufficient number, mix and geographic distribution of Providers and services in accordance with the standards set forth in this exhibit and Section V.BB.2 of the Agreement, Provider Agreements.

c. Compliance with Access Standards

The CHC-MCO must continuously monitor its contracted networks throughout the contract year to ensure participant access to services within the access criteria set forth above. The CHC-MCO must comply with the access standards in accordance with this exhibit and Section V.BB.2 of the Agreement, Provider Agreements. If the CHC-MCO fails to meet any of the access standards by the dates specified by the Department, the Department may terminate this Agreement. To the extent the Department designates new provider types in the future, the CHC-MCOs must adhere to designated standards for those new provider types or as determined by CMS, if the provider type is covered under the Agreement d. CHC-MCO's Corrective Action

The CHC-MCO must take all necessary steps to resolve, in a timely manner, any demonstrated failure to comply with the access standards. Prior to a

termination action or other sanction by the Department, the CHC-MCO will be given the opportunity to institute a corrective action plan. The CHC-MCO must submit a corrective action plan to the Department for approval within thirty (30) days of notification of such failure to comply, unless circumstances warrant and the Department demands a shorter response time. The Department's approval of the CHC-MCO's corrective action plan will not be unreasonably withheld. The Department will make its best effort to respond to the CHC-MCO within thirty (30) days from the submission date of the corrective action plan. If the Department rejects the corrective action plan, the CHC-MCO shall be notified of the deficiencies of the corrective action plan. In such event, the CHC-MCO must submit a revised corrective action plan within fifteen (15) days of notification.

If the Department does not receive an acceptable corrective action plan, the Department may impose sanctions against the CHC-MCO, in accordance with Section VIII.C. of the Agreement, Sanctions. Failure to implement the corrective action plan may result in the imposition of a sanction as provided in this Agreement.

EXHIBIT U

PROVIDER AGREEMENTS

The CHC-MCO is required to have written Provider Agreements with a sufficient number of Providers to ensure Participant access to all Medically Necessary Covered Services.

The CHC-MCO's Provider Agreements must include the following provisions:

- a. A requirement that the Provider participate, as needed, in the needs screening, Assessment and Reassessment, service planning, and service coordination processes.
- b. A requirement that the Provider comply with any accessibility, Cultural Competency, Linguistic Competency, and Disability Competency requirements the Department issues for meeting the needs of the CHC population.
- c. A provision that the CHC-MCO may not exclude or terminate a Provider from participation in the CHC-MCO's Provider Network due to the fact that the Provider has a practice that includes a substantial number of patients with expensive medical conditions.
- d. A provision that the CHC-MCO may not exclude a Provider from the CHC-MCO's Provider Network because the Provider advocated on behalf of a Participant for Medically Necessary and appropriate healthcare consistent with the degree of learning and skill ordinarily possessed by a reputable Provider practicing according to the applicable standard of care.
- e. Notification of the prohibition and sanctions for submission of false Claims and statements.
- f. The definition of Medically Necessary in Section II, Definitions.
- g. A provision that the CHC-MCO may not prohibit or restrict a Provider acting within the lawful scope of practice from discussing Medically Necessary care and advising or advocating appropriate medical care with or on behalf of a Participant, including information regarding the nature of treatment options in order to decide among those options; the risks, benefits, and consequences of treatment and non-treatment; alternative treatments; or the availability of alternative therapies, consultation or tests that may be self-administered.
- h. A provision that the CHC-MCO may not prohibit or restrict an LTSS Provider acting within the lawful scope of practice from discussing needed services and advising or advocating appropriate LTSS with or on behalf of a Participant, including information regarding the nature of LTSS options; risks; and the availability of alternative services.

- i. A provision that the CHC-MCO may not terminate a contract or employment with a Provider for filing a Grievance on a Participant's behalf.
- j. A provision which specifies that the agreement will not be construed as requiring the Provider to provide a counseling or referral service if the Provider objects to the provision of such services on moral or religious grounds.
- k. A requirement that the Provider cooperate with the QM/UM Program standards outlined in Exhibit F, Quality Management and Utilization Management Program Requirements.
- l. A requirement for cooperation for the submission of Encounter Data for all services provided within the time frames required in Section VIII, Reporting Requirements, no matter whether reimbursement for these services is made by the CHC-MCO either directly or indirectly through capitation.
- m. A continuation of benefits provision which states that the Provider agrees that in the event of the CHC-MCO's insolvency or other cessation of operations, the Provider must continue to provide benefits to the CHC-MCO's Participants, including Participants in an inpatient setting, through the period for which the capitation has been paid.
- n. A requirement that PCPs contact new Participants identified in the quarterly Encounter lists who have not had an Encounter during the first six (6) months of Enrollment or who have not complied with the scheduling requirements outlined in the RFA and this Agreement.
- o. A requirement that should the Provider terminate its agreement with the CHC-MCO for any reason, the Provider must provide services to the Participants assigned to the Provider under the contract up to the end of the month in which the effective date of termination falls.
- p. A requirement that each physician providing services to Participants must have a MMIS Provider ID Number.
- q. A requirement that the Provider disclose annually any Physician Incentive Plan or risk arrangements it may have with physicians either within its group practice or other physicians not associated with the group practice, even if there is no Substantial Financial Risk between the CHC-MCO and the physician or physician group.
- r. A requirement for cooperation with the CHC-MCO's and the Department's Recipient Restriction Program.

- s. A requirement that healthcare facilities and ambulatory surgical facilities develop and implement, in accordance with P.L.154, No. 13, known as the Medical Care Availability and Reduction of Error (Mcare) Act, an internal infection control plan that is established for the purpose of improving the health and safety of patients and healthcare workers and includes effective measures for the detection, control, and prevention of Healthcare-Associated Infections.
- t. A provision that the Provider must agree to the CHC-MCO's QM/UM Department's monitoring of the appropriateness of a continued inpatient stay beyond approved days according to established Medical Necessity guidelines under the direction of the CHC-MCO's Medical Director, and to provide all clinical information on the inpatient stay in a timely manner which allows for decision and appropriate management of care.
- u. Language requiring the Provider to hold harmless all Participants in the event of nonpayment by the CHC-MCO for failure to obtain Prior Authorization or failure to follow any other CHC-MCO rules. Participants may not be billed or balanced billed for Covered Services.
- v. Requirements regarding coordination with BH Providers (if applicable):
 - Comply with all applicable statutes and regulations pertaining to the confidentiality of Participant medical records, including obtaining any required written Participant consents to disclose confidential medical records.
 - Make referrals for social, vocational, education, or human services when a need for such service is identified through assessment.
 - Provide health records if requested by the BH Provider.
 - Notify the BH Provider of all prescriptions and, when advisable, consult with the BH Provider before prescribing medication. Make certain the BH Provider has complete, up-to-date record of medications.
 - Be available to the BH Provider on a timely basis for consultations.
- w. A provision that requires the Provider to comply with the procedures for reporting suspected abuse and neglect under the Older Adult Protective Services Act and the Adult Protective Services Act and for performing exams for the county.
- x. Requirements that Providers follow CHC-MCO requirements for ongoing communication with Participants' Service Coordinators.
- y. Requirements that Providers return Participant calls within three (3) business days of receipt.

- z. A requirement that the Providers must allow for and process voluntary payroll deductions of fringe benefits or wage supplements for any employee who requests it, in accordance with the Wage Payments and Collection Law (43 P.S. §§ 260.2a and 260.3).
- aa. A provision that the Provider agrees that, as required by the Department, the CHC-MCO may offset any past due amount that Provider owes to the Department against any payments due to the Provider under the Provider Agreement; provided that the CHC-MCO first provides written notice of its intention to do so.
- bb. A requirement that all Nursing Facilities in the CHC-MCOs network adhere to DOH regulations.
- cc. A provision that Providers in the CHC-MCOs network are prohibited from soliciting Participants to receive services from the Provider including:
 - Referring an individual for CHC evaluation with the expectation that, should CHC enrollment occur, the Provider will be selected by the Participant as the service provider;
 - Communicating with existing CHC Participants via telephone, face-to-face or written communication for the purpose of petitioning the Participant to change Providers;
 - Communicating with hospitals, discharge planners or other institutions for the purposes of soliciting potential CHC Participants. Providers in the CHC-MCOs network are allowed to outreach to hospitals, discharge planners or other institutions only to provide education and information about their agency/program, however, they cannot solicit for any potential CHC participants. The Provider cannot solicit for referrals of CHC participants, nor can they offer or provide any incentives to the hospital/institutions, discharge planner, or any other staff.

The CHC-MCO must make all necessary revisions to its Provider Agreements to be in compliance with the requirements set forth in this section. Revisions may be completed as Provider Agreements become due for renewal, provided that all Provider Agreements are amended within one (1) year of the effective date of this Agreement, with the exception of the Encounter Data requirements, which must be amended before the Implementation Date, if necessary, to ensure that all Providers are submitting Encounter Data to the CHC-MCO within the time frames specified in Section VIII.C.1, Encounter Data Reporting.

EXHIBIT V

CHC-MCO REQUIREMENTS FOR PROVIDER TERMINATIONS

1. Termination by the CHC-MCO

A. Notification to the Commonwealth

The CHC-MCO must notify the Department and PID in writing of its intent to terminate a Network Provider and services provided by a Network Provider (which includes, but is not limited to, a home care agency, nursing facility, hospital, specialty unit within a facility, and/or a large Provider group) ninety (90) days prior to the effective date of the termination.

The CHC-MCO must submit a Provider termination work plan and supporting documentation within ten (10) business days of the CHC-MCO notifying the Department of the termination and must provide weekly updates to this information. Workplans do not need to be submitted for Providers that have less than ten (10) Participants, unless specifically requested by the Department. The requirements for the work plan and supporting documentation are found in this Exhibit, under 3. Work plans and Supporting Documentation.

B. Continuity of Care

The CHC-MCO must comply with both this section and 28 Pa. Code § 9.684.

Unless the Provider is being terminated for cause as described in 40 P.S. § 991.2117(b), the CHC-MCO must allow a Participant to continue an ongoing course of treatment from the Provider for up to sixty (60) days from the date the Participant is notified by the CHC-MCO of the termination or pending termination of the Provider, or for up to sixty (60) days from the date of Provider termination, whichever is greater. A Participant is considered to be receiving an ongoing course of treatment from a Provider if during the previous twelve (12) months the Participant was treated by the Provider for a condition that requires follow-up care or additional treatment or the services have been Prior Authorized. Any adult Participant with a previously scheduled appointment shall be determined to be in receipt of an ongoing course of treatment from the Provider, unless the appointment is for a well adult check-up. Per 28 Pa. Code § 9.684(d), the transitional period may be extended by the CHC-MCO if the extension is determined to be clinically appropriate. The CHC-MCO shall consult with the Participant and the Provider in making the determination. The CHC-MCO must also allow a Participant who is pregnant to continue to receive care from the Provider that is being terminated through the completion of the Participant's postpartum care.

For a Participant who is receiving LTSS but whose LTSS Provider leaves the CHC-MCO Provider Network, the CHC-MCO must continue to allow the Participant to receive services for a sixty (60) day period and must pay that Provider until such time as an alternative Network Provider can be identified and begins to deliver the same LTSS services as the former Provider.

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

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

C. Notification to Participants

If the Provider that is being terminated from the Network is a PCP, the CHC-MCO, using the template notice titled C(1) Provider Termination Template For PCPs found on the Intranet supporting CHC, must notify all Participants who receive primary care services from the Provider forty-five (45) days prior to the effective date of the Provider's termination. Participants who are receiving an ongoing course of treatment from the Provider may continue to receive this treatment for up to sixty (60) days from the date the Participant is notified of the termination or pending termination of the Provider, or for up to sixty (60) days from the date of Provider termination, whichever is greater.

If the Provider that is being terminated from the Network is not a PCP or a hospital, the CHC-MCO, using the template notice titled C(3) Provider Termination Template for Specialist and FQHC Providers Who Are Not PCPs, found on the Intranet supporting CHC, must notify all Participants who have received services from the Provider during the previous twelve (12) months, as identified through referral and claims data; all Participants who are scheduled to receive services from the Provider; and all Participants who have a pending or approved Prior Authorization request for services from the Provider forty-five (45) days prior to the effective date of the Provider's termination. Participants who are receiving an ongoing course of treatment from the Provider may continue to receive this treatment for up to sixty (60) days from the date the Participant is notified of the termination or pending termination of the Provider, or for up to sixty (60) days from the date of Provider termination, whichever is greater.

If the Provider that is being terminated from the Network is a hospital (including a specialty unit within a facility or hospital), the CHC-MCO, using the template notice titled C(2) Hospital/Specialty Unit Within a Facility or Hospital Termination found on the Intranet supporting CHC, must notify all Participants assigned to a PCP with admitting privileges at the hospital, all Participants assigned to a PCP that is owned by the hospital, and all Participants who have utilized the hospital's services within the past twelve (12) months forty-five (45) days prior to the effective date of the hospital's termination. The MCO must utilize claims data to identify these Participants.

If the CHC-MCO is terminating a specialty unit within a facility or hospital, the Department may require the CHC-MCO to provide forty-five (45) day advance written notice to a specific Participant population or to all of its Participants, based on the impact of the termination.

The Department, at its sole discretion, may allow exceptions to the forty-five (45) day advance written notice depending upon verified status of contract negotiations between the CHC-MCO and Provider.

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

The forty-five (45) day advance written notice requirement does not apply to terminations by the CHC-MCO for cause in accordance with 40 P.S. §991.2117(b). The CHC-MCO must notify Participants within five (5) business days using the template notice titled C(1) Provider Termination Template For PCPs, found on the Intranet supporting CHC.

The CHC-MCO must update hard copy and web-based Provider directories to reflect changes in the Provider Network as required in Section V.O.17, Provider Directory, of this Agreement.

D. Notification to the Provider

The CHC-MCO must notify Network Providers in writing of their intent to terminate the Provider's contract a minimum of forty-five (45) days in advance of termination.

2. Termination by the Provider

A. Notification to the Commonwealth

If the CHC-MCO is informed by a Provider that the Provider intends to no longer participate in the CHC-MCO's Network, the CHC-MCO must notify the Department and PID in writing ninety (90) days prior to the date the Provider will no longer participate in the CHC-MCO's Network. If the CHC-MCO receives less than ninety (90) days' notice that a Provider will no longer participate in the CHC-MCO's Network, the CHC-MCO must notify the Department by the next business day after receiving notice from the Provider.

The CHC-MCO must submit a Provider termination work plan within ten (10) business days of the CHC-MCO notifying the Department of the termination and must provide weekly status updates to the work plan. Workplans do not need to be submitted for Providers that have less than ten (10) Participants, unless specifically requested by the Department. The requirements for the work plan are found in this Exhibit, under 3. Work plans and Supporting Documentation.

The CHC-MCO must comply with both this section and 28 Pa. Code §9.684.

B. Notification to Participants

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

If the Provider that is terminating its participation in the Network is not a PCP or a hospital, the CHC-MCO, using the template notice titled C(3) Provider Termination Template for Specialist and FQHC Providers Who Are Not PCPs, found on the Intranet supporting CHC, must notify all Participants who have received services from the Provider during the previous twelve (12) months, all Participants who were scheduled to receive services from the terminating Provider, and all Participants who have a pending or approved Prior Authorization request for services from the Provider forty-five (45) days prior to the effective date of the Provider's termination. The CHC-MCO must use referral and claims data to identify these Participants.

If the Provider that is terminating its participation in the Network is a hospital or specialty unit within a facility, the CHC-MCO, using the template notice titled C(2) Hospital/Specialty Unit Within a Facility or Hospital Termination, found on the Intranet supporting CHC, must, forty-five (45) days prior to the effective date of the hospital's termination, notify all Participants assigned to a PCP with admitting privileges at the hospital, all Participants assigned to a PCP that is owned by the hospital, and all Participants who have utilized the terminating hospital's services within the past twelve (12) months. The MCO must use referral and claims data to identify these Participants.

If the Provider that is terminating its participation in the Network is a specialty unit within a facility or hospital, the Department may require the CHC-MCO to provide forty-five (45) days advance written notice to a specific Participant population or to all of its Participants, based on the impact of the termination.

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

The CHC-MCO must update hard copy and web-based Provider directories to reflect changes in the Provider Network as required in Section V.O.17, Provider Directory, of this Agreement.

3. Work plans and Supporting Documentation

A. Workplan Submission

The CHC-MCO must submit a Provider termination work plan within ten (10) business days of the CHC-MCO notifying the Department of the termination and must provide weekly updates to the work plan. If the CHC-MCO wishes to request exception to any of the required work plan elements below, the CHC-MCO must submit a written request to DHS for prior review and approval. Workplans do not need to be submitted for Providers that have less than ten (10) Participants, unless specifically requested by the Department. The work plan must provide detailed information on the tasks that will take place to ensure the termination is tracked from the time it is first identified until the termination effective date. The work plan should be organized by task, responsible person(s), target dates, completed dates, and status. The work plan should define the steps within each of the tasks. The tasks may include, but are not limited to:

- Commonwealth Notifications (DHS and PID).
- Provider Impact and Analysis.
- Provider Notification of the Termination.
- Participant Impact and Analysis.
- Participant Notification of the Termination.
- Participant Transition.
- Participant Continuity of Care.
- Systems Changes.
- Provider Directory Updates for the IEB (include date when all updates will appear on Provider files sent to enrollment broker).
- CHC-MCO Online Directory Updates.
- Participant Service and Provider Service Script Updates.
- Submission of Required Documents to the Department (Participant notices and scripts for prior approval).
- Submission of Final Participant Notices to the Department (also include date that DOH received the final notices).
- Communication with the Public Related to the Termination.
- Termination Retraction Plan, if necessary, including Participant and Provider notices, call script updates, directory changes, and any other required materials

B. Supporting Documentation

The Department is also requesting that the CHC-MCO submit the following supporting documentation, in addition to the work plan, within ten (10) business days of the CHC-MCO notifying the Department of the termination and must

provide weekly updates as appropriate. The Department is not prescribing the format for the supporting documentation, but electronic means is preferable.

1) Background Information

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

2) Participant Access to Provider Services

- a) Submit information that identifies Providers remaining in the Network by Provider type and location that would be available within the appropriate travel times for those Participants once the termination is effective. Provide the travel times for the remaining Providers based upon the travel standards outlined in Exhibit T, Provider Network Composition/Service Access. For PCPs also list current panel sizes and the number of additional Participants that are able to be assigned to those PCPs.
- b) Submit geographic access reports and maps documenting that all Participants currently accessing terminating Providers can access services being provided by the terminating Provider from remaining Network Providers who are accepting new Participants. This documentation must be broken out by Provider type.
- c) Submit a comprehensive list of all Providers, broken out by Provider type, who are affected by the termination and that also indicates the current number of Participants either assigned (for PCPs) or utilizing these Providers.
- d) Submit information that includes the admitting privileges at other hospitals or facilities for each affected Provider and whether each affected Provider can serve the CHC-MCO's Participants at another hospital or facility.
- e) Submit a copy of the final Provider notices to the Department.

3) Participant Identification and Notification Process

- a) Submit information that identifies the total number of Participants affected by the termination, i.e., assigned to an owned/affiliated PCP or utilizing the hospital or owned/affiliated Provider within the twelve (12) months preceding the termination date, broken down by Provider.
- b) Submit information on the number of Participants with Prior Authorizations in place that will extend beyond the Provider termination date.
- c) Submit draft and final Participant notices, utilizing the templates included as C(1) – C(4), Provider and Hospital Termination Templates and Continuity of Care Denial Notice, found on the Intranet supporting CHC, as appropriate, for Department review and prior approval.
- d) After DHS has approved the final Participant notice, the CHC-MCO must submit a copy of the final Participant notice to PID at RA-INHCA3@pa.gov.

4) Participant Services

- a) Submit, for Department prior approval, the call center script to be used to respond to inquiries regarding the termination.
- b) Identify a plan for handling increased call volume in the call center while maintaining call center standards.
- c) Submit to the Department a call center report for the reporting of summary call center statistics, if requested as part of the termination. This call center report should include, at a minimum, the following elements:
 - Total Number of Inbound Participant services calls (broken out by PCP, Specialist, and Hospital).
 - Termination call reasons (broken out by Inquiries, PCP Change, Opt Out/Plan Change).

5) Affected Participants in Service Coordination

- a) Submit the total number of Participants in Service Coordination affected by the termination.
- b) Submit the criteria to the Department that the CHC-MCO will utilize for continuity of care for Participants affected by the termination.
- c) Submit an outreach plan and outreach script to the Department for prior approval if outbound calls are to be made to inform Participants in care management about the termination.

6) Participants Affected by Home Care Agency Termination:

- a) Submit the total number of Participants in the home care agency affected by the termination.
- b) Submit the criteria to the Department that the CHC-MCO will utilize for continuity of care for Participants affected by the termination.
- c) Submit an outreach plan and outreach script to the Department for prior approval if outbound calls are to be made to inform Participants about the termination.

7) Participants Affected by Nursing Facility Termination

- a) Submit the total number of Participants affected by the termination.
- b) Submit the criteria to the Department that the CHC-MCO will utilize for continuity of care for Participants affected by the termination.
- c) Submit an outreach plan and outreach script to the Department for prior approval if outbound calls are to be made to inform Participants in care management about the termination.

8) Enrollment Services

Submit final, approved Participant notices to the Department on CHC-MCO letterhead.

9) News Releases

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

10) Website Update

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

EXHIBIT W

EXTERNAL QUALITY REVIEW

External Quality Review (EQR) is a requirement under Title XIX of the Social Security Act, Section 1932(c)(2), for states to obtain an independent, external review body to perform an annual review of the quality of services furnished under state contracts with Managed Care Organizations, including the evaluation of quality outcomes, timeliness and access to services. The requirements for EQR were further outlined in 42 C.F.R. Parts 433 and 438, External Quality Review of Medicaid Managed Care Organizations. EQR refers to the analysis and evaluation of aggregated information on timeliness, access, and quality of healthcare services furnished to Participants. "Quality," as it pertains to EQR, means the degree to which a CHC-MCO maintains or improves the health outcomes of its Participants through its structural and operational characteristics and through the provision of services. The results of the EQR are made available, upon request, to specified groups and to interested stakeholders. This is one of many tools that facilitate achieving continuous quality improvement in the delivery of care and services, healthcare outcomes, and timeliness of care and services, access to services, quality and utilization management systems, and program oversight. The Department will use the EQR process for its early implementation process. The CHC-MCO must comply with all information requests from the External Quality Review Organization (EQRO). The Department requires as part of the EQR process that the CHC-MCOs:

- A. Actively participate in planning and developing the measures to be utilized with the Department and the EQRO. The Medical Assistance Advisory Committee will be given an opportunity to provide input into the measures to be utilized.
- B. Accurately, completely and within the required timeframe identify eligible Participants to the EQRO.
- C. Correctly identify and report the numerator and denominator for each measure.
- D. Actively encourage and require Providers, including subcontractors, to provide complete and accurate Provider medical records within the timeframe specified by the EQRO.
- E. Demonstrate how the results of the EQR are incorporated into the Plan's overall Quality Improvement Plan and demonstrate progressive improvements during the term of the contract.
- F. Improve Encounter Data in an effort to decrease the need for extensive Provider medical record reviews.
- G. Provide information to the EQRO as requested to fulfill the requirements of the mandatory and optional activities required in 42 C.F.R. Parts 433 and 438.

- H. Ensure that data, clinical records and workspace located at the CHC-MCO's work site are available to the independent review team and to the Department, upon request.
- I. Participate in Performance Improvement Projects whose target areas are dictated by the Department to address key quality areas of focus for improvements. The CHC-MCO will comply with the PIP timelines as prescribed by the EQRO.
 - 1. The CHC-MCO must perform at least two (2) PIPs, one (1) clinical and one (1) non-clinical. Clinical PIPs include projects focusing on prevention and care of acute and chronic conditions, high-volume services, high-risk services, and continuity and coordination of care and services; non-clinical PIPs include projects focusing on availability, accessibility, and cultural competency of services, interpersonal aspects of care and services, and appeals, grievances, and other complaints.
 - 2. The CHC-MCO must follow CMS protocols for PIPs and document all steps outlined in the CMS protocols for PIPs
 - 3. The CHC-MCO must identify benchmarks and set achievable performance goals for each of its PIPs. The CHC-MCO must identify and implement intervention and improvement strategies for achieving the performance goal set for each PIP and promoting sustained improvements.
 - 4. The CHC-MCO must report on PIPs as required in the Reporting Requirements for Performance Improvement Project topics that are conducted in the assigned Zone of the State. The CHC-MCO must submit one Performance Improvement Project Summary Report that includes Zone-specific data and information, including *improvement strategies* as required by CMS.
 - 5. After three (3) years, the CHC-MCO must, using evaluation criteria established by the Department, determine if one or all of the PIPs should be continued.

EXHIBIT W(1)

CRITICAL INCIDENT REPORTING AND MANAGEMENT AND PROVIDER PREVENTABLE CONDITIONS/PREVENTABLE SERIOUS ADVERSE EVENTS REPORTING

All CHC-MCO staff and staff of providers in their networks are mandatory reporters under both the Adult Protective Services Act (APS) and the Older Adult Protective Services Act (OAPSA). Reporting requirements can be found at:

- APS- <http://www.dhs.pa.gov/citizens/reportabuse/dhsadultprotectiveservices/>
- OAPSA- <http://www.aging.pa.gov/organization/advocacy-and-protection/Pages/Protective-Services.aspx>

CHC-MCOs must train or educate its Network Providers and ensure they comply with the reporting requirements established in the OAPSA and APS. In addition, CHC-MCOs must ensure that Network Providers comply with the following critical incident and adverse event reporting requirements outlined in this Exhibit.

Critical Incident Reporting to the Department

- A.** Network Providers and Subcontractors must report critical events or incidents to the CHC-MCOs.
- B.** Using the Department's Enterprise Incident Management System (EIM), the CHC-MCOs must investigate critical events or incidents reported by Network Providers and Subcontractors and report the outcomes of these investigations. CHC-MCOs must require all information entered in EIM to be written in English. To report the ongoing monitoring of incident reports and compliance with CMS' requirements, the Department has established an Operations Report for critical incidents (OPS 30: CHC Waiver Assurance Performance Measures – Health & Welfare). This reporting requirement is in addition to any other reporting requirements that may exist under the law.
- C.** CHC-MCO must establish a process to receive and manage critical incident reports that:
 1. Safeguards the health and welfare of the participant involved in a critical incident, including seeking emergency medical services if needed.
 2. Determines if an incident is reportable based on the definition of a critical incident.
 3. Requires the CHC-MCO staff person or Network Provider to submit a critical incident report in EIM within forty-eight (48) hours of discovery of the incident, excluding weekends and holidays. The forty-eight (48) hour clock begins at the time that the incident was discovered. If the incident was discovered on a weekend or holiday the clock would start at 12:00 a.m. on the first business day following the discovery of the incident.

4. Ensures all required fields are completed in EIM.
5. Requires the CHC-MCO to notify the Participant involved in the incident and the Participant's designated representative (unless the representative is suspected to be involved in the incident) within twenty-four (24) hours that a critical incident report was filed.
6. Requires CHC-MCO staff and Network Providers to report critical incidents even if the Participants involved choose not to report.
7. Respects the right of a Participant involved in a critical incident to: not report the incident; decline further interventions; refuse involvement in a critical incident investigation; and have an advocate present during any investigation resulting from a critical incident report.
8. Provides the number and percentage of substantiated cases of abuse, neglect and exploitation where potential issues related to health and welfare were addressed.

D. The following are critical incidents:

1. Death (other than by natural causes);
2. Serious injury that results in emergency room visits, hospitalizations, or death;
3. Hospitalization except in certain cases, such as hospital stays that were planned in advance;
4. Provider or staff misconduct, including deliberate, willful, unlawful, or dishonest activities;
5. Abuse, which includes the infliction of injury, unreasonable confinement, intimidation, punishment, mental anguish, or sexual abuse of a participant. Types of abuse include, but are not necessarily limited to:
6. Physical abuse, defined as a physical act by an individual that may cause physical injury to a participant;
7. Psychological abuse, defined as an act, other than verbal, that may inflict emotional harm, invoke fear, or humiliate, intimidate, degrade or demean a participant;
8. Sexual abuse, defined as an act or attempted act, such as rape, incest, sexual molestation, sexual exploitation, or sexual harassment and/or inappropriate or unwanted touching of a participant; and
9. Verbal abuse, defined as using words to threaten, coerce, intimidate, degrade, demean, harass, or humiliate a participant;
10. Neglect, which includes the failure to provide a participant the reasonable care that he/she requires, including, but not limited to, food, clothing, shelter, medical care, personal hygiene, and protection from harm. Seclusion, which is the involuntary confinement of an individual alone in a room or an area from which the individual is physically prevented from having contact with others or leaving, is a form of neglect;
11. Exploitation, which includes the act of depriving, defrauding, or otherwise obtaining the personal property from a participant in an unjust, or cruel manner, against one's will, or without one's consent, or knowledge for the benefit of self or others;

12. Restraint, which includes any physical, chemical or mechanical intervention that is used to control acute, episodic behavior that restricts the movement or function of the individual or a portion of the individual's body. Use of restraints and seclusion are both restrictive interventions, which are actions or procedures that limit an individual's movement, a person's access to other individuals, locations or activities, or restricts participant rights;
13. Service interruption, which includes any event that results in the participant's health and/or safety being at risk because of their inability to receive services. This includes involuntary termination by the provider agency, and failure of the participant's back-up plan. If these events occur, the provider agency must have a plan for temporary stabilization; and
14. Medication errors that result in hospitalization, an emergency room visit or other medical intervention.

For the purposes of Critical Incident reporting an emergency room visit is defined as the use of a hospital emergency room. This includes situations that are clearly emergencies, such as a serious injury, life-threatening medical conditions, medication errors, as well as those when an individual is directed to an emergency room in lieu of a visit to the PCP or as the result of a visit to the PCP. The use of an emergency room by an individual, in place of the physician's office, is not reportable.

A serious injury is defined as an injury that:

1. causes a person severe pain; or
2. significantly impairs a person's physical or mental functioning, either temporarily or permanently.

Critical Incident Investigation and Management

The CHC-MCO must ensure that the investigation of critical incidents begins within twenty-four (24) hours after the CHC-MCO discovers the incident.

The CHC-MCO must conclude critical incident investigations and provide the results of their investigations in EIM within thirty (30) calendar days of discovery of the incident. If the CHC-MCO is unable to conclude an investigation within thirty (30) days, the CHC-MCO must document the need for an extension and the reasons for the delay in EIM.

For any participant with more than three critical incidents within a 12-month period, the CHC-MCO must perform an analysis and take action as necessary to prevent or mitigate further incidents. The CHC-MCO must commence the analysis and implement the actions to address potential issues related to the health and welfare of the Participant within the 30-day investigation period. If additional time is needed to investigate and to implement any necessary actions to address potential issues related to the health and welfare of the Participant, the CHC-MCO must document an extension in EIM.

For critical incidents reportable under APS and OAPSA, including those involving suspected abuse, neglect, exploitation or abandonment, the CHC-MCO is responsible to report the incident to APS or OAPSA but not to investigate. CHC-MCO staff and service coordinators are required to provide information to and cooperate with APS and OAPSA staff who are conducting the investigation. In addition, the CHC-MCO shall fully cooperate with APS and OAPSA staff in the coordination of any services provided by the CHC-MCO. Upon being notified by APS and OAPSA staff that a case has been closed, or upon being notified by OLTL, the CHC-MCO will resume full responsibility for subsequent critical incident reporting and investigation for that Participant.

As part of its quality management plan, the CHC-MCO shall have a means to identify Participants who may be at risk of abuse or neglect and take steps to minimize those risks while balancing the right of the Participant to live in his or her community or place of choice.

The Department retains the right to review any incident reports or internal documentation, to conduct its own investigations and to require further corrective actions by the CHC-MCO.

Critical Incident Reporting Requirements for Providers

Providers must report in accordance with applicable requirements.

The CHC-MCO must require providers to cooperate with its investigation of critical incidents. The CHC-MCO must include critical incidents training in its annual training plan and quarterly updates to demonstrate all applicable CHC-MCO staff, Network Providers and their staff and contractors have received the training.

Provider Preventable Conditions/Preventable Serious Adverse Events (PSAE)

The CHC-MCO must require all Network Providers to identify provider preventable conditions as defined in 42 C.F.R. § 447.26 and may not pay for services related to provider preventable conditions unless the condition existed prior to the initiation of treatment for the patient. The CHC-MCO must submit all identified Provider Preventable Conditions in a form or frequency as required by the Department.

The CHC-MCO is prohibited from making payment to a provider for provider preventable conditions that meet the following criteria:

- a) Is identified in the State Plan;
- b) Has been found by the State, based upon a review of medical literature by qualified professionals, to be reasonably preventable through the application of procedures supported by the evidence-based guidelines;
- c) Has a negative consequence for the Participant;
- d) Is auditable;
- e) Includes, at a minimum, wrong surgical or other invasive procedure performed on a patient; surgical or other invasive procedure performed on the wrong body part; surgical or other invasive procedure performed on the wrong patient.

The CHC-MCO must develop and disseminate policies and procedures that prohibit payments for inpatient services related to treating provider preventable conditions.

The Department will recoup any funds expended by the CH-MCO for payments related to inpatient services for provider preventable conditions.

Please refer to the Department's website for additional information regarding PSAE
http://www.dpw.state.pa.us/cs/groups/webcontent/documents/document/c_101648.pdf

EXHIBIT W(2)
HEALTHCARE EFFECTIVENESS DATA AND INFORMATION SET (HEDIS®)
AND
CONSUMER ASSESSMENT OF HEALTHCARE PROVIDERS AND SYSTEMS
(CAHPS®)

Annually, the CHC-MCO must complete all HEDIS measures designated by NCQA as relevant to Medicaid. The HEDIS measure results must be reported separately for each Zone in which the CHC-MCO operates. The CHC-MCO must contract with an NCQA-certified HEDIS auditor to validate the processes of the CHC-MCO in accordance with NCQA requirements. Audited HEDIS results must be submitted to the Department, NCQA and the Department's EQRO annually by June 15th of each calendar year.

The CHC-MCO must utilize the Hybrid methodology (i.e., gathered from administrative and medical record data) as the data collection method for any Medicaid HEDIS measure containing Hybrid Specifications as identified by NCQA. If, in the event the CHC-MCO fails to pass the medical record review for any given standard and NCQA *mandates* that administrative data must be submitted instead of hybrid, the administrative data may be used.

The CHC-MCO must submit to the Department by June 15th of each calendar year a detailed explanation for any Medicaid HEDIS measure marked as "Not Reported."

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

- Effectiveness of care
- Access/availability of care
- Experience of care
- Utilization and Risk Adjusted Utilization
- Health plan descriptive information
- Measures Reported Using Electronic Clinical Data Systems

The Department requires that the CHC-MCOs:

- A. Must produce rates for all Medicaid reporting measures unless otherwise specified by the Department.
- B. Must follow NCQA specifications as outlined in the HEDIS Technical Specifications, clearly identifying the numerator and denominator for each measure.

- C. Must have all HEDIS results validated by an NCQA-licensed vendor. The Department currently contracts with an NCQA-licensed entity to validate the MCOs' HEDIS results used in public reporting. The MCO may utilize these validation results for other purposes such as pursuit of accreditation. The Department may at some future date relinquish the direct contracting of NCQA validation activities.
- D. Must assist with the HEDIS validation process by the Department's NCQA licensed contractor.
- E. Must demonstrate how HEDIS results are incorporated into the CHC-MCO's overall Quality Improvement Plan.
- F. Must submit validated HEDIS results annually on June 15th unless otherwise specified by the Department.
- G. Must provide Participant level data on select measures and must oversample select measures, as defined by the Department and the EQRO.

Consumer Assessment of Healthcare Providers and Systems (CAHPS)

The CHC-MCO must conduct any CAHPS survey required by the Department. CAHPS surveys are standardized instruments that assess various aspects of patient experience with care. CHC requires that both the Adult CAHPS and HCBS CAHPS surveys be conducted for Participants. Specific requirements are listed below for both surveys.

CAHPS Health Plan Survey (Adult CAHPS)

The Adult CAHPS is a subset of HEDIS reporting required by the Department. The CHC-MCO must conduct the Adult CAHPS using the most current CAHPS version specified by NCQA. Survey results must be reported to the Department both electronically and hardcopy in an Excel file in the format determined by the Department. The survey results must be reported separately for each Zone in which the CHC-MCO operates. Validated survey results must be submitted to the Department, NCQA and the Department's EQRO annually by June 15th of each calendar year unless otherwise specified by the Department.

The CHC-MCO must enter into an Agreement with a vendor that is certified by NCQA to perform CAHPS surveys. The CHC-MCO's vendor must perform the CAHPS Adult survey using the most current CAHPS version specified by NCQA.

The CHC-MCO must submit annually the Relative Resource Use (RRU) data to the Department within ten (10) business days of receipt from NCQA. The CHC-MCO must submit both the Regional and National RRU results.

CAHPS are a set of standardized surveys that assess patient satisfaction with the experience of care. The Adult CAHPS survey is a subset of HEDIS reporting required by the Department. For HEDIS, MCOs must contract with an NCQA-certified vendor to

administer the survey according to the HEDIS survey protocol that is designed to produce standardized results. The survey is based on a randomly selected sample of Participants from the CHC-MCO and summarizes satisfaction with the experience of care through ratings and composites. For the Department's purposes, the sample and response rate must be sufficient to ensure a margin of error for each question to be less than 5% for the CHC-MCO's enrolled population at a 95% confidence level. It is recommended that the CHC-MCOs work with their certified CAHPS vendors to determine an adequate sample size to meet the 5% margin of error at a 95% confidence level (CAHPS recommends a minimum of 300 completed responses).

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

- A. Must conduct the Adult CAHPS survey using the current version of CAHPS.
- B. Must include all Medicaid core questions in the survey.
- C. Must add all state specific modifications, which may include unique specifications or content as directed by the Department to the Adult CAHPS survey.
- D. Must add the following supplemental questions to the Adult CAHPS survey:
 - 1. In the last 6 months, did you get care from a dentist's office or dental clinic?
 - 2. In the last 6 months, how many times did you go to a dentist's office or dental clinic for care for yourself?
 - 3. We want to know your rating of all your dental care from all dentists and other dental providers in the last 6 months. Using any number from 0 to 10, where 0 is the worst dental care possible and 10 is the best dental care possible, what number would you use to rate your dental care?
- E. Must add the following supplemental question from the Supplemental Items for the Adult Questionnaires to the Adult CAHPS survey:
 - 1. In the last 6 months, how often was it hard to find a personal doctor who speaks your language?
 - 2. In the last 6 months, how often was it hard to find a personal doctor who knows your culture?
 - 3. In the last 6 months, how often did your personal doctor consider your cultural needs, including race, ethnicity or background, when providing care?
 - 4. In the last 6 months, if you utilized an interpreter or language services to help speak with your doctors or other healthcare providers, how would you rate your experience (with 0 being the worst possible experience, and 10 being the

best possible experience)?

- F. Must forward Adult CAHPS data to the Department both electronically and hardcopy in an Excel file in the format determined by the Department.
- G. Must submit validated Adult CAHPS results annually on June 15th unless otherwise specified by the Department.

The Department annually releases an Ops Memo that contains detailed information regarding the submission of HEDIS and Adult CAHPS, and may include additional Pa-specific questions.

Home and Community-based Services CAHPS Survey (HCBS CAHPS)

CHC-MCOs must contract with a vendor to administer the HCBS CAHPS survey. The CHC-MCO's vendor must conduct the HCBS CAHPS Survey using the most current version of the survey instrument provided by CMS. Each CHC-MCO's vendor will administer the survey using the mode determined by the Department, which can be in-person or via telephone. Survey results must be reported to the Department both electronically and hardcopy in an Excel file in the format determined by the Department. The survey results must be reported separately for each Zone in which the CHC-MCO operates. Validated survey results must be submitted to the Department, and the Department's EQRO annually each calendar year unless otherwise specified by the Department.

CAHPS are a set of standardized surveys that assess Participant satisfaction with the experience of care. CHC-MCOs must contract with a vendor to administer the survey according to CMS survey protocol that is designed to produce standardized results. The survey is based on a randomly selected sample of Participants from the CHC-MCO and summarizes satisfaction with the experience of care through ratings and composites. The Department also requires that the CHC-MCOs:

- A. Provide to the Department the name of the selected survey vendor and a copy of the contract with the selected survey vendor.
- B. Ensure that the selected survey vendor uses computer assisted interviewing software, has sufficient personnel to conduct recruitment of Participants as well as availability to schedule interviews to achieve required number of surveys considered complete due to the respondent providing a substantive response for at least 50% of the questions that all respondents are eligible to answer, not including the "About You" section.
- C. Ensure that the selected survey vendor develops and submits a comprehensive Quality Assurance Plan (QAP) for survey administration that details its implementation of and compliance with all required HCBS CAHPS Survey protocols and provide the Department with a copy of the selected survey vendor's QAP.

- D. Provide the selected survey vendor with a complete file of its HCBS population for use in selecting the statistically random sample as specified by the Department. If a minimum effective sample size is not specified by the Department, the selected vendor must select a statistically valid random sample based on a 95% Confidence Level, $\pm 5\%$ Confidence Interval, and a 50% Distribution. Ensure that the selected survey vendor stratifies the sample to assure equal race/ethnicity representation of the CHC waiver population and stratifies by region to assure geographic representation of the CHC waiver population.
- E. Must send a pre-notification letter to CHC Participants seven business days before the initial recruitment call after the letter has been reviewed and approved by the Department.
- F. Meet the following requirements if the selected survey vendor administers the survey to Participants by telephone and/or the Participant declines to take the survey:
- The CHC-MCO's vendor must ask the Participant *"Would you have preferred to take this survey in person? In that case, an interviewer would have come to where you live or another location you agreed on in advance."*
 - In the event the Participants decline to take the survey, the CHC-MCO's vendor must summarize in the plan-specific HCBS CAHPS Survey results the reasons why the Participants declined to take the survey.
- G. Ensure that the selected survey vendor obtains and records consent by Participants or their legal guardians, as well as consent by Participants when a legal guardian or proxy will be surveyed on their behalf. Consent can be verbal for telephone and written for in-person interviews.
- H. Ensure that the selected survey vendor has a process in place to report suspected participant abuse, neglect and/or exploitation to both the CHC-MCO and to the Department.
- I. Must conduct the HCBS CAHPS survey using the current version of CAHPS.
- J. Must include all HCBS core questions in the survey.
- K. Must include all HCBS supplemental employment questions in the survey.
- L. Must add all supplemental state specific questions as directed by the Department to the HCBS CAHPS survey.
- M. Must add the following supplemental dental care questions to the HCBS CAHPS survey. The Department reserves the right to modify these questions as necessary:

1. In the last 6 months, did you get care from a dentist's office or dental clinic?
 2. In the last 6 months, how many times did you go to a dentist's office or dental clinic for care for yourself?
 3. We want to know your rating of all your dental care from all dentists and other dental providers in the last 6 months. Using any number from 0 to 10, where 0 is the worst dental care possible and 10 is the best dental care possible, what number would you use to rate your dental care?
- N. Must forward HCBS CAHPS data to the Department electronically in an Excel format including an executive summary in the format determined by the Department.
- O. Must have selected survey vendor submit a First Twenty-Five Completed HCBS CAHPS Survey data file annually per the due date and in the format determined by the Department.
- P. Must have selected survey vendor submit a weekly Survey Administration Status report during the course of administering the survey beginning by the second week of survey administration in the format determined by the Department.
- Q. Must provide a validated disposition report using disposition categories defined by the American Association for Public Opinion Research (AAPOR) or developed by the selected survey vendor. This final disposition for all sampled cases indicates the final outcome in terms of whether the participant responded to the survey and, if not, why they did not respond. The disposition report must be submitted annually on November 15 unless otherwise specified by the Department.
- R. Must submit validated HCBS CAHPS results annually on November 15th unless otherwise specified by the Department.
- S. Provide Limited English Proficiency and Text Telephone services in support of the HCBS CAHPS Survey if requested by the survey participant.

The Department reserves the right to review the subsequent years' results and determine if an in-person interview will be required. The Department will notify the CHC-MCOs in advance of any change in the requirements.

The Department annually releases an Ops Memo that contains detailed information regarding the submission of HCBS CAHPS.

EXHIBIT X

ENCOUNTER DATA SUBMISSION REQUIREMENTS AND DAMAGES APPLICATIONS

The submission of timely, complete, and accurate Encounter Data is critical to the Department's ability to establish and maintain cost-effective and quality managed care programs.

Consequently, the requirements for submission and metrics for measuring the value of the data for achieving these goals are crucial.

- **CERTIFICATION REQUIREMENTS**

The CHC-MCO must be certified through the Department's MMIS prior to the submission of live encounter data. The certification process is detailed on the Pennsylvania HealthChoices Extranet.

- **SUBMISSION REQUIREMENTS**

- Timeliness:

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

- Metric:

On a monthly basis, encounters are analyzed for timeliness for each MCO plan code and encounter claim type.

Each MCO plan code is considered compliant when the overall timeliness standard benchmark is achieved for the quarter.

- Standard Benchmark: Encounters submitted to the Department's MMIS must be considered timely on or over 90% of the time.

Encounter data that does not meet the timeliness benchmark may subject to the MCO Corrective Action and liquidated damages, as set forth below. Liquidated damages for non-compliance will be considered, calculated, and imposed by the Bureau of Finance.

- Accuracy:

Encounter data submitted to the Department's MMIS is not deemed accurate until the encounter is accepted and has passed all Department edits.

- Metric:

On a monthly basis, encounters are analyzed for accuracy for each MCO plan code and encounter claim type.

Each MCO plan code is considered compliant when the overall accuracy standard benchmark is achieved for the quarter.

- Standard Benchmark: Encounters submitted to the Department's MMIS must be considered accurate on or over 90% of the time. Encounters are not considered accurate until they are accepted and pass all Department edits.

Encounter data that does not meet the accuracy benchmark may be subject to MCO Corrective Action and liquidated damages, as set forth below. Liquidated damages for non-compliance will be considered, calculated, and imposed by the Bureau of Finance.

- Completeness:

Completeness is based on consistency between Encounter Data submitted to the Department's MMIS and the information for the same service maintained by the CHC-MCO in its claims and service history database.

- Metric:

Completeness will be determined through a series of analyses of CHC-MCO Claims history data and Encounters received and processed through the Department's MMIS. The analysis will consist of making comparisons between encounter samples and what is found in the CHC-MCO's claims history. Samples may also be drawn from the CHC-MCO's service history and compared with Encounters processed through the Department's MMIS. The analysis will be done periodically, although at least once every three (3) years. The Department reserves the right to audit more frequently and to vary the audit period.

- **LIQUIDATED DAMAGES PROVISION**

- Timeliness:

Failure to comply with timeliness-requirements may result in liquidated damages of up to \$10,000 for each program month.

- Accuracy:

Failure to comply with accuracy requirements may result in liquidated damages of up to \$10,000 for each program month.

- Completeness:

Errors in completeness identified by the Department in an analysis may result in liquidated damages up to the amount shown in the following chart. An error in completeness, in one sample record, counts as one error.

Percentage of the sample that includes an error	Liquidated Damages
Less than 1.0 percent	None
1.0 – 1.4 percent	\$4,000
1.5 – 2.0 percent	\$10,000
2.1 - 3.0 percent	\$16,000
3.1 – 4.0 percent	\$22,000
4.1 – 5.0 percent	\$28,000
5.1 – 6.0 percent	\$34,000
6.1 – 7.0 percent	\$40,000
7.1 – 8.0 percent	\$46,000
8.1 – 9.0 percent	\$52,000
9.1 – 10.0 percent	\$58,000
10.1 percent and higher	\$100,000

EXHIBIT Y

GUIDELINES FOR SANCTIONS REGARDING FRAUD, WASTE AND ABUSE

The Department recognizes its responsibility to administer the Community HealthChoices (CHC) Program and ensure that the public funds which pay for this program are properly spent.

To maintain the integrity of the CHC Program and to ensure that CHC-MCOs comply with pertinent provisions of State and Federal law and rules and policies involving Fraud, Waste and Abuse issues, the Department will impose sanctions on the CHC-MCOs as deemed appropriate where there is evidence of violations involving Fraud, Waste and Abuse issues in the CHC Program. To that end, program compliance and improvement assessments, including financial assessments payable to BPI, will be applied by BPI for the CHC-MCO's identified program integrity compliance deficiencies. Note that the Department also retains discretion to impose additional remedies available under applicable law and regulations.

FRAUD, WASTE AND ABUSE ISSUES WHICH MAY RESULT IN SANCTIONS

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

- A. Failing to implement, develop, monitor, continue and/or maintain the required compliance plan and policies and procedures directly related to the detection, prevention, investigation, referral or sanction of Fraud, Waste and Abuse by providers, caregivers, members or employees.
- B. Failing to cooperate with reviews by oversight agencies or their designees, including the Department, the Pennsylvania Office of Attorney General Medicaid Fraud Control Section, the Pennsylvania Office of Inspector General, the Comptroller General, and other state or federal agencies and auditors under contract to CMS or the Department. See 42 CFR § 438.3(h).
- C. Failing to adhere to applicable state and federal laws and regulations.
- D. Failing to adhere to the terms of the CHC- Agreement, and the relevant Exhibits which relate to Fraud, Waste and Abuse issues.
- E. Failing to provide the data, information, and documentation required by 42 C.F.R. § 438.604 (relating to Data, information, and documentation that must be submitted), including encounter data; claims data; data relating to capitation rate actuarial soundness; data relating to compliance with the medical loss ratio requirement; data relating to provision against the risk of insolvency; documentation relating to compliance with requirements for availability and accessibility of services and adequacy of provider network; information on

ownership and control; annual report of overpayment recoveries; and data, documentation, or information relating to the performance of the entity's obligations..

- F. Engaging in actions that indicate a pattern of wrongful denial of payment for a health-care benefit, service or item that the organization is required to provide under its agreement.
- G. Failing to furnish services or to provide Participants a health benefit, service or item that the organization is required to provide under its Agreement. See 42 CFR § 438.700(b)(1).
- H. Engaging in actions that indicate a pattern of wrongful delay of at least 45 days or a longer period specified in the Agreement (not to exceed 60 days) in making payment for a health-care benefit, service or item that the organization is required to provide under its Agreement.
- I. Discriminating against Participants on any basis including, but not limited to, race, color, national origin, disability, sex, health status, or need for health care services. See 42 CFR §438.3(d)(3- 4).
- J. Failing to conduct a preliminary investigation of a potential fraud referral to the level of the indicia of potential fraud, i.e., there is indicia of reliability of the allegation of fraud.
- K. Failing to pay overpayments to DHS as identified through network provider audits, reviews, investigations conducted by BPI or its designee and other state and federal agencies.

RANGE OF SANCTIONS

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

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

These sanctions may, but need not be, progressive. The Department intends to maintain an effective, reasonable and consistent sanctioning process as deemed necessary to protect the integrity of the CHC Program.

EXHIBIT Z

PERSON-CENTERED SERVICE PLANNING

Federal and state regulations (42 CFR § 441.301, 55 Pa. Code §§ 52.25 and 52.26) require that Person-Centered Planning be used in Medicaid LTSS programs. Person-Centered Planning is a process directed by the CHC LTSS Participant. The process involves a PCPT actively coordinated by the LTSS Participant's Service Coordinator. The PCSP must be developed by the Service Coordinator, the Participant, the Participant's representative, and the Participant's PCPT. The process assists the Participant to articulate a plan for the future and helps determine the supports and services that the Participant needs to achieve identified outcomes.

Note: The information in this exhibit is to be used in conjunction with, and does not replace, the requirements in the CHC 1915(c) HCBS waiver.

Guidelines for Person-Centered Service Planning

- i. The CHC-MCO must deliver LTSS in a person-centered way:
 - a. LTSS must be furnished under a written service plan, based on a person-centered approach that identifies and addresses an LTSS Participant's needs, goals, and preferences while incorporating existing resources and supports as identified by the Participant.
 - b. Service plans must be:
 - 1. Approved by the CHC-MCO no more than fifteen (15) business days from the date the Assessment or Reassessment is completed.

PCSP Procedures Overview

- i. General
 - a. The PCSP must be adequate and appropriate according to needs identified by the Assessment.
 - b. If a legal guardian has been appointed for the Participant, the guardian must be an integral part of the PCPT. The Participant's legal guardian has the right to actively participate on the Participant's behalf in the

planning process and to file an appeal or grievance on behalf of the Participant.

- c. If the Participant uses an alternative means of communication or if the Participant's primary language is not English, the process must utilize the Participant's primary means of communication or an interpreter.
- d. The Participant's cultural preferences must be acknowledged and reflected in the planning process.
- e. The CHC-MCO must provide the necessary level of support to ensure that the individual directs the PCPT process to the maximum extent possible and is enabled to make informed choices and decisions.
- f. The Department may review, question, and request revisions to LTSS Participants' PCSPs. The CHC-MCO must provide the Department with monthly aggregate reports on PCSP changes in a format specified by the Department.
- g. CHC-MCOs must annually submit and obtain Department approval of their Service Coordination staffing, caseloads, the required frequency of in-person contact with Participants, and how Service Coordinators share and receive real-time information about Participants and Participant encounters.

ii. Participant Education

- a. The Service Coordinator must educate the Participant on the following:
 - 1. Strategies for resolving conflict or disagreement within the PCPT process, including clear conflict-of-interest guidelines for all members of the Person-Centered Planning Team.
 - 2. Informed choice regarding the services and supports they receive and from whom.
 - 3. Informed choice regarding their right to select their Service Coordinator and to change Service Coordinators at any time.

4. A method for the Participant to request updates to the PCSP as needed.
 5. Participant self-directed services.
 6. The Complaint, Grievance and Fair Hearing Appeals Processes.
 7. How to report abuse, neglect, and exploitation. The Service Coordinator must obtain a signature verifying that the Participant or their representative fully understand the process.
- b. The Service Coordinator provides Participants and their representative, if any, with a Participant handbook within 5 days of enrollment. The handbook is intended to provide Participants with a basis for self-advocacy safeguards. The Service Coordinator educates the Participant and/or their representative on the following:
1. Participant rights and responsibilities;
 2. Participant choice;
 3. the role of the Service Coordinator;
 4. the role of the PCPT;
 5. how to connect to other community resources;
 6. abuse, neglect and exploitation;
 7. fraud and abuse; and
 8. Participant self-directed services.
- iii. Content of the PCSP for Participants Receiving LTSS in the Community
- a. The holistic PCSP at minimum must include the following:
1. A Care Management Plan to identify and address how the Participant's physical, cognitive, and behavioral healthcare needs will be care managed. See Section V.G.1 of the CHC Agreement for the required components of PCSP Care Management Plans.
 2. An 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 requirements for the LTSS Service Plan are in Section

V.G.2 of the CHC Agreement. In addition to the requirements listed in the CHC Agreement, the CHC-MCO must also include the following in the PCSP and PCSP process:

- A. Individualized and emergency back-up plans to ensure the health and safety of Participants.
 - i. Service Coordinators must review the PCSP quarterly to validate that the strategies and back-up plans are working and are current.
 - ii. Service Coordinators must update back-up plans as necessary, or if the back-up has failed at any point.

3. The PCSP must document the following:

- A. The Participant's eligibility and CHC/MA ID number;
- B. The names of individuals who participated in the PCSP process;
- C. The Participant's household composition (i.e., does the individual live alone, with a sibling or other relative, or friend?);
- D. The Participant's emergency contacts;
- E. The Service Coordinator must describe contact with the Participant, family members, and providers in the case management notes of the PCSP.
- F. The Service Coordinator's quarterly review of the Participant's back-up plan, including updates to the back-up plan if necessary;
- G. The Participant's completed Assessment, including the Diagnosis, Medications, Allergies, and Medical Contacts;
- H. Any CHC services that reflect unmet needs identified in the Assessment;
- I. The Participant's strengths and capabilities;
- J. That the Participant was offered a choice of network providers;
- K. The review of rights and responsibilities with the Participant;

- L. The Participant's delivery preferences for all services;
- M. Any barriers, risks, and mitigation strategies;
- N. The assignment of responsibilities to implement and monitor the PCSP;
- O. A list of the Participant's preferences for employment, education, and community engagement, as well as an overview of the discussion the Service Coordinator had with the Participant on these issues;
- P. When a participant uses informal supports, the CHC-MCO must discuss with and document in the PCSP each informal support's availability, willingness, and ability to provide the needed HCBS and the participants' acceptance of assistance from that informal support. The PCSP also must identify each informal support, and, with respect to each informal support, the day(s) and number of hours per day informal supports is provided, as well as the specific type and scope of services provided.
- Q. If the Participant does not have informal support, include reasons why informal support is not available;
- R. The type, scope, amount, duration, and frequency of services needed by the Participant;
- S. Justification for all services;
- T. If a service definition requires a physician prescription, documentation that the Service Coordinator obtained the prescription prior to adding the service to the PCSP; and
- U. If the Participant refuses to have a need addressed, when the Participant refused to have the need addressed and why the Participant chose for the need to remain unaddressed.
- V. If a provider develops a treatment or service plan for the Participant, it must be incorporated into the overall PCSP.
- W. Any modification of a participant's rights in a setting, under 42 CFR § 441.301(c)(4)(vi)(A) through (F), must be supported by a

specific assessed need and justified in the PCSP. The following requirements must be documented in the PCSP:

- Identify a specific and individualized assessed need.
- Document the positive interventions and supports used prior to any modifications to the PCSP.
- Document less intrusive methods of meeting the need that have been tried but did not work.
- Include a clear description of the condition that is directly proportionate to the specific assessed need.
- Include regular collection and review of data to measure the ongoing effectiveness of the modification.
- Include established time limits for periodic reviews to determine if the modification is still necessary or can be terminated.
- Include the informed consent of the individual.
- Include an assurance that interventions and supports will cause no harm to the individual.

iv. Content of the PCSP for Participants Receiving LTSS in Nursing Facilities

1. For nursing facility residents, nursing facilities are responsible to develop care plans and provide services consistent with state licensing requirements and federal conditions of participation. The Department of Health will continue to enforce state licensing requirements and act as the State Survey Agency for federal survey and certification purposes.
2. The CHC-MCO Service Coordinator will review a Participant's nursing facility care plan as part of coordination of care and provide input into the plan. The CHC-MCO Service Coordinator will work with the nursing facility staff to determine the services that the Participant needs and the roles of who should be providing the services in the PCSP process. The CHC-MCO Service Coordinator will be responsible for the coordination of Medicare benefits, Veterans benefits, behavioral health services, and other health coverage insurers and supports in conjunction with the nursing facility. A separate PCSP does not have to be created as long as the NF care plan includes all appropriate services, goals for transitioning to the community (if desired by the Participant), and how Medicare benefits, Veterans benefits, behavioral health services, and other health coverage will be coordinated.

v. PCSP Process

1. The Service Coordinator describes and explains the concept of person-centered service planning to the Participant and/or his or her representative.
2. Prior to a PCPT meeting, the Service Coordinator works with the Participant and/or his or her representative to coordinate attendees and meeting dates, times and locations. The Participant chooses who to invite and when and where meetings will take place.
3. The Service Coordinator provides information to the Participant and to his or her representative, if any, in advance of the planning meeting so that the Participant can make informed choices about their services and service delivery in order to effectively develop a PCSP.
4. The Service Coordinator, along with the PCPT, utilizes the assessments, documentation obtained from direct services and discussions with the Participant to secure information about the Participant's needs, including health care needs, preferences, goals, health status, and available, willing, and able informal supports to develop the PCSP. This information is captured by the Service Coordinator and then documented in the Participant's record.
5. Service Coordinators ensure that the PCSP includes sufficient and appropriate services to maintain health, safety and welfare, and, for CHC Waiver Participants, provides the support that an individual needs or is likely to need in the community to avoid institutionalization. Service unit calculations must be accurate and appropriate. Each Participant need must be addressed unless the Participant chooses for a need not to be addressed.
6. The Service Coordinator reviews, in conjunction with the Participant, the Participant's services to ensure the services are adequate to meet the desired outcomes. Revisions are discussed with the Participant and incorporated into the PCSP. All service plan meetings and discussions with the Participant are documented in the Participant's record.

7. Annually, the Service Coordinator provides the Participant with the choice of receiving community services in the CHC Waiver, LIFE Program (if age 55 or older), nursing facility services, or no LTSS services. Completed forms detailing this must be maintained in the Participant's file.
8. Participants are also given the choice of willing and qualified Providers within the network at each Reassessment and at any time during the year when a Participant requests a change of services. The Service Coordinator must document the Participant's choice of provider as part of the Participant's PCSP. As noted above, the Service Coordinator must also document that the Participant was offered a choice of network providers.
9. The Service Coordinator provides Participants and/or his or her representative with information on services and supports available to LTSS Participants and the processes for selecting qualified Providers of services.
10. For Participants receiving home and community-based services, the Service Coordinator must provide information regarding opportunities for Participant-Directed Services and responsibilities for directing those services. The Service Coordinator must document these discussions in the Participant's record and record why the Participant declined this model when a reason is provided.
11. The Service Coordinator gathers information on an ongoing basis to ensure the PCSP reflects the Participant's current needs. The Service Coordinator discusses potential revisions to the PCSP with the Participant and individuals important to the Participant. All changes to existing PCSPs must be documented in the Participant's record.
12. The Service Coordinator must obtain the electronic or written signatures of the Participant, Participant's representative and any others involved in the planning process, indicating they participated in the process, they approve and understand the services outlined in the PCSP, and that services are adequate and appropriate to the Participant's needs. The

PCSP is not considered complete until all of the required signatures are received. The finalized PCSP must include the type, scope, amount, duration and frequency of the services authorized by the PCSP. If a Participant refuses to sign their PCSP, not because they do not agree with the plan, but because they simply refuse to sign it at that time and there is no representative to sign on their behalf, the PCSP should not be deemed invalid due to lacking the signature. For instances where this occurs the Service Coordinator should document the refusal of the Participant to sign the document and note verbal consent of the PCSP by the Participant. The Service Coordinator should attempt to obtain the Participant's signature during their next interaction.

A Participant may also sign indicating disapproval of the plan if the Participant disagrees with the PCSP.

When this occurs, the Service Coordinator must provide the Participant with a denial notice within two (2) business days that includes his or her right to file a grievance and assist the Participant through the process as appropriate. Every Participant must be given a copy or mailed a copy of his or her PCSP within two (2) business days of when initial completion or subsequent revisions are finalized. A copy of the signed PCSP is given to the Participant as well as all members of the PCPT who the Participant consents to receiving the PCSP or portions of the PCSP.

13. If the CHC-MCO makes the decision to deny in whole or in part, reduce, suspend, or terminate a service or item in the Participant's PCSP, the CHC-MCO must use the templates specified by the Department to issue a written denial notice which meets the following criteria:
 - A. Written at a 6th grade reading level;
 - B. Written in an individualized manner;
 - C. Specifically references the service or item that is being reduced or denied;
 - D. Includes specific references to approved medical necessity guidelines, rules, or protocols on which the decision is based.

14. Section V.B.2e of the CHC Agreement contains a limited number of exceptions to the notice requirement. One exception is the receipt of a clear written statement signed by a Participant that he or she no longer wishes to receive the requested service or gives information that requires termination or reduction of services and indicates that he or she understands that termination will be the result of supplying that information. If this occurs the CHC-MCO must still offer the Participant appeal rights. The CHC-MCO may not consider a Participant's signature on the PCSP in itself to be a "clear written statement" as described in V.B.2e.
15. If the Participant grieves the CHC-MCOs authorized PCSP, the Service Coordinator must provide the final, approved PCSP to the Participant at the conclusion of the grievance process.
16. Once the PCSP is authorized by the CHC-MCO, the Service Coordinator communicates the service plan content to the Participant and to the Participant's appropriate service provider or providers to ensure that service delivery matches the approved PCSP. The CHC-MCO must approve the PCSP prior to the provision of services.
17. The Service Coordinator initiates a Reassessment at least annually (at least once every 365 days) and when either there is a significant change in the Participant's situation or condition, a trigger event occurs, or the Participant requests Reassessment. 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.
18. The CHC-MCO must complete the PCSP in a format approved by the CHC Agreement and enter the PCSP in the CHC-MCO's designated information system.

EXHIBIT AA

MANAGED CARE DEFINITIONS FOR PARTICIPANT COMMUNICATIONS

The 2016 CMS “Medicaid and Children's Health Insurance Program (CHIP) Programs; Medicaid Managed Care, CHIP Delivered in Managed Care, and Revisions Related to Third Party Liability” final rule established a requirement (42 CFR § 438.10(c)(4)(i)) that mandated that all states which contract with MCOs for delivery of Medicaid services must develop standardized definitions for a set of managed care related terms to be utilized by MCOs in communications with Participants. The state developed definitions were required to be written at no higher than a sixth-grade reading level and are to be utilized by CHC-MCOs for communications with Participants such as newsletters, informational pamphlets, Participant handbooks, etc.

When using any of the terms below in communications to Participants, CHC-MCOs must utilize the terms with the same intent as defined by the state.

Managed Care Definitions

1. **Appeal-** To file a Complaint, Grievance, or request a Fair Hearing.
2. **Complaint-** When a Participant tells a CHC-MCO that he or she is unhappy with the CHC-MCO or his or her provider or does not agree with a decision by the CHC-MCO.
3. **Co-Payment-** A co-payment is the amount a Participant pays for some covered services. It is usually only a small amount.
4. **Durable Medical Equipment-** A medical item or device that can be used in a Participant's home or in any setting where normal life activities occur and is generally not used unless a person has an illness or injury.
5. **Emergency Medical Condition-** An injury or illness that is so severe that a reasonable person with no medical training would believe that there is an immediate risk to a person's life or long-term health.
6. **Emergency Medical Transportation-** Transportation by an ambulance for an emergency medical condition.
7. **Emergency Room Care-** Services needed to treat or evaluate an emergency medical condition in an emergency room.
8. **Emergency Services-** Services needed to treat or evaluate an emergency medical condition.
9. **Excluded Services-** Term should not be used. CHC-MCO should use “Services That Are Not Covered” instead.
10. **Grievance-** When a Participant tells a CHC-MCO that he or she disagrees with a CHC-MCO's decision to deny, decrease, or approve a service or item different than the service or item the Participant requested because it is not medically necessary.
11. **Habilitation Services and Devices-** Term should not be used by CHC-MCO. CHC-MCO should define specific service.

12. **Health Insurance-** A type of insurance coverage that pays for certain health care services. (If used by CHC-MCO, should be used to refer only to private insurance.)
13. **Home Health Care-** Home health care is care provided in a Participant's home and includes skilled nursing services; help with activities of daily living such as bathing, dressing, and eating; and physical, speech, and occupational therapy.
14. **Hospice Services-** Home and inpatient care that provides treatment for terminally ill Participants to manage pain and physical symptoms and provide supportive care to Participants and their families.
15. **Hospitalization-** Care in a hospital that requires admission as an inpatient.
16. **Hospital Outpatient Care-** Care provided by a hospital or hospital-based clinic that does not require admission to the hospital.
17. **Medically Necessary-** A service, item, or medicine that does one of the following:
- Will, or is reasonably expected to, prevent an illness, condition, or disability;
 - Will, or is reasonably expected to, reduce or improve the physical, mental, or developmental effects of an illness, condition, injury or disability;
 - Will help a Participant get or keep the ability to perform daily tasks, taking into consideration both the Participant's abilities and the abilities of someone of the same age.
 - Will help a CHC Participant receiving long-term services and supports (LTSS) to take part in community living, meet the Participant's goals, and live and work in the setting of the Participant's choice.
18. **Network-** Contracted providers, facilities, and suppliers that provide covered services to CHC-MCO Participants.
19. **Non-Participating Provider-** When referring to a provider that is not in the network, CHC-MCOs should use the term "Out-of-Network Provider."
20. **Physician Services-** Health care services provided or directed by a licensed medical physician (M.D. – Medical Doctor or D.O. – Doctor of Osteopathic Medicine).
21. **Plan-** A health care organization that provides or pays for the cost of services or supplies.
22. **Preauthorization or Prior Authorization-** Approval of a service or item before a Participant receives the service or item.
23. **Participating Provider-** When referring to a provider that is in the network, CHC-MCOs should use "Network Provider."
24. **Premium-** The amount a Participant pays for health care coverage.
25. **Prescription Drug Coverage-** A benefit that pays for prescribed drugs or medications.
26. **Prescription Drugs-** Drugs or medications that require a prescription for coverage.
27. **Primary Care Physician-** A physician (M.D. – Medical Doctor or D.O. – Doctor of Osteopathic Medicine) who directly provides or coordinates a range of health care services for a patient.

- 28. **Primary Care Provider-** A doctor, doctors' group, or certified registered nurse practitioner who provides and works with a Participant's other health care providers to make sure the Participant gets the health care services the Participant needs.
- 29. **Provider-** An individual or entity that delivers health care services or supplies.
- 30. **Rehabilitative Services and Devices-** Term should not be used by CHC-MCO. CHC-MCO should define specific service.
- 31. **Skilled Nursing Care-** Services provided by a licensed nurse.
- 32. **Specialist-** A doctor, a doctor's group, or a certified registered nurse practitioner who focuses his or her practice on treating one disease or medical condition or a specific part of the body.
- 33. **Urgent Care-** Care for an illness, injury, or condition which if not treated within 24 hours, could rapidly become a crisis or an emergency medical condition.
- 34. **Network Provider-** A provider, facility, or supplier that has a contract with an CHC-MCO to provide services to Participants.
- 35. **Out-of-Network Provider-** A provider that does not have a contract with an CHC-MCO to provide services to Participants.

EXHIBIT BB

CHC Waiver Assurance Performance Measure Requirements and Sanctions

The submission of timely, complete, and accurate Operations Reports is critical to the Department's oversight of the CHC program. The CHC 1915(c) Waiver requires the Department to have systems in place to measure and improve its performance in meeting certain waiver assurances. There are fifteen (15) CHC Waiver Assurance Performance Measures ("WPM"): two (2) for Administrative Authority; one (1) for Qualified Providers; five (5) for Person-Centered Service Plans ("PCSP"); and, seven (7) for Health & Welfare.

SUBMISSION REQUIREMENTS

CHC-MCOs must report WPM data on the following forms and by the due dates specified in the Operations Reporting Requirements Submission Schedule:

- a. OPS 004 (Complaint and Grievance Detail)
- b. OPS 011 (Provider Education)
- c. OPS 029 (CHC PCSP Waiver Assurance Performance Measures)
- d. OPS 030 (CHC Health & Welfare Waiver Assurance Performance Measures).
- e. OPS 038 (Financial Management Services)

- Metric 1:

During the reporting quarter, the total number of timely submissions in the reporting quarter is divided by the total number of required submissions in the reporting quarter. CHC-MCO zone level performance will be combined and measured at the plan level (e.g., four submissions of a report x 5 zones result in 20 total submissions for the applicable report). 86% of all required reports must be submitted by the established due date.

Failure to achieve the CMS required level of 86% may result in imposition of sanctions as provided under Sanctions for Metric 1.

- Metric 2:

CHC-MCO compliance will be measured based on the WPM for each identified OPS report. During the reporting quarter, the total number of WPM meeting the 86% required level of performance is divided by the total number of WPM measured in the reporting quarter. CHC-MCO zone level performance will be combined and measured at the plan level (e.g., fifteen WPMs x 5 zones result in 75 total WPM measured for the reporting period)

- Failure to achieve the CMS required level of 86% may result in the imposition of sanctions as provided under Sanctions for Metric 2.

• **SANCTIONS**

- Metric 1: Timeliness

Failure to comply with timeliness requirements may result in a sanction of up to \$10,000 for each program month.

- Metric 2: CHC-MCO Performance Compliance

Failure to meet the CMS required level of performance for a WPM may result in sanctions as follows. (e.g. if 4 WPMs have an 85% compliance, the CHC-MCO may be sanctioned \$4,000 x 4 WPMs = \$16,000)

WPM Performance Compliance	Sanction
86% or more	None
85.0% to 85.9%	\$4,000
84.0% to 84.9%	\$10,000
83.0% to 83.9%	\$16,000
82.0% to 82.9%	\$22,000
81.0% to 81.9%	\$28,000
80.0% to 80.9%	\$34,000
79.0% to 79.9%	\$40,000
78.0% to 78.9%	\$46,000
77.0% to 77.9%	\$52,000
76.0% to 76.9%	\$58,000
75% or less	\$100,000

Exhibit CC

Financial Management Services (FMS)

All HCBS LTSS participants have the option to make decisions about and self-direct their own waiver services as identified in Section E-1.g of the CHC Waiver and Section V.A.16 of the CHC Agreement. Participants in the CHC Waiver may choose to hire and manage staff using Employer Authority or manage an individual budget using Budget Authority. In addition, Participants may choose a combination of service models to meet their individual needs.

Financial Management Services (FMS) are provided to participants across the Commonwealth by qualified Vendor Fiscal/Employer Agent(s) (F/EA). The CHC-MCOs are responsible for FMS functions and must process, file, and pay all applicable state and federal taxes on behalf of participants and their direct service workers. The CHC-MCOs must operate as an F/EA or subcontract this function.

The CHC-MCOs must submit in writing for prior approval by the Department any subcontracts to perform part or all of the FMS administrative services described herein, together with documentation that the proposed FMS subcontractor meets all requirements herein, before commencing the provision of FMS with any subcontractor. The Department must pre-approve the proposed FMS subcontractor in writing. The Department reserves the right to reject any subcontractor who does not meet these requirements. Whether the CHC-MCO provides the FMS administrative services directly or through an approved subcontractor, the entity which provides those services (hereinafter the “FMS Entity”) must provide all the services and meet all the requirements below.

A. General Requirements

Conflict Free Requirements

The FMS Entity must be free of any conflict of interest with any existing or future waiver and program providers. To ensure an objective, unbiased provision of functions, the FMS Entity and any subcontractors must be free of real or perceived conflicts of interest.

1. The FMS Entity and its subcontractors may not be a part of or affiliated with and must remain independent from any provider of HCBS. Neither the governing body of the FMS Entity nor individual members of the governing body may be affiliated with any provider of HCBS. The FMS Entity or its subcontractors may not be affiliated with or a subsidiary of any existing provider of HCBS.

No personnel assigned to the FMS Entity may work for any provider of HCBS. Personnel assigned to the FMS Entity may receive direct care services or supports from such provider as long as the services are purchased at fair rates (either private pay, through an HCBS program, or through another third-party program).

FMS Entity Obligations

An FMS Entity enrolls Participants in FMS and applies for and receives approval from the IRS to act as an agent on behalf of the Participant. As the Participant's agent, the FMS Entity 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 each self-directed model. If choosing to subcontract this administrative service, the CHC-MCO must jointly collaborate with all other contracted CHC-MCOs to contract with a single statewide FMS Entity under the requirements described below, and each CHC-MCO must establish agreements and cooperate with this statewide entity in order that necessary FMS services are provided to participants. The FMS Entity must enroll in PA Medicaid and sign an MA provider agreement.

The FMS Entity must maintain an online portal to allow both Participants and those involved in their service delivery access to documents, time entry, utilization and budget information, access to pay stubs and tax documents, lists of employees, and the ability to communicate with the FMS Entity.

The CHC-MCO must provide sufficient funds to the FMS Entity so that payroll is satisfied on a timely basis. The amount, time period and other terms for those funds shall be set forth in policies established by the CHC-MCO and approved by the Department. The CHC-MCOs must notify OLTL as soon as possible when made aware that a payroll for all DCWs on a particular payroll schedule will be or has been missed for any reason.

The CHC-MCO must verify that before a direct care worker provides services, the direct care worker received a pre-service orientation provided through a training vendor organization who meets the requirements outlined in this agreement and under contract with the FMS Entity. The CHC-MCO must ensure each direct care worker obtains a Unique ID number from the DHS Unique ID registry and provide it to the FMS Entity prior to providing services.

Qualifications

The FMS Entity must have:

1. Demonstrated financial health. The CHC-MCO must ensure that a reserve of at least six (6) weeks of payroll is maintained and readily available to avoid a negative impact to operations of the organization;
2. At least five years of experience successfully managing and paying a distributed group of individuals and operate a current program(s) serving participant-directed participants in at least one other state;
3. Demonstrated experience providing FMS services to a self-directed service model;
4. A minimum of 10,000 individuals who are paid by the vendor in a current program or as of one year (365 days) before the start of the provision of this function. This count may be at the parent company or a partner or subcontracted organization level;

5. A transition methodology including industry standard project management tools (e.g. Project Management Institute standards tools for documenting and managing projects);
6. A current Comprehensive Policies and Procedures Manual for managing distributed DCWs;
7. Policies and procedures for data management standards reflecting data integrity and data governance practices;
8. A call center staffed by qualified representatives;
9. Demonstrated experience and arm's length references demonstrating collaboration with relevant stakeholders in participant-directed services, including the disability community, senior groups, and DCW organizations;
10. Ability to track and provide, upon request by the Department, accurate workforce data, including demographics, wages, benefits, DCW turnover, family caregivers, comprehensive list with contact information of active DCWs in the participant-directed program, participation and completion of orientation and/or training, average timeline for enrollment, and other workforce data and analysis as requested.

Training and Orientation

The CHC-MCO or FMS Entity is responsible for ensuring Participants obtain enrollment and informational materials. In addition, the CHC-MCO or FMS Entity is responsible for ensuring orientation is provided to the Participant or common law employer prior to employing their direct care worker. Orientation and training materials must be submitted to the Department for review and approval prior to implementation and must include the following at minimum:

- Review of the information and forms contained in both the Employer and Direct Care Worker enrollment packets and how they should be completed
- The role and responsibilities of the common law employer;
- The role and responsibilities of the FMS Entity;
- The process for receipt and processing timesheets and employee payroll checks;
- The process for resolving issues and complaints; and
- The process for reviewing workplace safety issues, managing workplace injuries, and workers compensation.

Providing Direct Care Worker Pre-Service Orientation Training

Pre-Service Orientation

The CHC-MCO or FMS Entity must:

1. Verify that all newly hired DCWs have completed an in-person, pre-service orientation. In the limited situations where in-person, pre-service orientation is not

possible due to geographical limitations or a health pandemic, the CHC-MCO or FMS Entity will verify that the newly hired DCW has completed pre-service orientation by a DHS approved alternative means, including real time, instructor-led virtual orientation.

2. Notify DCWs of this pre-service orientation requirement and how they may enroll and complete this pre-service orientation.
3. Provide standardized core training that includes the following required hours and elements which shall be offered as 8 hours of training within the first 4 months of hire.
 - First Aid & CPR
 - Home Health & Safety
 - Universal Precautions
4. Maintain documentation to verify a DCW's completion of this pre-service orientation along with the Qualified DCW Employment Packet. This pre-service orientation and documentation must be completed before a DCW is given clearance to provide services.
5. Receive prior approval by OLTL of the content of DCW pre-service orientation. Pre-service orientation must, at a minimum, cover the following topics: a basic understanding of the functions and requirements of the participant-directed programs; the role and responsibility of the common law employer as the employer to direct, supervise, train, and select the DCWs; operational procedures and paperwork; roles and responsibilities in independent living system; workplace safety; transparency and fraud; eligibility for public benefits and DCW support organization; electronic visit verification; and worker rights and responsibilities. The content of the pre-service orientation shall be consistent across the Commonwealth as well as consistent with information provided through SCEs, and other elements of the participant-directed program.
6. The CHC-MCO or FMS Entity must ensure that the pre-service orientation is provided by an OLTL approved statewide entity. The CHC-MCO or FMS Entity may use a subcontractor to satisfy the pre-service orientation experience requirements. The selected entity must have at least 2 years of experience in providing training and in-person orientation for participant-directed DCWs in Pennsylvania and home caregivers such as DCWs, in the development and implementation of relevant participant-directed orientation curriculum, and the demonstrated experience working in participant directed orientation programs that orient at least 5,000 DCWs per year. Any orientation subcontractor must be pre-approved by OLTL and have current statewide capacity in Pennsylvania to implement a consistent, timely pre-service orientation program, including in-person training sites in at least 30 locations across the Commonwealth, a call center specifically designated to handle DCW registration, the capacity to do proactive outreach to DCWs via text, phone, and mail, and trainers to ensure opportunities for all DCWs to attend a local, pre-

service orientation within 14 days of initial employment application.

7. Pay the DCW an hourly wage not to exceed the maximum DCW hourly wage rate (as defined by the PA Medicaid Fee Schedule or other criteria as specified and directed by OLTL) and not less than prevailing minimum wage rules in the applicable region in which the DCW is to provide services for all time spent in DCW pre-service orientation. The CHC-MCO or FMS Entity shall include the payment for the hours of this pre-service orientation in the first paycheck after a DCW has been cleared to provide services.

Training

To make available optional training for active DCWs, the CHC-MCO, or FMS Entity must:

Contract with a training vendor to offer and provide foundational skills training that include the following required hours and elements which may be offered as 24 hours of training.

- ADLs & IADLs
- Cultural Competency
- Communication
- Medication
- Body Mechanics
- Early Intervention

In the event a DCW chooses this optional training, the DCW must be paid for completing this training. DCWs may take this training more than once but are only required to be paid for the initial training.

Processing and Distributing Payroll, Related Taxes and Insurances for Qualified DCWs The CHC-MCO or FMS Entity must process requests for voluntary deductions from the wages paid to DCWs for the convenience of those employees as permitted and authorized by Section 3 of the Wage Payment and Collection Law (43 P.S. § 260.3) and its implementing regulations, provided that the third party receiving the deductions is a not-for-profit organization exempt from taxes under Section 501(c) of the Internal Revenue Code in good standing. The CHC-MCO will ensure:

- A. That the cost of processing such requests for voluntary deductions and transmittal of those deductions to the third party be borne by the third party, with the proviso that said costs shall be limited to the actual and reasonable costs of modifying the existing payroll system to permit these periodic deductions.
- B. That an accurate payroll deduction mechanism is in place to deduct the applicable payments each pay period and transmit the payments to the third party.
- C. That the amount deducted is printed on the DCWs payroll form.
- D. That any authorization for voluntary deductions from the wages paid to DCWs shall terminate and such deductions shall cease upon the happening of any of the following events:

- a. Termination of the DCWs employment.
 - b. Written notice by the third party that the DCWs authorization has been cancelled; or
 - c. When the third-party states that it will no longer accept payment from the DCW.
- E. That a record keeping system in place which maintains an accurate list of those DCWs who have submitted signed authorizations for the voluntary deductions and transmittal of those deductions to the third party.

Oversight and Monitoring Responsibilities

The CHC-MCO will ensure that the contract deliverables are met, and Participants are in receipt of FMS in accordance with their PCSP. The CHC-MCOs will monitor the performance of FMS administrative activities, as well as adherence to contract conditions and waiver requirements. These requirements include, but are not limited to, Participant satisfaction, timeliness of processing employer and employee paperwork, timeliness of and accuracy of payments to workers, accuracy of information provided to Participants and workers by the FMS Entity, timeliness and accuracy of tax fillings on behalf of the Participant, timeliness of executed agreements between the FMS Entity and the workers or other vendors and timeliness of criminal background checks and child abuse clearances as needed.

If the CHC-MCO or its subcontractor is not in compliance with contractual or waiver provisions, the CHC-MCO will take the necessary steps to address any issues of non-compliance, including the completion of remediation and/or Quality Improvement Plans (QIPs).

In addition to the process described above, the CHC-MCOs will monitor performance as described in the Reporting Requirements section below. CHC-MCOs will also conduct on-site monitoring more frequently if utilization or problem identification reports indicate additional review is necessary. CHC-MCOs will also be required to report any issues with the FMS Entity's performance to OLTL.

The CHC-MCO or its subcontractor will conduct a Common Law Employer Satisfaction Survey using the survey tool approved by the Department. The survey must be conducted 60 days after enrolling a new common law employer and annually. Survey data must be collected and analyzed by the CHC-MCO or its subcontractor, and a report must be prepared and submitted to OLTL based upon specifications determined by the Department.

Lastly, through an established claims oversight process, the CHC-MCO will monitor claims submitted by the FMS Entity to the CHC-MCO and ensure the payments to the vendor for both administrative fees and services are in accordance with all applicable regulations and requirements. The CHC-MCOs must also ensure that all EVV requirements outlined by the Department are followed. The CHC-MCOs are responsible for monitoring compliance with requirements outlined in corresponding EVV bulletins.

Performance Standards

The following standards must be adhered to:

1. Department-approved Common Law Employer (CLE) enrollment packets must be mailed within three (3) business days of referral. (Minimum Acceptable: Department approved CLE Enrollment packet mailed within five (5) business days of referral.)
2. Complete the processing of CLE enrollment paperwork within seven (7) business days of receipt of correctly completed-documents. (Minimum Acceptable: Seven (7) business days unless acceptable documentation for a delay is provided.)
3. Collect and process completed documents and forms for enrollment of DCWs, Vendors, Small Unlicensed Providers and Independent Contractors within seven (7) business days of receipt of correctly completed documents and file with the appropriate federal, state, and local government agencies. (Minimum Acceptable: Seven (7) business days (unless acceptable documentation for a delay is provided). This minimum standard assumes that only the State Police background check is required and that the DCW has no record. ChildLine and FBI Clearance require longer dissemination times by the agency.)
4. face to face meetings as requested by new Participants to orient them to the program and to assist in completion of any necessary paperwork. (Minimum Acceptable: The requested visit must occur on the date scheduled with the Participant.)
5. Level of customer satisfaction based on Employer Satisfaction Surveys. (Minimum Acceptable: 95% satisfaction rate from active Participants.)

If the standards are not met, the Department will notify the CHC-MCO of the specific deficiencies, request a CAP, and follow-up on the plan to ensure compliance. The CAP must be submitted to the Department within 15 business days. The Department will review and accept or reject the CAP within 30 business days. The Department will monitor the interventions to ensure the CAP was completed and successful in resolving the issue in accordance with the timeframes established for corrective action in the CAP. If the CAP was not successful in correcting the identified issue, technical assistance will be provided by the Department.

Reporting Requirements

The CHC-MCOs will be required to submit monthly and annual reports to the Department utilizing the OPS 38 template which covers activities performed and issues encountered during the reporting period and reflect progress in meeting all contractual obligations. Required reporting elements are as directed by the Department. The CHC-MCOs must coordinate with the selected entity to ensure all required reporting elements are transmitted to the CHC-MCOs in a timely manner to meet the Department's reporting deadlines.

OLTL staff will review this information and intercede, when necessary, with corrective actions to ensure compliance. Meetings will be held as needed between the CHC-

MCOs and the Department to discuss any issues and for the Department to provide any necessary technical assistance it feels is needed.

Direct Care Worker Referral and Matching System

The CHC-MCO or FMS entity must develop a secure statewide web-based DCW referral and matching system to match Participants utilizing Participant-Directed services with potential individual direct care workers. The intent of the referral and matching service is to create additional opportunities for direct care workers and to strengthen support for individuals who choose participant direction as the preferred model of service delivery. The CHC-MCO must jointly collaborate with all other contracted CHC-MCOs to contract with a single statewide vendor under the requirements described below, and each CHC-MCO must establish agreements and cooperate with this statewide entity.

The referral and matching portal shall manage worker and Participant information, match DCWs' qualifications with Participants' needs, and provide participants with lists of potential workers for them to interview. The portal must be directly usable by DCWs with specific functionality for creating profiles and searching for jobs with CHC Participants. The portal must be usable by Participants or their representative with specific functionality for posting jobs and searching from providers near them with availability.

The portal vendor should have at least three years of experience successfully operating a technology-driven referral system in a participant-directed Medicaid funded home care program.

Minimum portal requirements include the following:

1. Data Collection:
 - a. During the first year of implementation, which is one year from the go live date of the portal, the portal shall collect either the FMS entity's ID for the DCW or last four digits of the DCWs social security number, or birth date to validate the DCW's status as an enrolled provider or at minimum has completed the required background checks. The portal should be open to DCWs who are currently working, and workers who have had background checks within the past year (365 days) who are either currently enrolled or in the process of getting enrolled.
 - b. The portal shall allow common law employers and DCWs to view relevant certifications, credentials, and completed training when possible.
 - c. The portal shall also verify the Participant is enrolled in CHC.
 - d. The portal needs to have functionality to address consent to share data among DCWs and Participants.
 - e. Information management and privacy: Users can upload and enter data while keeping personal contact info (email, phone number and address) private from other users until they are ready to share it. Primary users can manage personal information, such as their availability, preferences, and updated contact information. Users choose when to share their personal

contact information and the system does not force a reveal of this information.

2. Training: The web-based system should have in-app training and other training materials in addition to options for train-the-trainer for local training organizations that can do on the ground support for Participants.
3. System auto-generated reminders: The web-based system must support engagement by enabling auto-generated reminders such as personal information updates, mandated training requirements, certifications, and worker credentials.
4. Geographic search results: The web-based system should present geographically based results that include travel time by car and public transport while not revealing exact addresses.
5. Equity & Accessibility: The system must conform to Web Content Accessibility Guidelines 2.0 (WCAG 2.0) Level AA or similar framework regarding sensory characteristics, such as color, sound, and accommodations for individuals experiencing low vision to read content on websites via screen readers and high-contrast text. The system should be available in more than one language and be capable of adding additional languages. To facilitate choice and promote dignity and independence, workers and consumers should be able to self-select categories related to their gender identities.

EXHIBIT DD(1)
CHC-MCO PAY FOR PERFORMANCE

This Exhibit DD(1) defines a potential payment obligation by the Department to the CHC-MCO for long-term services and support measures as defined below. This Exhibit is effective only if the CHC-MCO operates a statewide Community HealthChoices program under this Agreement in CY 2026. If the CHC-MCO does not operate a statewide CHC program under this Agreement in CY 2026, the Department has no payment obligation under this Exhibit. In cases where a CHC-MCO fails to successfully implement a corrective action plan from the previous year related to an associated Quality Performance Measure below in Section I, the CHC-MCO will not be eligible to receive an incentive payment for that measure.

This Exhibit does not supplant Exhibits that provide for any incentive payments directly impacting NFs.

I. Quality Performance Measures

For 2026, the Department selected National Committee for Quality Assurance (NCQA) and Pennsylvania Performance Measures (PAPMs) impacting nursing home transition, long-term services and supports, overall health plan satisfaction, Participant self-direction, competitive integrated employment, and participant satisfaction as quality measures using established statewide specific goals. The Department chose these indicators based on an analysis of past data indicating the need for improvement across the CHC Program as well as the potential to improve services and support for CHC participants receiving CHC services. The quality measures include:

1. Comprehensive Assessments (CAU)
2. Care Plans (CPU)
3. Reassessments and Care Planning after Inpatient Discharge (RAC)
4. Sharing Care Plans with PCP (SCP)
5. CAHPS Health Plan Survey- Overall Satisfaction with Health Plan (Aligned/Medicaid only population)
6. CAHPS Home and Community Based Services (HCBS) Survey- Person Centered Service Plan (PCSP) included all things important to you
7. Nursing Home Transition
8. Participant Self-Direction Enrollment by Zone
9. Participants in Competitive Integrated Employment

NOTE: The CHC-MCO P4P measures may be subject to change due to NCQA specifications or PAPM requirements.

The CHC-MCO P4P Program incentivizes Benchmark Performance and Incremental Improvement Performance. The incentive dollars will be distributed equally between the Benchmark and Incremental Improvement results as described in Section II.

A. Benchmark Performance: The Department will award a Benchmark Performance payout amount for each measure that meets the statewide goal that will be defined below in Table 1. The Department will distribute the payouts according to the following criteria: 100% payout will occur if the CHC-MCO meets or exceeds the established goal defined below for each measure. Note: The Department has the right to change current CY 2026 goals based on CY 2025 performance. This will be done in consultation with the CHC-MCOs. Each of the nine measures will be considered equally for a benchmark payment. Calendar year (CY) 2026 measurement results will be used to calculate results.

Table 1

Basis	Baseline Year	Measurement Year	Description	Statewide Goal
HEDIS	CY 2025	CY 2026	Comprehensive Assessment and Update (CAU)	
HEDIS	CY 2025	CY 2026	Comprehensive Care Plan Update (CPU)	
HEDIS	CY 2025	CY 2026	Reassessment and Care Plan Update after Inpatient Discharge (RAC)	
HEDIS	CY 2025	CY 2026	Shared Care Plan with Primary Care Practitioner (SCP)	
CAHPS HP	CY 2025	CY 2026	Overall Satisfaction with Health Plan (Aligned	

			SNP/Medicaid only population)	
HCBS CAHPS	CY 2025	CY 2026	PCSP included all things important to you	
Ops 32 Report	CY 2025	CY 2026	Number of Participants who, as defined on Ops 32, were successfully transitioned from the NF to the community and remained there for at least six months	
Encounter Data	CY 2025	CY 2026	Participant-Directed Services (including PAS, Agency with Choice, and Services My Way) by MCO by Zone, weight by HCBS in each zone	
Ops 22 Report	CY 2025	CY 2026	Supported Employment Benchmark for Competitive Integrated Employment - MCO Ratio Based on HCBS population age group 21-64	

B. Incremental Improvement Performance: The Department will award an Incremental Improvement Performance payout amount for each measure in Table 1 that will range from 0% up to and including

100% of the measure's value. Incremental performance improvements are measured comparing rates from HEDIS® 2026 (CY 2025) to HEDIS® 2027 (CY 2026) and PAPM 2026 (CY 2025) to PAPM 2027 (CY 2026). Each of the nine measures will be considered equally for an incremental payment.

The percent payout for each measure will be determined by the following sliding scale:

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

If a CHC-MCO is unable to obtain an Incremental Improvement Performance benchmark due to maintaining a high performance that exceeds a score of 99.5% of the state identified goal, the CHC-MCO will be eligible for the full percentage payout for that measure.

II. Payment for CHC-MCO Pay for Performance

The Maximum Program Payout amount will be proportionally split between the CHC-MCOs based on membership as of December 1, 2026, unless otherwise noted in the P4P Operations Memorandum. Each CHC-MCO's maximal allocation will then be split with 50% of the funds allocated to benchmark performance and 50% to incremental improvement. Within the benchmark allocation, each of the nine measures will be eligible for equal payment based on achieving the statewide goal. Within the incremental improvement allocation, each of the nine measures will be eligible for equal payment based on the sliding scale results for each measure.

The Department will inform the CHC-MCO of the Maximum Program Payout amount by November 30, 2027.

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

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

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

EXHIBIT DD(2)

NURSING FACILITY QUALITY INCENTIVE PROGRAM

This Exhibit DD(2) defines a potential payment obligation by the Department to the CHC-MCO for a Nursing Facility Quality Incentive Program to evaluate Nursing Facilities (NFs) that participate in the Medical Assistance Program and to develop a valued-based incentive arrangement. This Exhibit is effective only if the CHC-MCO operates a statewide Community HealthChoices program under this Agreement in CY 2026. If the CHC-MCO does not operate a statewide CHC program under this Agreement in 2026 the Department has no payment obligation under this Exhibit.

I. Quality Performance Measures

For 2026, the Department selected Centers for Medicare and Medicaid Services (CMS) Compare quality metrics impacting clinical care using the Minimum Data Set (MDS) system and utilization using Medicare Part A data. The Department chose these indicators based on national and state analysis of past data indicating the need for improvements across the NFs and to improve quality of care for a broad base of the CHC population. The NF quality metrics include:

1. Percentage of short-stay residents who were re-hospitalized after a NF admission (Claims)
2. Percentage of long-stay residents with pressure ulcers (MDS)
3. Percentage of long-stay residents experiencing one or more falls with major injury (MDS)
4. Percentage of long-stay residents assessed and appropriately given the seasonal influenza vaccine (MDS)
5. Percentage of long-stay residents assessed and appropriately given the pneumococcal vaccine (MDS)
6. Percentage of long-stay residents who received an antipsychotic medication (MDS)

The above quality metrics must be used in any NF VBP arrangements for calendar year 2026.

NOTE: The CHC-MCO NF quality metrics may be subject to change due to Battelle Partnership for Quality Measurement specifications, CMS requirements, or the Pennsylvania Department of Health requirements.

The CHC-MCO NF Quality Incentive Program rewards NFs based on achieving statewide benchmark goals and incremental improvement for these quality measures. The Department will establish CY 2026 statewide benchmark goals for measures 1-6 above. NFs will be rewarded for incremental improvement from the CY 2025 (base year) to CY

2026 results for measures 1-6 above. CHC adjusted payments will be made to NFs as described in Section II below. Note: NFs must be an MA facility, have achieved median or better performance or an increment improvement of at least 0.5%, on at least one of the six measures, and have attended at least one Long-Term Care Learning Network Webinar hosted by the Jewish Healthcare Foundation in 2026, to be eligible for payment.

A. Benchmark Performance: The Department will establish CY 2026 statewide benchmark goals for measures 1-6 above. The Department will award a benchmark performance payout amount for each metric in Section I. NFs will be rewarded one point for obtaining the statewide 50th percentile and one point for obtaining the next quartile of improvement for the quality and utilization metrics. NFs can receive up to 12 points for benchmark performance. These points will be used to calculate a CHC adjusted incentive payment described in Section II.

B. Incremental Improvement Performance: The Department will award an incremental improvement payment for measures 1-6 above. NFs will be rewarded for incremental improvement from CY 2025 (base year) to CY 2026. For each measure, NFs can earn from 0 to 2 points based on the sliding scale below. NFs can earn a maximal incremental improvement score of 12 points.

Sliding Scale:

- 2 points for ≥ 2.0 Percentage Point Improvement
- 1 point for ≥ 1 and < 2.0 Percentage Point Improvement
- 0.5 point for ≥ 0.5 and < 1 Percentage Point Improvement
- 0 points for < 0.5 Percentage Point Improvement

II. Payment for CHC-MCO Pay for Performance

The Department will direct the CHC-MCO to make Nursing Facility Incentive Program CHC adjusted payments based on performance measures defined in Section I for CY 2026 benchmark performance and incremental improvement from CY 2025 (base year) to CY 2026. NFs must participate fully in Medical Assistance Programs to be eligible for this incentive program. The NFs are eligible to earn up to 12 points for benchmark performance and 12 points for incremental performance with a maximum of 24 incentive points as described above in IA and IB. The Department will distribute CHC adjusted payments based on each NF's total incentive points and CHC MA occupancy. The Department will determine a maximum potential dollar amount for each incentive point. Payouts will be based on multiplying each NF's total number of points by the dollar amount per incentive point as adjusted for each facility's CHC MA occupancy. The Department will direct the CHC-MCO to make payments to assigned NFs.

The Department will inform the CHC-MCO of the Maximum Program Payout amount by November 30, 2027.

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

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

III. Value-Based Arrangements

The CHC MCOs will use the six quality measures listed above in Section I to develop value-based arrangements with nursing facilities in 2026 to help achieve the 25% VBP goal described in section VII.E.16.b.ii, Value-Based Purchasing. The CHC MCOs may use additional quality and utilization metrics to develop value-based arrangements with nursing facilities.

Exhibit EE

OPIOID USE DISORDER CENTERS OF EXCELLENCE

A. The CHC-MCO must develop an adequate network of physical health Opioid Use Disorder Centers of Excellence (OUD-COE) enrolled in the MA Program as Provider Specialty Type 232 – Opioid Center of Excellence according to the terms of Exhibit T of this Agreement.

B. The CHC-MCO must coordinate with a Participant's BH-MCO and any OUD-COE providing services to the Participant in accordance with Section V.D.2 of this Agreement to ensure that the Participant's care is coordinated and not duplicated.

C. The following services, when provided as clinically appropriate and included or reflected in the individual Participant's care plan, constitute community-based care management services. COE care management services may be provided via telemedicine in accordance with Medical Assistance Bulletin 99-21-06: Guidelines for the Delivery of Physical Health Services via Telemedicine.

1. Screening and Assessment

- a. Assessments to identify a Participant's needs related to Health Related Social Need (HRSN), administered in home and community-based settings whenever practicable.
- b. Level of Care Assessments, which may be completed either by the OUD-COE or through a referral. If a level of care assessment results in a recommendation of Medication for Opioid Use Disorder (MOUD), the OUD-COE must provide education related to MOUD.
- c. Screenings for clinical needs that require referrals or treatment, including screenings for risk of suicide.

2. Care Planning

- a. Development of integrated, individualized care plans that include, at a minimum:
 1. A Participant's treatment and non-treatment needs
 2. The Participant's preferred method of care management, such as in-person meetings, phone calls, or through a secure messaging application
 3. The identities of the members of the Participant's community-based care management team, as well as the members of the Participant's individual support system

- b. Care coordination with a Participant's primary care provider, mental health service provider, drug & alcohol treatment provider, pain management provider, obstetrician or gynecologist, and CHC-MCO, as applicable

3. Referrals

- a. Facilitating referrals to necessary and appropriate clinical services according to the Participant's care plan, including:
 - 1. Primary Care, including screening for and treatment of positive screens for: HIV, Hepatitis A (screening only); Hepatitis B; Hepatitis C; and Tuberculosis
 - 2. Perinatal Care and Family Planning Services
 - 3. Mental Health Services
 - 4. Forms of medication approved for use in MOUD not provided at the OUD-COE Provider's enrolled service location(s)
 - 5. MOUD for pregnant women, if the OUD-COE Provider does not provide MOUD to pregnant women
 - 6. Drug and Alcohol Outpatient Services
 - 7. Pain Management
- b. Facilitating referrals to any ASAM Level of Care that is clinically appropriate according to a Level of Care Assessment
- c. Facilitating referrals to necessary and appropriate non-clinical services according to the results of the Participant's needs identified through a Social Determinants of Health screening

4. Monitoring

- a. Individualized follow-up with Participants and monitoring of Participants' progress per the Participant's care plan, including referrals for clinical and non-clinical services
 - b. Continued and periodic re-assessment of a Participant's Social Determinants of Health needs
 - c. Performing Urine Drug Screenings at least monthly
5. Making and receiving warm hand-offs. In the event of a warm hand-off from an overdose event, the OUD-COE must provide education related to overdose risk and naloxone.

D. To determine whether OUD-COE care management services are appropriate for a Participant, the CHC-MCO, in coordination with the OUD-COE, shall utilize the inclusion and exclusion criteria established in the OUD-COE Fidelity Checklist and follow the guidance established in CHC OPS Memo #2025-02.

Exhibit FF
Requirements for Non-Commonwealth Hosted
Applications/Services

The purpose of this Attachment is to define requirements for business or technology solutions and services procured by the Commonwealth that are hosted within the Licensor's or its subcontractor's managed infrastructure.

A. Hosting Requirements

1. The Licensor or its subcontractor shall supply all hosting equipment (hardware and software) required for the cloud services and performance of the software and services set forth in the Quote and Statement of Work.
2. The Licensor shall provide secure access to applicable levels of users via the internet.
3. The Licensor shall use commercially reasonable resources and efforts to maintain adequate internet connection bandwidth and server capacity.
4. The Licensor or its subcontractors shall maintain all components of the hosted solution with commercially reasonable support and replace as necessary to maintain compliance.
5. The Licensor shall monitor, prevent and deter unauthorized system access. The Licensor shall use all commercially reasonable methods to confirm suspected breaches. In the event of any impermissible disclosure unauthorized loss or destruction of Confidential Information, the receiving Party must immediately notify the disclosing Party and take all reasonable steps to mitigate any potential harm or further disclosure of such Confidential Information. In addition, pertaining to the unauthorized access, use, release, or disclosure of data, the Licensor shall comply with state and federal data breach notification statutes and regulations, and shall report security incidents to the Commonwealth within **twenty-four (24) hours** of when the Licensor has reasonable confirmation of such unauthorized access, use, release, or disclosure of data.
6. The Licensor or the Licensor's subcontractor shall allow the Commonwealth or its delegate, at times chosen by the Commonwealth, with at least **ten (10) business days'** notice, to review the hosted system's data center locations and security architecture.
7. The Licensor's employees or subcontractors, who are directly responsible for day-to-day monitoring and maintenance of the hosted system, shall have industry standard certifications applicable to the environment and system architecture used.

The Licensor or the Licensor's subcontractor shall locate servers in a climate- controlled environment. The Licensor or the Licensor's contractor shall house all servers and equipment in an operational environment that meets industry standards including climate control, fire and security hazard detection, electrical needs, and physical security.

8. The Licensor shall examine applicable system and error logs daily to minimize and predict system problems and initiate appropriate action.
9. The Licensor shall completely test and apply patches for all third-party software products in the server environment before release.
10. The Licensor shall provide all Commonwealth data to the Commonwealth, upon request, in a form acceptable to the Commonwealth, at no cost to the Commonwealth.

B. System and Organization Controls (SOC) Reporting Requirements

1. Subject to this section and unless otherwise agreed to in writing by the Commonwealth, the Licensor shall, and shall require its subcontractors to, engage, on an annual basis, a CPA certified third-party auditing firm to conduct the following, as applicable:
 - (i) Reserved
 - (ii) a SOC 2 Type II report with respect to controls used by the Licensor relevant to internal and external procedures and systems that access, process, host or contain Commonwealth Data designated as Class "C" Classified Records or Closed Records, as defined in ITP-SEC019, or in compliance with mandates by federal or state audit requirements and/or policy.

The Licensor shall receive and review their subcontractor's relevant SOC reports, and the Licensor shall provide the Commonwealth with a Letter of Attestation that includes an analysis of their subcontractor's SOC report.

2. Unless otherwise agreed to in writing by the Commonwealth, the Licensor's SOC Report(s) shall be provided upon contract execution and annually thereafter. While it is preferable that SOC Reports coincide with Pennsylvania's fiscal year (July 1 through June 30), SOC Reports, at the very least, must cover at least **6 consecutive months** of Pennsylvania's fiscal year.
3. SOC 2 Type II reports shall address the following:
 - (i) Security of Information and Systems;

- (ii) Availability of Information and Systems;
 - (iii) Processing Integrity;
 - (iv) Confidentiality; and
 - (v) Privacy.
 - (vi) Reserved
4. At the request of the Commonwealth, the Licensors shall, and shall require its subcontractors, as applicable, complete a SOC for Cybersecurity audit, or another risk management framework as may be approved by the Commonwealth in its sole discretion, in the event:
- (i) repeated non-conformities are identified in any SOC report required by subsection 1; or
 - (ii) if the Licensors' business model changes (such as a merger, acquisition, or change sub-contractors, etc.).

The SOC for Cybersecurity report shall detail the controls used by the Licensors or its subcontractor setting forth the description and effectiveness of the Licensors' or subcontractor's cybersecurity risk management program and the policies, processes and controls enacted to achieve each cybersecurity objective.

The Licensors shall provide to the Commonwealth a report of the SOC for Cybersecurity audit findings within **60 days** of its completion.

5. The Commonwealth may specify other or additional standards, certifications or audits it requires under any Purchase Orders or within an ITP.
6. The Licensors shall adhere to Statement on Standards for Attestation Engagements (SSAE) 18 audit standards. The Licensors acknowledges that the SSAE guidance may be updated during the Term of this Contract, and the Licensors shall comply with such updates which shall be reflected in the next annual report.
7. In the event an audit reveals any non-conformity to SSAE standards, the Licensors shall provide the Commonwealth, within **45 days** of the issuance of the SOC report, a documented corrective action plan that addresses each non-conformity that is identified within the SOC report, including any subcontractor's SOC report. The corrective action plan shall provide, in detail:
- (i) clear responsibilities of the personnel designated to resolve the non-conformity;
 - (ii) the remedial action to be taken by the Licensors or its subcontractor(s);
 - (iii) the dates when each remedial action is to be implemented; and
 - (iv) a summary of potential risks or impacts to the Commonwealth that are associated with the non-conformity(ies).

8. The Commonwealth may in its sole discretion agree, in writing, to accept alternative security report in lieu of a SOC report.

C. Security Requirements

1. The Licenser shall conduct a third-party independent security/vulnerability assessment at its own expense on an annual basis.
2. The Licenser shall comply with the Commonwealth's directions/resolutions to remediate the results of the security/vulnerability assessment to align with the standards of the Commonwealth.
3. The Licenser shall use industry best practices to protect access to the system with a firewall and firewall rules to prevent access by non-authorized users and block all improper and unauthorized access attempts.
4. The Licenser shall use industry best practices to provide applicable system intrusion detection and prevention in order to detect intrusions in a timely manner.
5. The Licenser shall use industry best practices to provide applicable malware and virus protection or compensating controls on all servers and network components.
6. The Licenser shall limit access to Commonwealth-specific systems, data and services and provide access only to those staff, located within CONUS (any of the Continental United States and Hawaii) that must have access to provide services proposed. If Licenser staff located outside of the United States require access to the Commonwealth's data for any purpose, such as **but not limited to** system administration and support services, investigation, or debugging, these provisions shall apply to any offshore support provided by the Licenser and any subcontractors:
 - i. No offshore support shall be permitted from any countries that are identified as state sponsors of terrorism by the US Department of State, which shall be monitored by the purchasing Agency to ensure compliance through the life of the Agreement, Contract, or Purchase Order;
 - ii. Access by offshore vendor resources shall be limited to solely that which is required to perform the Services, including support services;
 - iii. Offshore vendor resources who are providing the services shall be trained in the proper handling of Commonwealth Data;
 - a. Any vendor offshore resources that are dedicated to the Commonwealth shall be required to undergo Commonwealth Security Awareness Training provided by the Commonwealth and the vendor shall provide monthly compliance report.
 - b. Vendor attests that offshore vendor resources shall comply with Management Directive 205.34 and Management Directive 245.18 and

that the Vendor has trained the offshore resources in the proper handling of Commonwealth Data.

- iv. Offshore vendor resources that are providing the services shall be obligated to handle Commonwealth Data in ways at least as restrictive as the requirements outlined in the Agreement;
- v. Offshore vendor resources that are providing the services and require access must be uniquely identified (e.g., by a unique User ID);
- vi. Offshore vendor resources that are providing the services shall access Commonwealth systems, data, or services in a manner that meets or exceeds the minimum requirements set forth in Commonwealth ITPs;
- vii. The date, time (including time zone), resource name, source IP, and nature of the access (i.e., read-only or modify) shall be recorded in a log file which is maintained and preserved according to applicable data protection law(s) and industry best practice standards;
- viii. Any offshore vendor resource access must be granted by an authorized Commonwealth resource and shall only be granted on least required privilege or need-to-know basis prior to any offshore vendor resource obtaining access and shall only be granted to offshore vendor resource that must have access to provide and/or support the services;
- ix. The vendor shall agree explicitly in the agreement that with respect to any services provided by any offshore vendor resources, the vendor shall be obligated to comply with the terms and conditions of the Agreement, Contract or Purchase Order, as though the offshore vendor resources were located within the United States and that the vendor shall assume all obligations and risks associated with the use of offshore vendor resources as if those resources were located within the United States;
- x. The purchasing agency shall ensure that background check requirements apply to all offshore vendor resources assigned to perform services under the Agreement, Contract or Purchase Order.
 - a. The vendor shall identify each offshore vendor resource that will perform services under the Agreement, Contract or Purchase Order and shall perform the following background checks on each individual offshore vendor resource providing services:
 - i. Criminal Records Database check (country where the offshore vendor resource is located);
 - ii. Civil Litigation Database check (country where the offshore vendor resource is located);
 - iii. Credit and Reputational Risk Database Check (country where the offshore vendor resource is located);
 - iv. Compliance Authorities (global check);
 - v. Regulatory Authorities (global check);
 - vi. Serious and Organized Crimes (global check); and
 - vii. Web and media searches (global check).
 - b. On an annual basis, the vendor shall provide written confirmation that the above required background checks have been completed and that the background checks did not identify any criminal record that includes a felony or misdemeanor (or equivalent) involving terroristic behavior, violence, use of a lethal weapon, or breach of trust/fiduciary

responsibility or which raises concerns about building, system or personal security or is otherwise job-related. This written confirmation must be provided prior to the subject offshore vendor resource being provided access to Commonwealth data or systems. The vendor shall not assign any offshore vendor resource that fails to pass the background checks required in this section to any Commonwealth services and shall remove any access privileges already given to the offshore vendor resource unless the Commonwealth consents to the access, in writing, prior to the access.

- xi. No recording, streaming, monitoring, or photographic devices enter, are accessible, or utilized in the workspace where work under the Agreement, Contract or Purchase Order is performed while located outside of the United States.
- 7. The Licensor shall provide the services, using security technologies and techniques in accordance with industry best practices and the Commonwealth's ITPs set forth in Attachment 1, including those relating to the prevention and detection of intrusions, and any other inappropriate use or access of systems and networks.

D. Data Protection

- 1. The Licensor shall only host, store or backup Commonwealth Data in physical locations within CONUS.
- 2. The Licensor shall use industry best practices to update and patch all applicable systems and third-party software security configurations to reduce security risk.
- 3. The Licensor shall protect their operational systems with applicable anti-virus, host intrusion protection, incident response monitoring and reporting, network firewalls, application firewalls, and employ system and application patch management to protect its network and customer data from unauthorized disclosure.
- 4. The Licensor shall be solely responsible for applicable data storage required.
- 5. The Licensor shall encrypt all Commonwealth data in transit and at rest. The Licensor shall comply with ITP-SEC031, and ITP-SEC019, encryption policies and minimum standards or stronger.
- 6. The Licensor shall take all commercially viable and applicable measures to protect the data availability including, but not limited to, real-time replication, traditional backup, and/or georedundant storage of Commonwealth data in accordance with industry best practices and encryption techniques.
- 7. The Licensor shall have appropriate controls in place to protect critical or sensitive data and shall employ stringent policies, procedures, to protect that

data particularly in instances where such critical or sensitive data may be stored on a Licensor-controlled or Licensor-owned electronic device.

8. The Licensor shall utilize a secured backup solution to prevent loss of data. Stored backups must be kept in an all-hazards protective storage environment at the primary location and any additional locations where the data is being maintained. All back up data and media shall be encrypted.

E. Adherence to Policy

1. The Licensor support and problem resolution solution shall provide a means to classify problems as to criticality and impact and with appropriate resolution procedures and escalation process for classification of each problem.
2. The Licensor shall abide by the applicable Commonwealth's Information Technology Policies (ITPs), a list of the most relevant being attached hereto as Attachment 1.
3. The Licensor shall comply with all pertinent federal and state privacy regulations.

F. Closeout

When the purchase order's or other procurement document's term expires or terminates, and a new purchase order or other procurement document has not been issued by a Commonwealth Agency within **60 days** of expiration or termination, or at any other time at the written request of the Commonwealth, the Licensor must promptly return to the Commonwealth all Commonwealth's data (and all copies of this information) that is in the Licensor's possession or control. The Commonwealth's data shall be returned in a format agreed to by the Commonwealth.

Upon confirmation that Commonwealth data is in possession or control of the Commonwealth, the Licensor shall ensure all residual user account(s) are promptly deleted or reset in the solution. The Licensor shall notify the Commonwealth within **10 business days** that all user account(s) have been deleted or reset.

ATTACHMENT 1

Information Technology Policies (ITPs) for Outsourced/Licensors-hosted Solutions

ITP Number - Name	Policy Link
ITP_ACC001 - Accessibility Policy	https://www.oa.pa.gov/Policies/Documents/itp_acc001.pdf
ITP_APP030 - Active Directory Architecture	https://www.oa.pa.gov/Policies/Documents/itp_app030.pdf
ITP_BUS007 - Enterprise Service Catalog	https://www.oa.pa.gov/Policies/Documents/itp_bus007.pdf
ITP_BUS010 - Business Process Management Policy	https://www.oa.pa.gov/Policies/Documents/itp_bus010.pdf
ITP_BUS012 - Artificial Intelligence General Policy	https://www.oa.pa.gov/Policies/Documents/itp_bus012.pdf
ITP_INF000 - Enterprise Data and Information Management Policy	https://www.oa.pa.gov/Policies/Documents/itp_inf000.pdf
ITP_INF001 - Database Management Systems	https://www.oa.pa.gov/Policies/Documents/itp_inf001.pdf
ITP_INF006 - Commonwealth County Code Standard	https://www.oa.pa.gov/Policies/Documents/itp_inf006.pdf
ITP_INF009 - e-Discovery Technology Standard	https://www.oa.pa.gov/Policies/Documents/itp_inf009.pdf
ITP_INF010 - Business Intelligence Policy	https://www.oa.pa.gov/Policies/Documents/itp_inf010.pdf
ITP_INF011 - Reporting Policy	https://www.oa.pa.gov/Policies/Documents/itp_inf011.pdf
ITP_INF012 - Dashboard Policy	https://www.oa.pa.gov/Policies/Documents/itp_inf012.pdf
ITP_INFRM001 - The Life Cycle of Records: General Policy Statement	https://www.oa.pa.gov/Policies/Documents/itp_infrm001.pdf
ITP_INFRM004 - Management of Web Records	https://www.oa.pa.gov/Policies/Documents/itp_infrm004.pdf
ITP_INFRM005 - System Design Review of Electronic Systems	https://www.oa.pa.gov/Policies/Documents/itp_infrm005.pdf
ITP_INFRM006 - Electronic Document Management Systems	https://www.oa.pa.gov/Policies/Documents/itp_infrm006.pdf
ITP_INT_B_1 - Electronic Commerce Formats and Standards	https://www.oa.pa.gov/Policies/Documents/itp_int_b_1.pdf
ITP_INT_B_2 - Electronic Commerce Interface Guidelines	https://www.oa.pa.gov/Policies/Documents/itp_int_b_2.pdf
ITP_INT006 - Business Engine Rules	https://www.oa.pa.gov/Policies/Documents/itp_int006.pdf
ITP_NET004 - Internet Protocol Address Standards	https://www.oa.pa.gov/Policies/Documents/itp_net004.pdf
ITP_NET005 - Commonwealth External and Internal Domain Name Services (DNS)	https://www.oa.pa.gov/Policies/Documents/itp_net005.pdf

ITP_PRV001 - Commonwealth of Pennsylvania Electronic Information Privacy Policy	https://www.oa.pa.gov/Policies/Documents/itp_prv001.pdf
ITP_SEC000 - Information Security Policy	https://www.oa.pa.gov/Policies/Documents/itp_sec000.pdf
ITP_SEC001 - Enterprise Host Security Software Policy	https://www.oa.pa.gov/Policies/Documents/itp_sec001.pdf
ITP_SEC002 - Internet Accessible Proxy Servers and Services	https://www.oa.pa.gov/Policies/Documents/itp_sec002.pdf
ITP_SEC003 - Enterprise Security Auditing and Monitoring	https://www.oa.pa.gov/Policies/Documents/itp_sec003.pdf
ITP_SEC004 - Enterprise Web Application Firewall	https://www.oa.pa.gov/Policies/Documents/itp_sec004.pdf
ITP_SEC006 - Commonwealth of Pennsylvania Electronic Signature Policy	https://www.oa.pa.gov/Policies/Documents/itp_sec006.pdf
ITP_SEC007 - Minimum Standards for IDs, Passwords and Multi-Factor Authentication	https://www.oa.pa.gov/Policies/Documents/itp_sec007.pdf
ITP_SEC008 - Enterprise E-mail Encryption	https://www.oa.pa.gov/Policies/Documents/itp_sec008.pdf
ITP_SEC009 - Minimum Contractor Background Checks Policy	https://www.oa.pa.gov/Policies/Documents/itp_sec009.pdf
ITP_SEC010 - Virtual Private Network Standards	https://www.oa.pa.gov/Policies/Documents/itp_sec010.pdf

ITP Number - Name	Policy Link
ITP_SEC011 - Enterprise Policy and Software Standards for Agency Firewalls	https://www.oa.pa.gov/Policies/Documents/itp_sec011.pdf
ITP_SEC012 - System Logon Banner and Screensaver Requirements	https://www.oa.pa.gov/Policies/Documents/itp_sec012.pdf
ITP_SEC015 - Data Cleansing	https://www.oa.pa.gov/Policies/Documents/itp_sec015.pdf
ITP_SEC016 - Information Security Officer Policy	https://www.oa.pa.gov/Policies/Documents/itp_sec016.pdf
ITP_SEC017 - Copa Policy for Credit Card Use for e-Government	https://www.oa.pa.gov/Policies/Documents/itp_sec017.pdf
ITP_SEC019 - Policy and Procedures for Protecting Commonwealth Electronic Data	https://www.oa.pa.gov/Policies/Documents/itp_sec019.pdf
ITP_SEC021 - Security Information and Event Management Policy	https://www.oa.pa.gov/Policies/Documents/itp_sec021.pdf
ITP_SEC023 - Information Technology Security Assessment and Testing Policy	https://www.oa.pa.gov/Policies/Documents/itp_sec023.pdf
ITP_SEC024 - IT Security Incident Reporting Policy	https://www.oa.pa.gov/Policies/Documents/itp_sec024.pdf
ITP_SEC025 - Proper Use and Disclosure of Personally Identifiable Information (PII)	https://www.oa.pa.gov/Policies/Documents/itp_sec025.pdf
ITP_SEC029 - Physical Security Policy for IT Resources	https://www.oa.pa.gov/Policies/Documents/itp_sec029.pdf
ITP_SEC031 - Encryption Standards	https://www.oa.pa.gov/Policies/Documents/itp_sec031.pdf
ITP_SEC032 - Enterprise Data Loss Prevention (DLP) Compliance Standards	https://www.oa.pa.gov/Policies/Documents/itp_sec032.pdf
ITP_SEC034- Enterprise Firewall Rule Set	https://www.oa.pa.gov/Policies/Documents/itp_sec034.pdf
ITP_SEC035 - Mobile Device Security Policy	https://www.oa.pa.gov/Policies/Documents/itp_sec035.pdf
ITP_SEC038 - Commonwealth Data Center Privileged User IAM Policy	https://www.oa.pa.gov/Policies/Documents/itp_sec038.pdf
ITP-SEC039 - Keystone Login and Identity Proofing	https://www.oa.pa.gov/Policies/Documents/itp-sec039.pdf
ITP_SEC040 - Commonwealth Cloud Computing Services Requirements	https://www.oa.pa.gov/Policies/Documents/itp_sec040.pdf
ITP SFT000 - Software Development Life Cycle (SDLC) Policy	https://www.oa.pa.gov/Policies/Documents/itp_sft000.pdf
ITP_SFT001 - Software Licensing	https://www.oa.pa.gov/Policies/Documents/itp_sft001.pdf

ITP_SFT002 - Commonwealth of PA Website Standards	https://www.oa.pa.gov/Policies/Documents/itp_sft002.pdf
ITP_SFT003 - Geospatial Enterprise Service Architecture	https://www.oa.pa.gov/Policies/Documents/itp_sft003.pdf
ITP_SFT004 - Geospatial Information Systems (GIS)	https://www.oa.pa.gov/Policies/Documents/itp_sft004.pdf
ITP_SFT005 - Managed File Transfer (MFT)	https://www.oa.pa.gov/Policies/Documents/itp_sft005.pdf
ITP_SFT007 - Office Productivity Policy	https://www.oa.pa.gov/Policies/Documents/itp_sft007.pdf
ITP_SFT008 - Enterprise Resource Planning (ERP) Management	https://www.oa.pa.gov/Policies/Documents/itp_sft008.pdf
ITP_SFT009 - Application Development	https://www.oa.pa.gov/Policies/Documents/itp_sft009.pdf
ITP_SYM003 - Off-Site Storage for Commonwealth Agencies	https://www.oa.pa.gov/Policies/Documents/itp_sym003.pdf
ITP_SYM004 - Policy for Establishing Alternate Processing Sites for Commonwealth Agencies	https://www.oa.pa.gov/Policies/Documents/itp_sym004.pdf
ITP_SYM006 - Commonwealth IT Resources Patching Policy	https://www.oa.pa.gov/Policies/Documents/itp_sym006.pdf
ITP_SYM008 - Server Virtualization Policy	https://www.oa.pa.gov/Policies/Documents/itp_sym008.pdf
ITP_SYM010 - Enterprise Services Maintenance Scheduling	https://www.oa.pa.gov/Policies/Documents/itp_sym010.pdf

Cloud Services Requirements

Offeror/Contractors proposing solutions that include cloud services must respond to the questions included in this document. The purpose of this document is to gain the necessary information from the Offeror/Contractor to fully understand and evaluate the cloud service being proposed.

Offeror/Contractor shall describe if any part of the proposed cloud service is provided by another third party or subcontractor. The ability of each subcontractor to meet these Cloud Services Requirements must be incorporated into this document. Offeror/Contractor may add a separate attachment or denote responses as "Offeror/Contractor" or "Name of Subcontractor".

If using links in Offeror/Contractor Response column, please provide specific reference point that addresses the question.

REQ #	Category	Question	Offeror/Contractor Response
1	General	Offeror/Contractor shall provide an overview of the proposed cloud service. Please list the solution components, hosting environments, as well as the service organization and subservice organizations operating all aspects that are a part of the overall proposed solution. • Solution Component(s) – SKU/Product Titles and/or Resources utilized by solution provider • Solution Environment(s) – Which public cloud provider, which private cloud stack, and/or who's datacenter for traditional hosting of components. • Solution Operator(s) – Organizational name of the Service Organization and any Subservice Organizations actively supporting the proposed solution.	
2	General	Offeror/Contractor shall describe if the proposed cloud service is a dedicated single tenant or shared (multi-tenant) cloud solution. If multi-tenant, Offeror/Contractor shall describe the security controls to isolate the tenants.	
3	General	Offeror/Contractor shall describe Service Level Agreements (SLAs) included with the proposed	

		Cloud Service that identify both the services required and the expected level of service including, but not limited to, the following: • Availability • Performance • Disaster Recovery expectations (RTO/RPO) • Pandemic Recovery expectations • Location of the data Primary/Secondary (if applicable?) • Access to the data • Portability of the data (ability to move data to a different hosting provider) • Metrics used to measure the service, e.g. service level objectives	
4	General	Offeror/Contractor shall describe controls for record retention and data destruction of data past retention period in accordance with ITP-SEC019 Policy and Procedures for Protecting Commonwealth Data and ITP-SEC015 Data Cleansing Policy. Offeror/Contractor shall describe how they will confirm that the data has been destroyed. Commonwealth preference is certified letter(s) of confirmation at end of contract and quarterly for aged data.	
5	General	Offeror/Contractor shall, upon contract expiration or at any other time at the written request of the Commonwealth, return to the Commonwealth all of its data (and all copies of this information) in a format agreed to by the Commonwealth. Offeror/Contractor shall provide method of export of Commonwealth data during the contract term.	
6	General	Offeror/Contractor shall provide current FedRamp Status (ready, in process, authorized, not yet applied) and level (Low, Moderate, or High). If FedRamp status is "authorized," Offeror/Contractor shall provide details for the following: • Service Model	

		• Deployment Model • Impact Level • Independent Assessor • Authorization Date • Service Description • Agencies using this service	
7	General	Offeror/Contractor shall indicate if the following NIST guidelines are adhered to: • NIST SP 800-53 Assessing Security and Privacy Controls in FIS organizations • NIST SP 800-63 Digital Identity Guidelines • NIST SP 800-92 Guide to Computer Security Log Management • NIST SP 800-144 Guideline on Security and Privacy in Public Cloud Computing • NIST SP 800-145 NIST Definition of Cloud Computing and Deployment Models • NIST SP 800-146 NIST Cloud Computing Synopsis and Recommendations Please also indicate if other NIST guidelines apply to the proposed cloud service.	
8	Regulatory Compliance Verification	Offeror/Contractor shall indicate if the proposed cloud service is subject to any of the following laws: • CJIS and CHRIA for criminal history data • HIPAA for health-related data • IRS Pub 1075 and SSA for federal protected data • PCI-DSS for financial data Offeror/Contractor shall provide certifications or letters of attestation for any deemed applicable to the proposed cloud service.	
9	Access to Commonwealth specific systems, data, and	Offeror/Contractor shall limit access to Commonwealth-specific systems, data and services and provide access only to those staff,	

	services (ITP-SEC040 CSR-L3)	located within CONUS, that must have access to provide services proposed. Offeror/Contractor shall describe their support model including after-hours support. Offeror/Contractor shall indicate if any support mechanism or staff are located outside of CONUS and describe in detail the offshore access required to provide services proposed. a) If OCONUS, Offeror/Contractor shall indicate if logging is enabled to capture the date, time, named user, and nature of the offshore access (i.e., read-only or modify) and whether such logs are maintained and preserved according to applicable data protection law(s) and industry best practice standards. b) If OCONUS support is required, Offeror/Contractor shall indicate whether offshore staff are direct employees or are subcontracted staff. c) If OCONUS, Offeror/Contractor shall indicate whether offshore staff have direct access to Commonwealth data or if the Commonwealth must grant access? If Commonwealth must grant access, please provide request and approval process flow. d) Please describe any additional protections in place with respect to Commonwealth data that vendors employees and/or subcontractors would have access to while OCONUS.	
10	Data Hosting (ITP-SEC040 CSR-L4)	Offeror/Contractor shall only host, store, or backup Commonwealth Data in physical locations within CONUS. • Offeror/Contractor shall describe which data centers are intended for use with the proposed cloud service. • Offeror/Contractor shall provide a description of the physical security measures in place within the proposed data centers. Describe both the physical	

		data center access as well as server room and physical host access. Offeror/Contractor shall completely test and apply patches for all third-party software products before release. • Offeror/Contractor shall describe how often the infrastructure, hardware, and software are upgraded, hardened, and patched and what notifications are provided to the customer.	
11	System and Organization Controls (SOC) Reporting (ITP-SEC040 CSR-L5)	Offeror/Contractor shall provide relevant SOC reports, which have been performed by an independent CPA-certified auditor, for the proposed cloud service. Reports should be submitted to the Contract Manager. Link to OPD_SEC040B SOC Reporting Procedures SOC 1 TYPE II Report is required under the following conditions: • The service organization is hosting financial information that could affect or have a material impact on a Commonwealth agency's financial statements and/or reporting. • Compliance mandate for federal or state audit requirements and/or policy. • A third-party provides financial service(s) (such as, but not limited to, payroll processing, accounts receivable, payable, or collection service). SOC 2 TYPE II Report is required under the following conditions: • The service organization is hosting, handling, or processing Class "C" Classified Records or Closed Records as defined in ITP-SEC019 • Compliance mandated with federal or state audit requirements and/or policy.	
12	Accessibility Standards (ITP-SEC040 CSR-A1)	Offeror/Contractor shall comply with the Accessibility Standards in Section 6 of ITP-ACC001 for all provided	

		products and services. • Offeror/Contractor shall submit a completed VPAT using the most current version of the VPAT template for the proposed cloud service(s). ○ The VPAT template should be filled out in its entirety and include testing methodology, conformance level, and remarks for any partially supported or non-supported level. ○ If VPAT(s) are submitted, using an older version of the template, Offeror/Contractor should provide an explanation, as to why the most current version is not being used.	
13	System Monitoring Audit Logging (ITP-SEC040 CSR-S1)	Commonwealth policy requirements: • Audit logging must be enabled and accessible to the Commonwealth (Information Security Office or designee) • Verbose logging is required • Vendor must have ability to correlate events, create security alerts, and based on severity of event (critical, severe, high-level) send incident notifications to Commonwealth Information Security Officers (ISOs). • Maintain reports online for a minimum of 90 days and archive for a minimum of 1 year. If the Commonwealth requires longer retention periods, the longer retention requirement takes precedence and should be documented in the SOW. a) Offeror/Contractor shall review and evaluate the system monitoring and audit logging requirements listed in ITP-SEC040 Section 5.2 and describe which apply and how they are being addressed as part of the proposed cloud service. Offeror/Contractor shall also indicate if any additional monitoring and logging is included.	

		b) Offeror/Contractor shall describe which system monitoring and audit logs are available to the customer and indicate how they are made available to the Commonwealth Information Security Officers (ISOs). Please indicate if authorized direct access, available only upon request, or other. c) Offeror/Contractor shall provide an example of the logs to show what level of detail is available. d) Offeror/Contractor shall describe if any dashboards and/or analytics are in place for Commonwealth ISO use. e) Offeror/Contractor shall provide examples of monthly reporting. f) Offeror/Contractor shall provide examples of annual reporting. g) Offeror/Contractor shall define their continuous monitoring strategy, including measures, metrics and control assessments including frequencies. h) Offeror/Contractor shall provide examples of log review, contingency plan testing, incident response plan testing and vulnerability scans i) Offeror/Contractor shall describe responses to assessment findings, threshold alerts, decisions to either mitigate, transfer, or accept risks related to identified vulnerabilities j) Offeror/Contractor shall describe method of access for all of the above.	
14	Data Segmentation Boundary Protection (ITP-SEC040 CSR-S2)	Offeror/Contractor shall provide a network/architecture diagram showing what security and technical controls are performing the network segmentation within the cloud service offering. • If solution spans more than one hosting environment (such as	

		integration to Commonwealth managed environments, or across multiple hosting providers), provide details on what solution components and data are deployed in which environment. • Include border gateway, perimeter and/or network firewall, web application firewall, VPN tunnels, security zone access as applicable to the solution. • Describe data encryption methods at rest and in transit across environments. • Include the direction of connectivity (specify whether initiated inbound, outbound, or both) and specifications for API calls, protocols, etc. • Estimated Transaction size, and frequency to be identified for each connection. Offeror/Contractor shall describe how data segregation (physically or logically) of Commonwealth data from non-Commonwealth data is guaranteed. Offeror/Contractor shall maintain the diagram throughout the contract term and provide updates if changes occur.	
15	Exploit and Malware Protection (ITP-SEC040 CSR-S3)	Offeror/Contractor shall provide and manage security controls. These are required to identify attacks, identify changes to files, protect against malware, protect user web services, Data Loss Prevention (DLP) and provide for forensic analysis. Offeror/Contractor shall describe which of these security controls are included in the proposed cloud service and how these additional controls would generate a notification to the Commonwealth. Please indicate if any are not used and also if any are used that are not listed below. • File Monitoring controls	

		• Antivirus controls • Cloud Aware IDS/IPS • DLP controls • Forensic controls • Advanced Persistent Threat (APT) controls	
16	Encryption (ITP-SEC040 CSR-S4)	Commonwealth policy requires the vendor to comply with SEC031, and SEC019 encryption policies and minimum standards with the proposed cloud service. Encryption technical controls are required to protect data in transit and data at rest. Link to SEC031 Encryption Standards Data in Transit Link to SEC019 Protection of Commonwealth Data Offeror/Contractor shall describe what encryption protocols are used to secure data in transit, file uploads or transfers. Offeror/Contractor shall describe what encryption technology is used for data at rest. Describe how those encryption keys are managed. Offeror/Contractor shall describe what encryption technology is used for data backup and recovery. Describe how those encryption keys are managed. If databases are used, describe what level of encryption is applied.	
17	Identity and Access Management (ITP-SEC040 CSR-S5)	Offeror/Contractor must provide technical controls for authenticating users, provisioning and deprovisioning users, identity interaction and nonrepudiation needs for admins, internet users, and internal users. Offeror/Contractor must describe reporting and audit mechanism for new staff, access changes, and deprovisioning of Offeror/Contractor staff. Offeror/Contractor must support use of Commonwealth Authentication services and Commonwealth Multi-Factor Authentication services.	

		If cloud service is accessed by Commonwealth employees, Offeror/Contractor shall indicate if they can support Microsoft Azure Active Directory (AAD) or integration with ADFS. If cloud service is accessed by citizens or business partners, Offeror/Contractor shall indicate if they can support use of Keystone Login. If Offeror/Contractor cannot support use of Commonwealth authentication methods, Offeror/Contractor shall describe the technical controls used for authenticating users, multifactor services, provisioning and deprovisioning users, identity interaction and nonrepudiation needs for admins, internet user, internal users, etc.	
18	Vulnerability Assessment (ITP-SEC040 CSR-S6)	Offeror/Contractor shall conduct third-party independent security/vulnerability assessments on an annual basis. Offeror/Contractor shall describe its vulnerability assessment practices for the proposed cloud service and indicate how the following requirements will be addressed: a) Offeror/Contractor shall ensure cloud hosted application(s) are securely coded, vetted, and scanned. b) Offeror/Contractor shall conduct quarterly vulnerability assessments, or sooner if due to compliance regulations or other requirements, or upon a major change to the solution. c) Offeror/Contractor shall conduct a vulnerability assessment on an annual basis during the term of the contract and shall provide a copy of the results to the Commonwealth. (Refer to ITP-SEC021 and ITP-SEC023 for guidance) d) Offeror/Contractor shall be able to identify and validate vulnerabilities required for remediation and provide a mitigation plan and timeline to the Commonwealth. e) Offeror/Contractor shall ensure patching is up to date.	

19	Data Protection Recovery (ITP-SEC040 CSR-S7)	Offeror/Contractor shall provide a business continuity plan that addresses the following (indicate N/A if not applicable to the proposed cloud service and/or if customer responsibility): ○ Data / Database Recovery ○ Application Recovery ○ Operating System Recovery ○ Infrastructure Recovery Offeror/Contractor shall describe its capability to do a complete restoration in the event of a disaster. Offeror/Contractor shall describe what tests are performed as part of its disaster recovery plan. Offeror/Contractor shall describe its capability to provide services during a pandemic event.	
20	Compliance (ITP-SEC040 CSR-S8)	Offeror/Contractor shall describe its capability to meet compliance requirements if the proposed cloud service is subject to any regulations. At minimum, all offerings shall meet Commonwealth ITP requirements and NIST Moderate Level security controls specified in the Federal Information Processing Standards (FIPS) and Special Publications (SPs). NIST control enhancements shall also apply unless specified otherwise. The agency reserves the right to upgrade the NIST control level. The agency also reserves the right to mandate additional regulations or standards such as HIPAA, PCI, IRS, CMs/ARS, etc.	
21	Security Incident Handling (ITP-SEC040 CSR-S9)	Offeror/Contractor shall agree to monitor, prevent, and deter unauthorized system access as per the requirements outlined below and per the Requirement for Non-Commonwealth Hosted Applications/Services. Offeror/Contractor shall provide a copy of its customer facing Incident Response Plan (IRP). IRP should include incident handling practices, severity classification levels, customer	

		notification and escalation processes, expected timeframes from time of impact to resolution, etc. The Commonwealth will provide escalation contacts and resource account to be used for notification purposes.	
22	Inventory (ITP-SEC040 CSR-S10)	Offeror/Contractor shall describe how it maintains a complete, accurate, and up-to-date asset inventory of all resources involved in the proposed cloud service. Offeror/Contractor shall provide a detailed asset inventory list, including country of origin, that will be used for the proposed cloud service offering. The Commonwealth reserves the right to prohibit use of certain hardware based on risk. Include manufacturer, model numbers, processors, disk drives, database hardware, data center networking components (routers, switches, etc.), security devices (firewalls, etc.), load balancers, and any other hardware relevant to the delivery of the service. Offeror/Contractor shall provide notice to the Commonwealth for any changes to the asset inventory used to support the cloud service being provided to the Commonwealth that would impact regulatory compliance (refer to REQ#5 Regulatory Compliance Verification)	
23	Capacity (ITP-SEC040 CSR-I4)	Offeror or contractor shall provide capacity data associated with their offering. If metrics were provided by the agency, values should be based on those metrics. If exact numbers are not available, Offeror shall provide the following details: - Typical values for organizations of similar size and type (note any known deviations in the expected PA implementation). - Values for individual transactions and connections (ex: Each connection of type X consumes approximately 200	

		Kbps, or each transaction is approximately 5KB). For each of the above, provide details indicating whether such connections/transactions are batch processes (and expected/recommended intervals and run times) or not.	
24	Data Backup and Recovery (Hosting Terms)	Offeror/Contractor shall take all necessary measures to protect the data including, but not limited to, the backup of the servers on a daily and weekly basis in accordance with industry best practices and encryption techniques in accordance with Commonwealth retention requirements. Offeror/Contractor shall describe its backup and archival process including but not limited to the following: - What is the length of time backups are available? - Do you perform test restores? - What archival backup/restore/versioning is part of the agreement and what actions require any additional service fees? - Explain any shadowing or redundancy you have across multiple datacenters or repositories and if those data repositories are within the US and controlled by the vendor. - Is storage of backup media offsite provided? If so, for how long? - Location of backups and key management and storage for any backup encryption keys.	